Maternal and Child Health Services Title V Block Grant

Puerto Rico

FY 2016 Application/
FY 2014 Annual Report
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I. General Requirements

I.A. Letter of Transmittal

I.B. Face Sheet
The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications
The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA’s request.

I.D. Table of Contents
This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary
II. Components of the Application/Annual Report

II.A. Overview of the State

The needs and health status of populations must be understood within the macro-level context within which the lives of people and public health actions are embedded in a given historical period. Context includes social and economic conditions, demographics, government structure, education and health care system, among other factors.

Puerto Rico (PR) is a territory of the US with a Commonwealth status. It is divided in 78 jurisdictions known as municipalities, each headed by a mayor who is elected every four years. Two municipalities – Vieques and Culebra – are offshore smaller islands whose residents travel to the Great Island (PR) in small planes and/or ferry to access secondary and tertiary health care as well as social services.

Every four years, a governor, 28 senators, and 51 House members are elected to serve in the Commonwealth government. A non-voting delegate to the US House of Representatives is also elected. PR has administrative autonomy for internal affairs but subject to US federal laws and regulations: currency, defense, external relations, foreign trade, immigration, commerce and other areas of governance. Puerto Ricans are US citizens, serve in the US military, and contribute to Social Security but since they do not pay federal taxes, they are not eligible to receive the Earned Income Tax Credit, an important source of support for many low-income working families in the US.

The government executive branch (called Central government) is highly centralized with 16 executive departments, each with their own divisions, agencies, bureaus and offices. While municipalities provide services, the Central government is responsible for police and fire protection, education, public health, welfare programs, economic development and other services. Each major state agency is divided into a Central office and Regional offices distributed across the island but none match each other. For example, the Family Department is composed of 10 regions whereas the Health Department has 7 regions.

There are also a number of government-owned corporations (i.e. electric energy and waterworks among others) which are separate legal entities that generate their income and expenses independently.

Health Care System

Historically health care clinics and hospitals that served low-income populations were owned and administered by the PR government under the Department of Health. In early 1990’s a Health Care Reform known as the Reforma (The Reform) was launched whereby healthcare was transferred from the government to contracted private insurers to provide health care services on a capitated payment plan. A new public corporation, the PR Health Insurance Administration (PRHIA), was created to oversee the managed care and negotiate contracts with private insurers. The exception to the privatization is the PR Medical Center administered by the Medical Services Administration of the PR Health Department.

In 2010 a second reform was implemented known as Mi Salud (My Health, stands for Integrated Model of Health) that integrates physical and mental health in one facility and expands preventive medicine and screening. It also provides direct access to specialists without need for referral within a Preferred Provider Network.

The Government Health Plan (GHP) is financed by a combination of state, municipal and federal funds (Medicaid and SCHIP). ACA funds (non-recurrent) have been added to the GHP to expand eligibility to those who do not qualify for Medicaid but cannot afford a private plan. Through ACA a number of benefits such as family planning and contraception methods services were added to GHP’s coverage. PRHIA provides health insurance coverage to approximately 1.6 million people and has contracted five health insurance companies to manage its 8 health regions.

Upon examination of mother’s health insurance at the time of birth (Vital Statistics 2014) one can observe that a majority (74.4%) were insured by GHP. Over 90% of adolescent mothers aged 19 and under were GHP insured. This means that most births in PR are paid by the GHP insurance.

Population
Puerto Rico is an area of approximately 3,500 square miles and a population of 3.6 million people, which translates to a 1,055.9 density per square miles. This makes PR the third most densely populated jurisdiction in the US.

Puerto Rico is mainly a Spanish speaking country where the majority of its residents are Puerto Ricans (95.4% in the 2010 Census) followed by other foreign Hispanic ethnic groups like Dominicans and Cubans. Regarding racial composition, 75.8% of people in PR identified themselves as white, 12.4% as black, 7% as some other race, and 3.3% as two or more races in the 2010 US Census.

It must be noted that race is a historically and culturally grounded concept that varies from one society to another. Race taxonomies in PR, contrary to the US polarized white/non-white racial system, are constructed on the basis of phenotype traits such as texture of hair, skin tone, and lip and mouth shape. Thus intermediate categories exist between white and black that are not represented in the US Census. Some examples are: “indio” (literally Indian, light brown and brown skinned with straight hair), “jabao” (fair skinned with kinky hair), and “trigueño” (light to dark brown skinned). According to PR cultural standards, a person is considered white if he/she has light skin color (fair and light brown), relatively thin lips and straight and/or curly hair, regardless of ancestry.

People in PR may also opt to report their race as white (despite skin tone) due to an unstated contempt for everything associated with being dark or black skinned. For example, in PR people make a distinction between “bad hair” (kinky hair linked to being black) and “good hair” (straight hair linked to white and Indio). The euphemism “de color” (literally of color) is commonly used as the word black is seldom used as a direct term of reference. There is also a generalized denial of racial prejudice and discrimination in the island. While it is not possible to explain in depth the manifestation of racism in PR, suffice is to say that it takes a covert form exemplified by sly comments and racial jokes (often seen as harmless) in day-to-day interactions. On an institutional level, dark/black skinned people are underrepresented in the main media outlets and high status positions in both the corporate world and government, according to the PR Civil Rights Commission.

The population living in PR has been decreasing for nearly a decade. The population fell from 3.8 million in 2004 to about 3.6 million in 2013, a decrease of 212,000 people or 5.5% over a 9 year period, according to an analysis of the Federal Reserve Bank of NY. The population under 18 years of age fell by 17% between 2000 and 2010.

There are two main factors linked with population decline in PR. First, the natural population growth continues to decrease due to declining natality and fecundity rates; the latter fell to 1.6 births per women in 2010. Second, the migration of young Puerto Ricans (median age was 29.3 in 2012) and their families to US mainland in search of better job opportunities and living conditions. The number of children between 5 and 18 who left PR has also increased. In 2013 about 18,107 children moved to US compared to 15,462 in year 2012. According to the Secretary of Education, for academic year 2013-2014 about 7,133 students left the public school system to move to US.

Despite these changes, the PRMCA population has remained a sizeable segment of the overall PR population. For 2010, the MCH population represented about 48% of the total population in the island. In 2011 it comprised about 47% of the total population. According to 2013 PRCS estimates the MCA group represents 47.8% of the population.

Education

In practice there are two educational systems prevailing in PR: the public and the private. The public school system serves a majority of the PR children and youth population, mainly from lower and middle class families. Within the private system, there are schools that cater to the wealthy and upper classes while others cater to the middle classes. In PR it is common for middle and low-income working families to “make sacrifices” - as it is commonly said – to send their children to a private school seeking a better education and a safer school environment.

In 2013 there were 1,460 public schools and 764 private schools. Public school K-12 enrollment for the academic year (runs from August through May) 2012-2013 was 458,531 students while 153,187 students were attending private schools, according to data from the PR Education Council. Both educational systems experienced student loss of about 205,000 between 2002 and 2013; the public system lost 154,000 and the private system lost 51,000. The reduction in public school enrollment has led the PR Education Department to make plans for closing down schools with low student enrollment. The potential closing down of schools have resulted in discontent among parents and teachers alike.

Although children and youth aged 21 and under are required by law to attend school, many students do not complete their basic education. In 2012, about 12.6% of 16-19 year olds were high school dropouts; a rate much higher than that of the 5.4% for the US as a whole. Certainly, this poses a problem as a high school diploma is a prerequisite for many entry level jobs as well as for post secondary education. Some of the causes identified for dropping out of school are...
entry-level jobs as well as for post-secondary education. Some of the causes identified for dropping out of school are pregnancy, marriage, getting a job, academic failure, and disciplinary problems.

The 2012 PRCS reports that people 25 years and over with less than high school was 27.4% and those with a high school diploma was 28.8%. Of those 25 years and over with post-secondary education, 21.6% had some college or associate’s degree; 17.6% a bachelor’s degree; and 6.6% a graduate or professional degree.

Pursuing a post-secondary education in PR is occurring against the backdrop of diminishing employment opportunities. For example, in 2012 about 50,000 people attained university and non-university degrees while the projected labor market job offer was about 8,000 jobs of which 25% (1,500) required a post-secondary degree, according the PR Education Council.

Socioeconomic Conditions

While in the latter half of 20th century PR experienced an economic boom it presently faces certain social and economic conditions that impinge upon the well-being of its residents.

Over the last several decades, PR has been experiencing a reduction in employment in both private and public sectors. Between 2004 and 2008 over 100,000 jobs were lost. This trend has been steady and employment has continued to fall. For instance, the number of non-farm workers fell to roughly 909,400 in March 2015, a decrease of 7,200 from the 916,660 during the same month in 2014. The island’s labor force participation stands at 40.3% that contrasts with the 62.7% in the US.

The loss of jobs affects adversely the possibilities for having employment. Unemployment rates among the working age population in PR have almost doubled since 2000 from 10.5% to 18% in 2012. This represents a 71% increase in a twelve-year period.

Behind these numbers lie the impact of the economic crisis on men and women that desperately seek job opportunities in government sponsored “Employment Fairs”. Quite often local news depict large numbers (hundreds and even thousands) of people arriving early in the morning at fair sites awaiting in a long line for an opportunity to be interviewed or submit a resume or fill out an employment form. For example, in an employment fair that took place at the end of 2013, about 1,200 people showed up for 361 jobs announced to be available.

Lack of employment is accompanied by income levels that in PR are still far behind from the rest of the states. The per capita income for PR in the 2012 PRCS was $10,927, compared with the US $27,385. The 2012 PRCS median household income was $19,429 much lower than that of Mississippi ($37,634) the state with the lowest US median household income. In regard to income, ESMIPR (PRAMS-like) 2012 findings reveal that of the mothers who reported their monthly family income, 46.2% had an income of less than $900 a month which translates to less than $10,800 annually.

The adverse effects of the economic crisis are also reflected in an increase of housing foreclosures. According to data from the Office of the Commissioner of Financial Institutions the number of housing foreclosures rose from 14,681 in 2008 to 18,781 in 2012. In the first six months of 2015, 8,799 homes foreclosed and 19,564 homes were in the process of foreclosure. Similarly, home payment delays rose from 2% in 2004 to 16.5% in 2015.

Poverty is a significant problem in PR affecting women, children and families. In a five year period (2005-2010) the percent of children under 18 years of age living in families with incomes below the poverty level increased from 48.8% to 51%. Family structure influences poverty rates as single female-headed families tend to be poorer than married-couple families. While the percent below poverty level in 2010 Census in married-couple families with children was 34.7%, the percent of families heads a female with no husband present incremented twice (68.4%). The difference is significant when we compare with the USA (7% and 37.4%, respectively).

In PR there has been an increasing trend in the proportion of infants born to unwed mothers. For instance, the percentage of children born to unwed mothers rose by 36% between 2000 (49.7%) and 2014 (67.6%). These mothers are most likely to form single-headed families experiencing poverty and an array of life difficulties.

One consequence of high rates of poverty and low-income levels is the need to rely on public assistance programs for survival. In 2010 the average number of beneficiaries of the Nutritional Assistance Program was 1.3 million persons and 484,897 families. In FY 2012-2013 the number of families enrolled in the Nutritional Assistance Program rose to 658,041. The TANF program has also seen an increase in family enrollment. For FY 2012-2013 there were 53,107
The PRM program has also seen an increase in family enrollment. For FY 2012-2013 there were 53,107 families enrolled compared to 52,166 in FY 2011-2012.

Increases in the cost of living further deepen the economic hardships of families by reducing their purchasing power. There was an increase between March 2012 and March 2013 in some specific items: food (1.5%), electricity (11%), transportation (1.9%), health care (2.9%), lodging and housing (2.8%), according to the PR Consumer Price Index. Given these increases the purchasing power of a dollar in March 2013 was 86 cents (PR Department of Labor and Human Resources).

A key issue for families is transportation for working, studying and accessing services. In many PR municipalities, mass transportation is unavailable and people must rely on private transportation services (12 passenger vehicles) called “carros públicos” (public cars) in order to access services. In many areas, these private transportation services are not available after 2 PM or even earlier. Even if families have their own private cars, they may have to drive a long distance from and to their homes to receive services. To cover gaps in transport, there are municipalities that provide transportation mainly to the Greater Metropolitan Area to people in need of specialized health services.

While mass public transportation in San Juan municipality, - capital of PR - is available, there are limitations as the waiting time in some routes can be anywhere between one to two hours or even more. Presently, some routes have been eliminated thus reducing people’s ability to move from one place to another. The Urban Train (covers two municipalities – San Juan and Bayamón) lacks sufficient connecting buses to and from its 16 stations.

Like families, the PR government has been experiencing severe economic difficulties for almost a decade. The government debt amounts to over $70 billion, its bonds have been downgraded, and it lacks sufficient liquidity to operate and meet its obligations.

According to the Commonwealth of Puerto Rico Quarterly Report of May 2015, the fiscal stability of the government health plan (GHP) is one of the most significant budgetary challenges it faces. The PR Health Insurance Administration owes approximately $140 million in unpaid medical claims and its credit line with the Government Development Bank (GDB) expired in March 2015 and was not renewed. The 11% reductions in Medicare Advantage funding for PR most likely will increase the GHP healthcare costs. Furthermore, upon exhaustion of ACA funds estimated to occur in 2018, could result in higher requirements of Commonwealth funding and/or reductions in benefits and eligibility.

To face these difficulties, the PR government has taken measures to reduce costs and increase revenues. For example, Law 7 of 2010 allowed the government to bypass collective bargaining and existing labor laws when laying-off public workers. This led to permanent lay-offs of about 30,000 public workers affecting all public state agencies and services. Three years later (2013) the government passed a law that increased employees’ contributions and retirement age. These changes led an unspecified number of Central government public workers - with ample experience - to hasten their retirement. In early 2015 the government imposed the petroleum-products tax which raised the gasoline price by nearly 16 cents a gallon.

Since the sales tax system (IVU in Spanish) does not meet revenue expectations of the PR government, Law 72-2015 was recently passed that increases the sales tax from 7% to 11.5% (excludes tuition, health plans/services, utilities and raw/semi-processed foods bought in grocery stores). Another measure being contemplated by the Commonwealth is budget cuts across agencies and funds provided to non-profit NGO’s. Increases in the tax sales and proposed budget cuts have caused great concern among diverse sectors due to the potential negative impact on services, familial budget, employment (potential lay-offs), and increases in small business closings.

Alongside economic difficulties, PR is plagued with social maladies which affect adversely the quality of life of its residents: robberies, assaults, drug abuse, street drug selling/buying, low-income housing shortage, homelessness, violence, apathy, distrust, erosion of social relations and the closing down of small businesses in urban centers in many municipalities. In fact, concerns for these issues have been brought up in dialogues undertaken by PRMCA with staff, youth, and families.

PR society strengths

The people of PR despite economic hardships and stressful social conditions have strengths and resiliency seldom publicly recognized.

Culturally, great value is placed on seeking a post-secondary education to better one’s life which accounts for the skilled or semi-skilled labor force that has been and still is sought after in the US for its capacity to work. There are
about 49 accredited (licensed) higher education institutions including three private schools of Medicine. The UPR (founded in 1963) is the most prestigious higher-education institution with 11 campuses island-wide including the Medical Sciences Campus with the leading School of Medicine and the School of Public Health. There are also a large number of technological institutions that provide a wide range of post-secondary degrees to those seeking short-term careers.

There are also NGO’s such as Sor Isolina Ferré Centers and Nuestra Escuela (Our School) that has been successful in providing alternative education to school drop outs to attain a high school diploma. In this respect, PRMCA Nurse Home Visiting Program strongly supports pregnant and mothers adolescent participants to stay in and complete high school and even continue a post-secondary education. With proper support those facing life difficulties will have the resolve to gain an education.

In PR, most of the activities of women and families revolve around kinship and neighborhood networks. In general, relations among neighbors in low-income communities are highly personal and reciprocal despite any internal conflicts. This is most evident in times of crisis, deaths, fires and other emergencies. “La gente de mi barrio” (people of one’s neighborhood/community) is an expression that manifests a strong sense of belonging. It is worth noting that youth participants in the PRMCA school-based Youth Promoters Programs enjoy helping others and feel great pride in the work they do in the school and community settings. Definitively, mutual help and reciprocity is still an important cultural value despite an erosion of social relations.

Extended families ties (kinship) provide emotional and financial support (may include housing) to women and children as resources are pooled, borrowed and shared. Grandparents (as well as other kin) are very influential in parent’s and children’s lives. In PR culture, for example, it is common for grandparents to provide unpaid childcare to working mothers and/or at times of need. Grandparents also enjoy greatly taking their grandchildren out and having them stay in their homes overnight.

In PR, there is a wide variety of informal and formal organizations (about 11,000 formal non-profits) in communities and municipalities geared to improve life through cultural promotion (arts, music, dance), neighborhood revitalization, environmental protection, youth development, and community development (may include micro enterprises, health promotion and community/home vegetable gardens). There are also a number of NGO’s aimed at analyzing, researching and finding solutions to the prevailing economic, legal, and social conditions. A strong and economically sound cooperative movement is another important asset in PR society.

All together, these societal assets make up the tapestry of social capital in PR society that can be tapped for the creation of safer and healthier environments.

Implications of the macro-context for PRMCA

The issues highlighted in this overview illustrate that at this historical time PR society is experiencing a myriad of conditions that impact the life and health trajectories of populations that start before birth and continues throughout life.

Some of the issues relate to the Social Determinants of Health (SDH) which are “conditions in which people are born, grow, live, work, and age, including the health system” (WHO) that affect health outcomes. First, social disadvantage is significant for women and children; it means lacking sufficient funds (money), food insecurity, low education, poorer health, discrimination and the stigma attached to being poor. Moreover, as has been noted by experts, middle class families may be experiencing downward mobility due to job loss and/or high cost of living. Most likely, more people will be in dire need for services having an impact on public health, health care and social welfare.

Second, health disparities in PR are closely linked with socioeconomic position. Historically, the lower-income sectors have faced social and economic disadvantage, deteriorated physical environments, substandard housing units, prejudice/stigma, and relocation of entire communities due to urban renewal. Low-income populations residing/living in rural areas and/or municipalities fairly distant from main urban centers and the Greater Metropolitan area also experience geographic disparities in accessing health care. Very limited transportation hinders access to and/or continuity of health care. Besides transportation, access to health care services is limited due to the shortage of specialists and facilities as these concentrate in certain major municipalities, particularly the Greater Metropolitan Area. Indeed, insufficiency of pediatric services was of great concern for families and professionals involved in PRMCA dialogues. In municipalities where these services are available, these can be very limited, for example, the specialist may see patients once or twice a week only.

Third, social exclusion mentioned earlier plays great stress on women’s and children’s lives. For instance, the networks
Third, social maladies mentioned earlier, place great stress on women’s and children’s lives. For instance, the analysis of PRFMIR (2010) on 38 cases of I&M in two health regions reveals that almost half of the women faced social problems such as violence (domestic and community violence), food insecurity, unemployment and little or no money to pay for basic services. An unsafe environment may affect parents’ choices to let children engage in physical activity in public places or even play outside the home. This is the case of parents consulted in a PRMCA dialogue that despite awareness of childhood obesity, prefer to let their children play video games in order to protect them from criminal activity and street shootings.

Given the prevailing macro-contextual conditions, it is of utmost importance for PRMCA to enhance its efforts on health promotion across life course stages. This means that PRMCA must necessarily work towards maximizing protective factors in order to foster a healthy population both at a single time and over time. This has been and will continue to be done through three interconnected levels of action: health education, public policy and collaborative networks.

At the health education level, a three-tier approach is in place: 1) Information and education to families and the public about health issues, services, and health rights through print materials, media campaigns, workshops, presentations, trainings, group work and one-on-one education; 2) Training and education to service providers from diverse professional fields (e.g. education, social and health) about maternal, child and youth health including public policies; 3) Training and education to PRMCA staff on all aspects that are important to work with communities, families and populations.

At the public policy level, PRMCA will strengthen the promotion of existing public policies and legislation that protect the health of women, children and youth in PR. For example, promote Pediatric Preventive Health Guidelines a theme that recurred in PRMCA dialogues. According to stakeholders, lack of preventive pediatric care is largely due to common views among parents and physicians alike that one only takes a child when he/she is sick. Another example is the promotion of Administrative Order 336 that requires hospitals to establish breastfeeding programs.

In terms of legislation, promote two important laws: 1) Law 79 that mandates informed consent to provide human milk substitutes in maternity service centers and, 2) Law 156 that assures the right for newborn in-rooming and the presence of a support person during labor.

Since stakeholders have been pointing out the need to establish guides for preventive care for women, PRMCA will develop and promote a Reproductive-Age Women’s Preventive Health Guidelines. In so doing, it will contribute not only to improve women’s health but also empower them to take more control over their health and, as stated by stakeholders overcome “fear” to ask questions and demand tests.

At the network level, promoting health across domains cannot be done single-handedly but in collaboration with a broad base of organizations, groups, and agencies within and beyond the health field. Collaborations with programs and organizations include health education workshops, cross-agency professional trainings, participation in committees and/or alliances, information sharing, referrals, and coordination of services and activities. Through existing PRMCA sponsored committees leadership has been provided for improving health among populations: Breastfeeding Committee, FMIR, COIIN, Healthy Start Consortium, ECCS Committee and Title V Regional Boards. The Regional Boards (one in each of the seven Health Regions) are composed of representatives from government and non-government entities that meet regularly to address maternal, child and adolescent health issues.

Nevertheless, to address health needs more effectively, PRMCA will both enhance its ties with existing partners and expand its networks to include non-traditional partners like the Recreation and Sports Department and grass-roots organizations working in the areas of youth and community development. This means building stronger networks based not only on data, skills and resource sharing, but very importantly and processes and relationships to enable work with a diversity of stakeholders across sectors. It also entails focusing on the strengths of PRMCA, partners, families, youth and communities rather than emphasizing deficits.

Work at these three levels will contribute much to heighten PRMCA leadership towards a more integrated public health agenda through which to create a healthier environment amidst difficult times.
II.B. Five Year Needs Assessment Summary

II.B.1. Process

The PR Maternal, Child and Adolescent Health Division (MCAH) and the Children with Special Health Care Needs Program (CSHCN) are essential public health programs that provide and advocate for services for over 46% of the PR population. Given the particularities of CSHCN, PR used a separate process for the needs assessment of the general MCAH and CSHCN populations and system capacity analysis.

MCAH

The HNA 2015 goals were:

1. Determine PR priority health needs for the MCAH populations.
2. Enhance stakeholders’ participation in all aspects of the needs assessment.
3. Improve health outcomes for the MCAH populations.
4. Strengthen partnerships with agencies and organizations working for the wellbeing of MCAH populations and families.

A Workgroup - composed of EMRSDS researchers (Demographer/SSDI Coordinator, Biostatistician, Reproductive Health Epidemiologist, Pediatric Epidemiologist, Health Program Evaluator, and Cultural Anthropologist), Pediatric Consultant, MCAH Director and other key staff - was set up to devise the framework, strategies, and methodologies.

MCAH used a four phase framework to determine priority needs, assess resources, and establish outcomes and performance measures.

1. **MCAH populations Needs Assessment.** On-going data collection and analysis, research and MCAH document program review formed the basis for obtaining potential priorities.
2. **System Capacity Assessment.** Assessed the state/local actions, services and programs by pyramid levels for each domain and MCAH strengths and challenges related to the core functions.
3. **Setting potential priorities.** Narrowed potential needs priorities, matched them to capacity, set targets, identified actions and allocated resources. A Stakeholders Meeting was held to discuss and narrow 73 identified potential priorities. Using the Needs Prioritization Method Instrument, stakeholders came up with 10 priorities. Based on stakeholders’ input, MCAH selected final priority needs, set national and state performance measures.
4. **Development of the action plan.** Identification of several measures and annual objectives, strategies and resources to establish a workable action plan.

Quantitative and qualitative methods were used to gather and analyze data on the needs, strengths and health status of populations.

The statistical methods included percentages and rates of health indicators, odd ratios and trend analysis. Trend analysis was performed for the indicators that represent the identified needs such as mortality rates by age group, birth rates, prenatal care, LBW and very low birth weight and unintentional injuries, among others. For those needs that were not represented by a specific indicator, a trend analysis was made using indicators that were related to such identified needs.

Population-based data from PR Vital Statistics (VS) was collected. Data from public and NGO agencies/programs providing services to MCAH populations on morbidity, lifestyle, screening and risk factors was also sought. Research, surveillance systems and surveys used were: PR Community Survey, Monitoring the Future, PR Maternal Infant Health Survey, Perinatal Period of Risk, 2007-2010, IMIHS by Municipality, Asthma Surveillance System, YBRFSS, BRFSS, and PR STDs Surveillance System.

Data from a sample of 500 clients of the Federally Qualified Health Centers (FQHC) across PR- through a Needs Assessment Questionnaire - was obtained and analyzed. We also surveyed MCAH Regional Board Members and
physicians/pediatricians that participated in the PR Annual Convention Meeting of the PR College of Physicians and Surgeons.

Qualitative data collection methods and sources used were: 1) Dialogues with four types of stakeholders: MCAH staff, families from the HV Program Consumer Committees, parents serving on the Policy Council of the Administration for the Integral Development of Children and youth leaders. 2) Dialogues with male youth on masculinity and parenthood and: 4) Interviews with staff and HVP participants that completed the program.

The input and suggested actions offered by stakeholders were critical to better grasp health issues, service needs, barriers and system capacity. Their input enabled us to set priorities, assess available resources and determine the best strategies to meet needs.

CSIHCN

The goal of the Needs Assessment process focused on identifying, through a collaborative effort with families and other stakeholders, a set of specific priorities that will guide the work of the CSIHCN Program and the use of Title V resources to meet these priorities through state/local partnerships and collaboration so that results are achievable and evident in the next five years. CSIHCN outcome measures formed the basis for the assessment framework. This outcome approach allowed us to see their collective relevancy and utility in improving the health status of the CSIHCN population in PR. The method used to assess the strengths and needs of the CSIHCN population consisted of developing prioritization criteria, data analysis and presentation, identification of needs, and setting priorities among the identified needs.

Direct input from families and other stakeholders enriched and strengthened the content and validity of the CSIHCN Five-Year Needs Assessment Process. Thirty-nine (39) families and 21 representatives of agencies, academy and community based organizations participated in the focus groups to collect qualitative data. The groups were carried out with the purpose of learning about the community opinions and perspectives on CSIHCN health care needs, as well as the capacity of the health care system to address those needs. The groups were guided by 8 questions about CSIHCN and their families' health needs, barriers, family participation in healthcare, care coordination, health plan coverage, transition to adult health care, and accessibility to resources in the community.

Data sources

Qualitative data was obtained through focus groups conducted during the months of January-May 2014. A total of eight (8) focus groups were carried out with participation of diverse stakeholders, including CSIHCN families, youth with special health care needs and public, academic and community-based organizations. Three of the focus groups were carried out in Ponce, Mayagüez and Bayamón RPCs, respectively; one group in the Down Syndrome Foundation facilities, two groups in APNI (Parent training and Information Center), and two groups in the central offices of the PRDOH.

Data for PR is not available from the National Survey of Children with Special Health Care Needs (NSCSHCN) or the National Survey of Children’s Health (NSCH). The PR Survey of Children with Special Health Care Needs (PRS-CSHCN) conducted in 2009 provided the first state-level data regarding prevalence estimates of CYSHCN, types of services they need and use, characteristics of the systems of care, health care coverage estimates and other data related to CYSHCN NPMs for PR. The PRS-CSHCN was conducted as a module similar to the SLAITS from April through June 2009. The study used a revised and adapted Spanish version of the questionnaire used in the 2005-2006 NSCSHCN. Data from the 2009 PRS-CSHCN was used to inform the 2015 Needs Assessment for the CSIHCN domain as data from the 2015 PRS-CSHCN is not yet available. Other quantitative data sources included 2014 Part C and Part B IDEA Child Counts and the PR Birth Defects Surveillance and Prevention 2014 Annual Report.

The 2015 PRS-CSHCN is currently in progress. A revised and adapted Spanish version of the questionnaire
used in the 2009-2010 NSCSHCN is being used. The study uses a stratified probabilistic sample representative of the seven health regions and the Island of Puerto Rico and is divided in two phases. In Phase 1, a sample of 1,000 household telephones was selected to estimate CSHCN prevalence, obtain preliminary demographic and geographic characteristics and complete the questionnaire from households with children that qualified as with special needs according to the screening questions. Information from the number of households with children in PR was obtained from the 2010 Census. Phase I was completed on April 2015 and the data was used to inform the 2015 Needs Assessment. Phase II consists of 750 detailed interviews for CSHCN. As of June, 2015, a total of 506 interviews have been completed.

II.B.2. Findings

CSHCN

Access to health care services: There is a limitation in specialty services for the pediatric population. Services are fragmented which affects the continuity of care. Families identified delays in getting appointments for specialists and bureaucratic and slow administrative processes to get referrals and approvals. Most specialized services are located in the San Juan Metropolitan region and families that live in the West and South regions need to travel long distances to get the services. Office hours are usually limited, 8 AM- 4 PM, which creates a conflict for families that work during the day. Mothers need to quit their jobs to care for their children resulting in an economic hardship for the family. Families also expressed difficulties in obtaining assistive technology and orthopedic equipment. In many cases, they have to pay high deductibles or pay the total cost out of their pockets. They also shared that the process is tedious and slow and many times when the equipment arrived the child has outgrown it.

Health care providers’ knowledge about special health conditions and services: Families expressed that physicians and allied health professionals lack of knowledge of specific health conditions and needs, as for example, inborn errors of metabolism. They link this issue to delays and errors in treatments. It is important for the families that physicians explain to them the child’s diagnosis, management, treatment, and consequences of not following the treatment.

Care Coordination: Families and providers identified an urgent need to improve communication and coordination between government agencies so that they obtain needed services for their children. Most of the time, families need to arrange or coordinate services by themselves. Frequently, they need to file complaints in order to obtain the services, laboratories and medications for their children.

Psychological and emotional support for CSHCN and their families: Families reported that services are focused on the child without considering the family needs for psychological and emotional support to cope and manage their child with special needs. On the other hand, in some cases, children are referred to mental health clinics that only treat adults.

Health insurance coverage: Families are facing difficulties enrolling and maintaining their CSHCN in the Special Coverage Registry under Mi Salud. For some diagnoses they need to re-enroll every six months. Approval processes for specialized studies is a slow and bureaucratic process. Private health insurance limits the number of therapies covered. This issue was not reported by the beneficiaries of the Mi Salud Special Coverage. The health insurance case manager is a key person in obtaining needed services but families report having found that they often lack knowledge on special health conditions, needs and equipment. In some cases, the health insurance determines the medication without considering secondary effects. Therefore, physicians need to do extra work to document the need for a specific medication.
**Family-centered care:** Families feel they are considered in the health care process and decision making but in a limited manner. They call for more empathy and sensibility from the physicians, allied health professionals and agency employees that provide services for their children.

**Transition to adult life:** Youth and their families see the transition process as a change in routine care and interruptions in services. PCP usually does not prepare and plan with youth or their families for the transition. Mi Sahid ends the Special Coverage once youth attain 21 years of age. The Vocational Rehabilitation Administration is the only government agency that provides transition (work study) services to youth with special needs that are eligible under their regulations.

**Children with Special Health Care Needs Registry:** Agency representatives proposed the development of a unique CSHCN data registry as an option to control duplicity of services and to facilitate coordination of services and follow-up of CSHCN families. The registry can also provide data about CSHCN conditions and needs.

### II.B.2.a. MCH Population Needs

#### MCAH

**Women/Maternal Health**

Health and wellbeing before, during and after pregnancy is crucial to women and their families. The survey conducted in FQHC revealed that issues mostly affecting WRA in communities were overweight and obesity (43.1%), lack of physical activity (33.5%), inadequate nutrition (23.2%), depression and other mental conditions (16.7%) and diabetes (14.7%). While shaped by socio-cultural factors, these conditions require changes in attitudes and habits that can be addressed during a preventive medical visit. According to PR BRFSS, by 2013 around 73% of women had a past year preventive health care visit, a 1.2% increase since 2009 (72.4%).

Proper guidelines aid health care providers for optimum preventive medical visits in WRA for early detection of conditions and risky behaviors, early initiation of treatment, and promotion of healthy lifestyles. They also provide specific strategies to improve WRA preconception and interconception health care, that lessens the incidence of chronic diseases that complicate pregnancy and adversely affect birth outcomes and maternal health and morbidity. Thus, PR Healthy People Objectives (PR HPOs) aim to increase by 10% the proportion of women delivering a live birth who received preconception care services and practiced key recommended preconception health behaviors. It is crucial for MCAH to develop and promote Preventive Health Services Guidelines for Women in Reproductive Age (PHSHWRA) for PR. This will require the collaboration of experts in women’s health from other PRDOH programs, medical professional organizations and medical faculty from medical schools.

The PNC visit is important for the early identification of high risk pregnancies for early interventions to protect the outcome of the mother and infant. According to respondents of the FQHC survey, the principal problems that affected pregnant women in their communities were: not visiting the health care provider once they knew of their pregnancy (42.1%), inadequate nutrition (39.3%), not seeking education or guidance during pregnancy (30.8%), cigarette consumption (20.4%) and alcohol consumption (12.9%). The strength of the MCAH program is the outreach work of the HVP, identifying high risk pregnancy and making referrals to early prenatal care services. The PRDOH Guidelines for Preventive Perinatal Services are also assets for optimum prenatal health care.

PNC in PR has improved over the years (Figure 1). By 2014, VS data shows that about 86% of live births in PR, their mothers initiated PNC during the first trimester of pregnancy. An age-linked disparity is observed with 78% of women in the 10-19 age range versus 80.8% women 20 years or older initiating PNC during their first trimester of pregnancy. To address this issue, the HVNs verify that the PNC offered to adolescent pregnant participants follow the PRDOH Guidelines for Preventive Perinatal Services. The MCAH Program staff also offers a prenatal course that covers important health issues related to the prenatal, postpartum and pre and interconceptional stages. These are strengths of our MCAH HVP.

Improvement in early PNC in PR has influenced improved birth outcomes (Figures 2-4). By 2014, about 11% of births were low birth weight (LBW). AAPC shows a significant decrease of 1.8% since 2005 (12.8%). If LBW births are...
stratified by weight it is observed that very low birth weight births follow a stationary tendency (1.4%), while intermediate low birth weight births dropped significantly to 9.3% in 2014 when compared to 2005 (11.4%).

Prematurity has also improved significantly in PR since the last HNA (Figures 5-7). Overall, premature birth dropped to 15.1% by 2014, with a significant reduction of 1.6% since 2005 (17.9%). The more significant decrease (3.5%) can be observed during the late preterm period with 10.8% of births by 2014, reaching the PR HPO’s that aim to reduce late premature births to 12.1% by 2020. MCAH participation in PR CoIN for infant mortality reduction allows leading and collaborating in the strategies selected. As part of CoIN’s strategies, the reevaluation of PNC guidelines for PR will be included in the Preventive Health Services Guidelines for WRA to be developed. These guidelines will enable Ob/Gyn’s to identify pregnant women with a previous premature birth and refer them for treatment with 17P hydroxyprogesterone. These guidelines will empower pregnant women of what to expect and require in PNC. The MCAH Program will continue educating women about the signs and symptoms of premature birth and raising awareness about the benefits of waiting until 39 weeks of gestation.

C-section rates in PR have been higher than those in mainland. The exponential increase of the use of this method began in 1995, just when the Health Care Reform was established in PR. Since then C-section rates have kept rising (Figure 8). An aim of PR 2020 HPO’s is to reduce cesarean births among low-risk women to 39.9%. AAPP trend analysis (Figure 9) shows a significant reduction of 1.1% from 2005 (46.6%) to 2014 (41.3%). Yet, there is much work to do in order to achieve PR HPO’s. During 2013, with the aid of the PR Association of Hospitals, March of Dimes PR Prematurity Taskforce (PRPT) collected data on the implementation of the Hard Stop (HS) policy and the decrease of early elective deliveries (EED’s) in PR. The MCAH Program actively participated with PRPT to identify those hospitals that successfully implemented the HS policy and decreased EED’s. Since this strategy was successful, the implementation of the HS policy as part of a requirement in all PR birthing facilities will be one of the CoIN’s strategies to reduce infant mortality. This should have an effect over C-section’s among low-risk women and elective inductions that end in a C-section.

Maternal mortality is one of the basic health indicators that reflect the nation’s health status. Reports based on death certificates usually underestimate maternal deaths as the actual numbers are two to three times greater. Maternal mortality in PR varies greatly between years (Figure 10). However an AAPP trend analysis shows that it is significantly decreasing. Nine out of 100,000 women who had a delivery during 2014 died due to pregnancy, childbirth and puerperium complications. AAPP analysis showed a significant reduction of 27% since 2005 (9.9/100,000 live births). It is necessary to properly identify the reasons why women are hospitalized during pregnancy and postpartum period. This will facilitate the development of strategies for the reduction of maternal mortality in PR. There is a need to reevaluate the Maternal Death Review Advisory Committee and advocate that a MCAH proposed bill for the legal establishment of the MDR Advisory Committee in PR is sent to and approved by the Legislators. This bill will provide the MDR with a legal tool for the evaluation of data pertaining to maternal care in private Ob-Gyn offices needed for a complete review.

Perinatal/Infant Health

According to respondents of the FQHC survey, the principal problems that affected infants in their communities were: infant abuse/negligence (53.6%), lack of immunization (29%), finding vaccines that are needed (25%), accidents (22%) and mother support for breastfeeding (19%).

The number of infants who die before the first birthday is a sentinel indicator not only of health conditions but also of the socioeconomic conditions of a community or nation. That is why PR HPO’s sets that infant mortality in PR must be 7.2/1,000 per live births or less by 2020. While not statistically significant, infant mortality is falling in PR (Figure 11) and reached PR HPO’s. AAPP show a reduction of 2.9% since 2005 (7.0/1,000 per live births vs. 9.2/1,000 per live births).

Preterm related causes (24.6%) are the first cause of infant mortality in 2014, followed by congenital anomalies (10.4%) and diseases of the circulatory system (2.9%). Most infant deaths occur during the neonatal period (Figure 12). For 2014, this rate is 4.8/1,000 per live births, this reflects a 3% reduction since 2005 (6.6/1,000 per live births). Sudden infant deaths and infant deaths due to accidents are very few in PR (Figures 13-14) thus they are not major contributors to infant deaths.

While neonatal deaths are associated with events surrounding the pregnancy and delivery, the posneonatal deaths are more likely associated with conditions or events that arise after delivery and discharge of the baby from the hospital. By 2014 posneonatal mortality decreased to 2/1,000 per live births.
To better understand infant mortality, the PR MCAH Program established the Fetal and Infant Mortality Review (FIMR) in 2006. Case reviews began during 2009, focusing on the health regions with higher infant mortality rates, Mayaguez and Ponce. FIMR made recommendations regarding nutrition, prenatal care, preconception care, support system, hospitals services and education. Some have been implemented; others will require further follow up and strengthening of the Community Action Committees. The FIMR requires a revision of the protocol and actualization. One challenge is to maintain active participation and involvement of members in the FIMR and in the Community Action Committees. Another challenge is the development of a bill for the legal establishment of the FIMR - a legal tool to evaluate data pertaining to maternal care in the private Ob-Gyn offices necessary for a complete review. Aiming at reducing infant mortality rates in PR, the FIMR recommendations are disseminated to relevant agencies and stakeholders.

The outcome of high risk births is shaped by an institution’s capacity to handle complications. With the purpose to identifying accurately where these births were taking place in PR, the MCAH Program established a Perinatal Care Guidelines Review Committee (PCGRC) in 2007 geared to adapt the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists Guidelines for Perinatal Care, in order to classify the hospitals that offer perinatal services Island wide. By 2008 a classification of these birthing facilities was performed. In 2011 the PCGRC revised these guidelines. Another classification of the perinatal facilities was performed in birthing facilities around the Island in 2012. Based on the revised PCGRC, of the 35 birthing hospitals evaluated, 20% were identified as basic perinatal services, 42.9% as specialized and 37.1% as subspecialized (34.3% IIIA and 2.9% IIIB). When compared to 2008 data (27.3%), subspecialized facilities increased 35.9%. Using this most recent classification, 2014 VS preliminary data reveals that 68.9% of all VLBW were born at facilities adequately prepared to manage high-risk deliveries and neonates. One of the challenges to decrease infant mortality in PR, for which the MCAH program is a strong advocate and collaborator, is the implementation of these guidelines as part of all birthing hospital’s requirement for perinatal services as well as the perinatal regionalization.

Breastfeeding haves multiple benefits for the mother and the infant. According to ESMIPR (2002 to 2012), immediate postpartum breastfeeding increased 33% since 2002 (54.3% vs. 72.3%), infants breastfed until six months rose 61.2% (20.4% vs. 32.9%) and infants breastfed until twelve months increased 164% (8.5% vs. 22.4%). Exclusive breastfeeding at 6 months reached 18%. Challenges to establishing breastfeeding in PR include the non-existence of Baby Friendly (BFH) birthing hospitals with the ten steps proven to promote breastfeeding. To overcome this limitation, making changes in newborn feeding routine in hospitals and adoption of the 10 steps toward a BFH is a top priority of the MCAH led EPC. One strategy developed is an administrative order requiring hospitals a lactation support program and compliance with all the laws that protect and support breastfeeding in PR. Another strategy is to offer workshops to hospitals on the administrative order and ways to comply with it. Also, posters and brochures on current laws about women’s and infants breastfeeding rights were distributed in all birthing facilities. Breastfeeding is further promoted in communities by the HVN’s. Collaboration of other agencies such as WIC in breastfeeding education has also been successful.

**Child Health**

Improving children’s health and wellbeing is one priority identified in the HNA. To those surveyed in the FQHC the most common problems affecting children in their communities were: child abuse/neglect (33.1%), bullying (30.2%), finding appointments with specialists (29.0%), learning problems (24.6%) and cavities and gum diseases (12.3%). Another issue mentioned was overweight children (9.2%). Some of these needs reflect the statistical findings of the common conditions prevailing in this population. Mortality rates among children 1 to 9 years (VS) have decreased from 15.0 in 2005 to 11.1/100,000 in 2014, a drop of 0.7% (Figure 16). During 2011-2012 about 59% of children 1 to 9 years had an updated and complete schedule of immunization (PRIP) (Figure 17). The obesity and overweight prevalence in children aged 2-5 (WTC Data) fell by 28% between 2005 (40.3%) and 2013 (32.3%) (Figure 18). Mortality rates due to unintentional injuries in children 1 to 9 years decreased 9.9%, from 2.4 in 2005 to 0.6/100,000, in 2014 (VS) (Figure 19). Hospitalization rates due to unintentional injuries in children 1 to 14 years decreased 5.5% from 548.1 in 2005 to 254.6/100,000 in 2013 (VS) (Figure 20). ER visits due to unintentional injuries in children 1 to 14 years rose to 7.5% from 8,998.7 in 2010 to 15,217.1/100,000 in 2013 (Figure 21).

In a survey among physicians who provide service to the pediatric population the following barriers to optimum pediatric health care for 0 to 12 year olds were identified: parents’ misuse of emergency rooms for outpatient care (69%), limited access of sub-specialists to refer pediatric patients (65%), limited access to resources to refer patients with suspected abuse (60%), lack of parental knowledge of the need for preventive visits (58%). They also reported as barriers for 1 to 4 y/o misinformation that keep parents from immunizing their children (55%), and for 5 to 12 y/o limited access to resources for mental health service referral (64%).

Data from ICO related to the 10 most common diagnostic codes on health care bills (GHP and Private Insurance Plans)
Data from ICD related to the 10 most common diagnostic codes on health care bills (public and private insurance plans) showed that only 44,023 (7.5%) visits at medical office were claimed during 2013 for preventive visits in children aged 1 to 9 years.

Data from Head Start Program shows that about 16% of children have conduct problems and attention deficit disorder, 2.3% are exposed to abuse and neglect and 1.8% are exposed to domestic violence.

The main causes of death in infants less than 1 y/o are preterm related (24.6%) and congenital anomalies (10.4%), in children 1 to 5 y/o are congenital anomalies (19.7%) followed by sepsis (9.7%) and unintentional injuries (9.7%), in children from 6 to 14 y/o are unintentional injuries (13%), malignant neoplasms (16%) and congenital anomalies (10%).

To address these issues, the MCAH Program will continue promoting children’s preventive care and the use of the PR PPHSG. Further efforts will be made to evaluate medical child preventive care services and barriers.

Early identification and management of stress and trauma in early infancy impacts the optimum development and wellbeing of children. The MCAH Program will continue to develop and adopt evidence based strategies to identify and intervene in early childhood psychosocial status and identify early signs of developmental delays for early intervention and referral. The MCAH Program developed the curriculum “Positive Responsible Parenting” to be given in communities. It covers developmental stages, preventive services, unintentional injuries prevention, nurturing skills, pediatric healthcare and overall wellbeing.

Physical activity and adequate nutrition is another key aspect of children’s wellbeing. Since there are no data available on children’s physical activity in PR, PRMCAH Program is working with PR BRFSS to include questions related to this topic in order to monitor this indicator over the next 5 years. Our staff will continue collaborating with organizations and agencies within and outside the PRDOH in educating and developing public policy to reduce the prevalence of childhood obesity in PR as well as promoting the Pediatric Preventive Guidelines.

**Adolescent Health**

Improving adolescent health and wellbeing is another priority identified in the HNA. According to respondents of the FQHC survey, the top conditions that affect adolescents in their communities were: drug, alcohol and tobacco abuse (23.6%), inadequate nutrition (22.6%), not visiting health care providers for physical exams (22.2%), sexual activity at early age (22.0%) and bullying (19.2%). YRBSS data suggested that there was a 10.4% decrease in obesity and overweight prevalence in adolescents 14-17 years: 26.9% in 2005 to 24.1% in 2013 (Figure 21). In terms of mortality, the mortality rates among adolescents 10 to 19 years (VS) fell from 39.3/100,000 in 2005 to 29.9 in 2014, a drop of 23% (Figure 22). The death rate in adolescents 10-19 years due to unintentional injuries was 12.1/100,000 in 2005 and 5.6 in 2014, a decrease of about 6% (Figure 23). Mortality rate due to motor vehicle crashes represents the first cause of deaths due to unintentional injuries among adolescents 15-19 years. This rate decreased 3.3%, from 16.1/100,000 in 2005 to 7.8 in 2014 (Figure 24). The suicide rate among adolescents 15-19 years has shown a slight decrease from 2.0/100,000 in 2005 to 1.9 in 2014 (VS) (Figure 25). However, the rates of suicide attempts are higher. YRBSS data reported that 11.8% of adolescents 14-17 year olds pondered suicide in 2008 compared to 14.3% in 2013 (Figure 26).

During 2012 about 41% of adolescents 10 to 19 years had and updated and complete schedule of immunization (PRIP) compared to 49.4% in 2013 (Figure 27). In 2014, 9% of children and between 6 months and 17 years were vaccinated against seasonal influenza. In the adolescent group aged 13-17 years: 52% received at least one dose of HPV vaccine, 75% received at least one dose of Tdap vaccine and 70% received at least one dose of the meningococcal conjugate vaccine.

Sexually transmitted diseases are another issue affecting the adolescent population. The chlamydia incidence rate for 2005 was 188.9/100,000 and 184.8 in 2014 among adolescents 10 to 19 years (Figure 28). This rate shows a drop of 2.2%. However incidence rates of gonorrhea show an increase of 42%; this rate was 7.6/100,000 in 2005 and 10.8 in 2014 (Figure 29). The incidence rates of primary and secondary syphilis also rose in the period between 2005 and 2014: 2.2/100,000 and 4.2 in respectively (Figure 30). YRBSS data revealed that in 2008, 37.6% of adolescents 14-17 years were sexually active and in 2013 this percent was 29.8%; a drop of 22.3% (Figure 31). The percent of adolescents sexually active before 13 years of age was 8.0% in 2008 and 4.8% in 2013 and the percent of adolescents that have sex with 4 or more sexual partner fell from 8.0% in 2008 to 4.8% in 2013 (Figures 32 and 33).

Alcohol, tobacco and marijuana are the most commonly used substances among the adolescent population in PR. However the use of these substances showed a decrease as YRBSS data shows. Alcohol use among adolescents between 14 to 17 years was 39.0% in 2005 and 25.5% in 2013, a decrease of 34.6%. Tobacco use dropped from 10.5%
between 14 to 17 years was 88.5% in 2005 and 83.5% in 2013, a decrease of 5.0%, tobacco use dropped from 10.5% in 2005 and 3.6% in 2013 and marijuana use rose from 6.8% in 2005 to 4.8% in 2013 (Figure 34).

Data from ICO showed that 25,160 (5.0%) medical office visits were claimed as preventive medical visit in adolescents 10-19 years during 2013. This low percent denotes lack of knowledge of the importance of preventive visits. In a survey with physicians who provide services to the pediatric and adolescent population, the following barriers to optimum pediatric health care in the age range 13-19 years old were mentioned: lack of parental knowledge of the need for preventive visits (68.5%), patients go for medical evaluations only in case of emergency (67.4%), limited access of sub-specialists to refer pediatric patients (62.9%), misuse of emergency rooms for outpatient care by parents (60.7%) and lack of time to make screenings and high risk behaviors tests during visits (59.6%).

To adequately address these issues, the MCAH Program will continue to promote and disseminate the PR PPHSG to health care providers, youth and parents. It will also develop the PR Youth Friendly Health Services Guidelines for health care and services facilities.

**Cross-Cutting/Life Course**

Good oral health is an important protective factor across life course stages linked to the overall health of populations.

It has been found that pregnant women are not receiving the necessary preventive oral health so important for healthy birth outcomes. An analysis of claims (private and GIP) for 2013 from the Insurance Commissioner’s Office (ICO) show that 16.2% of 36,580 women who had a live birth had a dental visit during pregnancy. The 2012 ESMIPR shows that 43.1% of women surveyed (1,728) had received oral health services during pregnancy. One possible contributing factor for these percentages could be the failure of health professionals to give due attention to oral health during pregnancy. For instance, the ESMIPR 2012 reveals that 30.6% of women reported they were advised - before they got pregnant - by a health professional about the importance of visiting a dentist and/or hygienist. Another factor could be dentists’ reluctance to tend to pregnant women due to the risks involved and potential lawsuits. Perhaps, women themselves are unaware of the importance of oral health during pregnancy.

In relation to reproductive age women, BRFSS 2010 data by age group show that younger women age 24 and younger are more likely to visit a dentist and/or hygienist. The percent of women who visited a dentist, dental hygienist or dental clinic within the past year was higher for the 18-24 age groups (82.6%) than the 25-44 age group (76.8%). The data also shows that 82.6% of the younger women (18-24 years) and 74.8% of the older group (25-44 years) had their teeth cleaned by dentist or dental hygienist within the past year.

The percentage of adolescents of both sexes who had a preventive dental visit has remained relatively the same between 2012 (47.3% of 521,058 youth) and 2013 (47.4% of 503,974 youth) according to data provided by ICO.

Dental caries is a major problem for children. The Head Start reported dental cavities as a top prevalent health condition among their participants: 13.4% in 2013 and 14.3% in 2014. According to Head Start representatives in Title V Boards, the problem with caries is due largely to children’s intake of sugary foods and failure of parents to take their children to see a dentist. They also pointed out that parents need to become aware of the importance of sealants. In fact, data from ICO show that only 7.8% of children between 8-9 years of age received dental sealant in at least one molar in 2014.

While preventive oral health is a pressing need, the PRHLIA reported a 43% reduction of dentists that provide services to the GHP population in 2013 which points to a service gap for low-income people.

To enhance oral health we will promote Pediatric Preventive Guidelines and continue public education.

**CShCN**

Based on Phase I of the 2015 PRS-CShCN, 18.6% of children from birth to 17 years have special health care needs. According to the 2013 Puerto Rico Community Survey (PRCS) population estimate, this percent translates to 161,765 CShCN. Although the percentage of CShCN is higher than in 2009 (2009 PRS-CShCN), 18.6% versus 16.6%, the number of CShCN is lower, 161,765 versus 180,889. Prevalence of CShCN ranges from 15.1% to 23.9% across the seven health regions (Mayagüez: 23.9%, Bayamón: 21.8%, Fajardo: 19.9%, Ponce: 19.4%, Caguas: 16.2%, Metropolitan: 15.7% and Arecibo: 15.1%). However, these differences are not statistically significant. With the exception of Caguas, the prevalence is higher than in 2009 in all regions (Mayagüez: 13.1%, Bayamón: 19.7%, Fajardo: 8.4%, Ponce: 18.7%, Comerío: 21.8%, Metropolitan: 14.6% and Arecibo: 12.3%). The prevalence in Caguas decreased
9.4%, Ponce: 18.7%, Caguas: 21.8%, Metropolitan: 14.0% and Arecibo: 12.3%). The prevalence in Caguas decreased 5.0%, while the prevalence in Fajardo and Mayagüez increased substantially, 10.5% and 10.8%, respectively.

According to the 2013 Census, in Puerto Rico there are 508,256 homes with a child or youth, younger than 18 years. Based on the 2015 PRS-CSHCN, the estimated number of homes with a child or youth with a special health care need in PR is 123,207 (24.2%). This percentage is similar to the 2009 estimate of 25.0%. Of the 123,207 homes with a child or youth with special health care needs, there are 240,412 children younger than 18 years old (with or without special health care needs) that reside in these homes. This means that 27.7% of children live in households where at least one of them has a special health care need. Households where at least one child with special health care needs lives have a higher percentage of males (58.4%) versus females (41.6%), the family income is lower ($10,000-$14,999) compared to homes without CSHCN ($15,000-$24,999), and 16.5% report that someone in the family has received monetary governmental help in the past 12 months. There are no statistically significant differences between households with and without CSHCN, in children’s age (median age: 11 years old), family size (median size: 4 children) and educational level (median level: associates degree).

Another source of information regarding the CSHCN population is the number of children with disabilities receiving early intervention services (EIS) and special education services under IDEA. The 2014 IDEA Part C Child Count indicated that 3,851 infants and toddlers, 3.3% of the population ages birth through 2, were receiving EIS. This represents a decrease in the percentage of infants and toddlers receiving EIS when compared to 2010: 3.97% (5,204) and 2011: 3.9% (4,883) and a slight increase when compared to 2012: 3.0% (3,683) and 2013: 3.1% (3,639). The 2014 Part B Child Count indicated that 16,868 children ages 3 to 5 years, inclusive, were receiving special education services. This represents a 13.5% of the population ages 3 to 5 years old. This represents an increase in the number of children ages to 5 years receiving special education services when compared to 2010: 10.1% (13,952), 2011: 11.1% (14,791), 2012: 10.3% (13,276) and 2013: 12.15 (15,038). The 2014 Part B Child Count also indicated that 112,218 children ages 6 to 21 years old, inclusive, were receiving special education services. This represents a 14.3% of the population ages 6 to 21 years old. This represents an increase in the percentage of children and youth receiving special education services when compared to 2010: 13.2% (112,608), 2011: 13.7% (114,523), 2012: 14.4% (116,936) and 2013: 13.8% (108,716).

II.B.2.b Title V Program Capacity

II.B.2.b.i. Organizational Structure

The PRDOH is the umbrella agency assigned in Article IV, Section 6 of the Constitution of PR responsible for all matters related to public health. The Secretary of Health is appointed by the Governor and confirmed by the Legislature.

The agency is organized in two main structural levels that respond directly to the Secretary: 1) Advisers and Support Units and 2) Operational units and Implementation of Public Policy. The Assistant Secretariat for Family Health and Integrated Services is included in the second level, under which are the MCAH Division (TV- A & B, SSDI, CISS, MIECHV) and the Children with Special Medical Needs Division (TV-C).

II.B.2.b.ii. Agency Capacity

MCAH

Several MCAH core and support programs facilitate and complement the health services offered at the health care system primary level in PR. The services are divided in seven Health Regions with a Medical Director (including one Pedestrian and one OB/GYN) and six Public Health Educators.
Pediatrician and one OB/GYN), and six Public Health Educators.

**Home Visits Program (HVP)** The HVP identifies health and social needs and offers case management and coordination services to participating families through individual education, screenings, referrals and follow-ups to different public agencies and community organizations. The HVP also collects information of social and health conditions and experiences of the participant, father of the child, children and her family (Family Case Coordination Form).

Currently about 66 nurses provide services to families in more than 70 of the 78 PR municipalities. The average caseload is 45 families reaching about 3,812 families per year.

The HVP provides services to pregnant women with multiple social and health risk factors. The interventions are classified according to the trimester of gestation. The HVP is voluntary and the woman continues participating in the HVP up to 24 months after delivery if no other pregnancy occurs.

The HVP provides services to children aged up to 24 months who received intensive medical attention as newborns or have a special care needs. Interventions focus on healthy development and preventive visits according to the EPSDT and Pediatric Preventive Guidelines.

**Community Outreach Program**

The Community Outreach Program (COP) is staffed by 23 Community Health Workers (CHW) in 23 of the 78 municipalities. Their charge is to identify MCA population and facilitate their enrollment into the HVP, GHP and other health services, coordinate interagency services, support the HVP including referral follow-ups, provide community health education on MCAH topics, disseminate educational materials, participate in health fairs and data collection.

The CHWs also gather information regarding private and public agencies and services available in communities, identify problems of access to health services and report it to the appropriate level. This serves to update the directory of services used by the HVP and other MCAH programs.

**Perinatal Services**

The MCAH Program has 9 perinatal nurses (PN) that visit the birthing hospitals. These nurses are trained in breastfeeding techniques, provide family planning counseling, and identify high risk pregnant women candidates for the HVP. They provide individual and group education, make referrals, collect perinatal data and participate in MCAH surveys and are resources for the prenatal courses.

**Comprehensive Adolescent Health Program: Youth Health Promoters Project (YHPP)**

The MCAH’ Comprehensive Adolescent Health Program (CAH) components integrates all activities intended to reduce adolescent health risk factors. CAH is also responsible for the implementation of the Positive Youth Development Model (PYD). Regional Social Workers (SWs) train middle school voluntary students from 7th through 9th grade as Youth Health Promoters (YHPP) of healthy lifestyles. YHPP has about 589 promoters in 28 schools across the Island. The Regional SWs provide support to the HVP and conduct youth dialogues to collect information about their needs.

At the central level CAH has a physician as an Associate Director, a Healthy Youth Development System Coordinator and a SW. At the regional level there are seven SW’s that are supervised by the Regional MCAH Directors.

Following are MCAH services provided by population health domains.

<table>
<thead>
<tr>
<th>MCAH Programs</th>
<th>Women/Maternal Health</th>
<th>Perinatal/Infant Health</th>
<th>Child Health</th>
<th>Adolescent Health</th>
<th>Cross-cutting/Life Course</th>
<th>CSHCEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Visiting Program</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Community Outreach Program</td>
<td>Perinatal Services</td>
<td>Youth Health Promoters</td>
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</tbody>
</table>

The MCAH Program will continue staff recruitment and training to enhance its effectiveness in achieving Title V goals.

A concerted action plan among diverse public/private entities and community organizations is vital to achieve MCAH goals. Some relevant relationships with non-profit community organizations are March of Dimes and the Naranjito Adolescent Program, Inc. (PANI). March of Dimes Preterm Taskforce offers public and professional education and investigates risk factors linked with the high preterm rate in PR. MCAH is active in this Taskforce providing analysis and statistics to develop and implement successful strategies.

MCAH contracted PANI to continue promoting the PDY Model in their service area. PANI also collaborates in creating a PYD Guide for NGO’s and government agencies.

**CSHCN**

The CSHCN Program coordinates and provides services through the RPCs currently operating at different levels of service. All seven RPCs are providing a Primary Level of services that includes screening, medical evaluation, eligibility determination for Title V services, services coordination, referrals and family support. Core staff for these services include: a Pediatrician/Medical Director, Social Worker, Graduate Nurse and Services Coordinator. All RPCs with the exception of Fajardo are providing a Secondary Level of services that includes: consultation, evaluation/services and primary level staff support by allied health professionals of the following disciplines: Psychology, Speech and Language Pathology, Physical Therapy, Occupational Therapy and Nutrition. The scope of these services varies based upon the materials and equipment available at each RPC. A Tertiary Level of services, accessible through referrals to available community services and/or through the RPCs, includes the following: Audiology, Ophthalmology, Orthopedics, Gastroenterology, Physical Medicine and Rehabilitation, Neurology and Genetics consultation/evaluation. The availability and accessibility to these services vary greatly by Health Region. A Supratertiary Level of services, accessible through referrals to available community services and/or through the Metropolitan RPC, includes the following: Neurosurgery, Plastic Surgery, ENT, Orthodontia, Urology and Nephrology. The following Special Interdisciplinary Clinics at the Metropolitan RPC will continue operating: Neural Tube Defects, Cranio-Facial Disorders and Complex Orthopedic Conditions.

As part of the transformation process, improvements were made to the physical facilities of the Metropolitan RPC. Improvements of the physical facilities are also underway in the Arecibo and Mayaguez RPCs. The Caguas RPCs is in need of major improvements so that services can be expanded. Diagnostic and evaluations materials, as well as, necessary equipment are being purchased so that physical therapy, occupational therapy, speech and language pathology and nutrition services can be provided at the RPCs. The CSHCN Program is working with the DOH Office of Informatics and Technological Advances to provide the RPCs with the necessary technological infrastructure for internet access and to support the electronic medical record and billing for the services provided. This infrastructure will provide the capability for reporting unduplicated counts of the children and youth served by the CSHCN Program.

Effective July 1st, 2015, the Autism Center will be administered by the CSHCN Program to provide a unifying collaborative and administrative structure designed to ensure the successful execution of plans and strategies that support the implementation of the PR Autism Law. Under the Law, the DOH is responsible of the identification, diagnosis, assessment, intervention and coordination of services for the population under 22 years old with Autism Spectrum Disorder (ASD) through the RPCs. The Autism Center will be synergistic and will work collaboratively with the CSHCN RPCs.

Blind and individuals with disabilities who are residents of Puerto Rico are not eligible for receiving Supplemental Security Income under Title XVI.
II.B.2.b.iii. MCH Workforce Development and Capacity

MCAH

a. The MCAH Division Components A&B is a multidisciplinary team of professionals dedicated to provide quality services to the maternal, infant and adolescent population. Our team provides the MCAH services from Central Level and 7 Regional Offices established islandwide.

At June 30, 2015 our workforce consists of 148 regular/transitory employees and 9 professional services contracts. Of the regular employees 136 (136 FTE) are located at our 7 Regional Offices island wide. Among that are our 65 Home Visiting Nurses, 25 Community Health Workers, 7 Perinatal Nurses, 7 Adolescents Coordinators and 6 Health Educators across the Island. Most Regional teams comprised with at least a Regional MCAH Director, Coordinator of Maternal and Infant Health Services, Coordinator of Adolescent Health Services, Health Educator, administrative and support staff. At the central level we have 12 regular (11.95 FTE) positions which includes the PR MCAH Director, Manuel Vargas, MD, MPH an experienced OB-Gyn with more than 30 years of experience. The 9 (8.5 FTE) Professional Services Contracts are localized at the Central Level, this positions includes a group of skilled public health professionals and highly experienced in the maternal, infant and adolescent area that forms the Evaluation and Data analysis Section of the MCAH Division: one Biostatistician, Aurea Rodriguez, MPH; two Epidemiologists, Marianne Cruz, MS and Leslie Soto, MS; one Evaluator Sixto Merced, MS; one Cultural Anthropologist Norma Boujouen PhD; two Physicians Gloria Montalvo, MD and Cindy Calderon, MD. Also as a Contract positions there are one Fiscal Affairs Coordinator Ruth López, MBA, JD; and one Health Education Component Coordinator, Darem Davila, Ed.D.

b. The PRMCAH addresses cultural competency with the following approaches:

- The staff native language is Spanish, principal language in PR.

- The Life Course Training includes culture and cultural competency.

- All the MCAH services provided focuses in the importance of the PR cultural values such as respect and trust.

- Educational materials use words that are understood by groups other than Puerto Ricans (e.g. Dominicans) and persons with low educational levels.

- Families, youth and community leaders are consulted in the needs assessment and evaluation of activities.

- Assistance is provided to community groups in areas of their interest.

- A four-part training on conducting culturally relevant Dialogues was designed by the Cultural Anthropologist and offered to staff who will be Dialogue Facilitators. The training emphasizes listening, asking non-judgmental questions, cultural meanings and cultural reflexivity.

- Anthropological qualitative research is carried on the experiences and cultural views of populations.

CSHCN

The CSHCN program staff at the RPCs consists of 99 FTE regular/temporary positions, and 21.76 FTE contractual positions. Additionally, the following staff provides services to the CSHCN program at the RPCs on fee for services basis: 4 audiologists (1 in Bayamón, 2 in Metropolitan and 1 in Ponce) and 1 occupational therapist (Ponce). Neurosurgery (Metropolitan RPC), orthopedics (Metropolitan and Mayaguez RPCs), orthodontia (Metropolitan RPC) and plastic surgery (Metropolitan RPC) services are contracted with the UPR Medical Sciences Campus or directly with the service provider on a fee for service basis.

The CSHCN Program staff at the state level consists of 8 FTE regular/temporary positions and 3.13 FTE contractual positions. Senior level management includes the Children with Special Medical Needs Division Director who is also the CSHCN Program Director. He is a pediatrician with a developmental pediatrics fellowship who has worked for the DOH since December 1986 in different positions including Acting Director/Director of the CSHCN Program from 1986
II.B.2.c. Partnerships, Collaboration, and Coordination

MCAH

MCAH is a focal point for a wide range of agencies and programs working towards the social, mental and physical wellbeing of the MCA population. Formal agreements - including committees, task forces and coalitions- between the DOH and other state/local public agencies, academic institutions, FQHC and tertiary health care facilities enhance the capacity of the MCAH/CSHCN programs to promote health.

i. The SSDI, MIECHV, Healthy Start, and ECCS Programs which are part of MCAH structure represent other MCHB investments and efforts. These joint efforts address injury prevention, WRA health, pregnant women health, adolescent health, screenings, and access to MCA data and information, among others. They share the MCAH Director as their Project Director and receive support from the administrative and support MCAH staff (accountant, purchasing agent, secretaries).

ii. Other Federal investments that closely collaborate with the MCAH Program are WIC, the Immunization Program, Early Intervention, the Abstinence Education Program, and the Personal Responsibility Education Program (these three grants are part of MCAH). These joint efforts address healthy nutrition, overweight and obesity, vaccines, developmental disabilities and adolescent health. The Immunization Program and MCAH Program are located administratively in the Assistant Secretariat for Family Health and Integrated Services in the DOH.

iii. Other HRSA programs that serve the MCAH population are the FQHC and the Ryan White HIV/AIDS Program. The FQHC provide primary health care service in PR through 53 centers and collaborate in the HNA. The Ryan White HIV/AIDS Program works under the administration of the Central Office for the Management of AIDS and Sexually Transmitted Diseases of the DOH, and provides all the services and support to low income patients that are HIV positive or with AIDS.

iv. The MCAH Program has under its direction seven regional MCAH programs distributed geographically throughout PR. They implement the strategic plan: give feedback and report accomplishments and barriers to make needed revisions in achieving MCAH Program goals.

v. The MCAH Program has access other DOH programs like the Auxiliary Secretariat of Health Promotion which includes chronic disease and prevention health programs. It also has access to vital, health and immunization statistics, and information on behavioral, mental health and substance abuse from the Administration of Health Services for Drug Addiction (ASSMCA; Spanish acronym). Other agencies and/or institutions that provide access or share data are: Office of Informatics and Advanced Technology (OITA), WIC Program, Birth Defects Surveillance and Folic Acid Campaign, Medicaid Program, Demographic Registry Office, Immunization Program, Newborn Screening for Hereditary Diseases, PRHIA and IDC. There are collaborations with external agencies and/or institutions to conduct MCAH surveillances and research like hospitals that participate in the PR Maternal and Infant Health Survey (PRAMS-like surveillance), the public school system and Head Start.

vi. Other governmental agencies with whom MCAH collaborates are:
*Medicaid Program: Provide services to eligible MCA populations and member of the Infant Mortality CoIIN Committee.

* Education Department: Serve children, youth and families. Supports MCAH Youth Health Promoters.

* Family Department Child abuse/neglect prevention; its visiting program Nido Seguro replicates the MCAH HVP.

*Head Start and Early Head Start Programs: Promotion of health and optimum early childhood development.

vii. PR has no tribes, Tribal Organizations or Urban Indian Organizations.

viii. The University of PR, Mayaguez Campus (Agricultural Extension Service): Trains staff about the PEAN curriculum used in the ICC-LC. ASSMCA offers trainings on mental health issues. MCAH staff also participates in professional trainings offered to larger audiences from diverse professional fields.

ix. Family/consumer partnerships:

*Families and youth give input through Dialogues and research

*MCAH Youth Health Promoters are peer leaders in their schools

*A group of youth, community organizations and agencies is organizing the MCAH Youth Advisory Council.

*Healthy Start Consumer Committees address local issues and give input to MCAH.

*Mothers groups are engaged in the Breastfeeding Alliance.

x. Other State and local public and private organizations that serve the state’s MCAH population and collaborate in our efforts:

*Family Planning Agency (PROFAMILIA): family planning services

*Association of Primary Health Care of PR: preventive medical services

*March of Dimes: prematurity and infant mortality

*Hospital Association: reduce infant mortality and improve hospital maternal/infant care

*AAP PR Chapter, PR Pediatric Society: child/adolescent health promotion

*Highway Safety Commission: injury prevention

*Pediatric Obesity Prevention Alliance Inc.: obesity prevention

*Asthma Coalition: asthma related morbidity and mortality

*Oral Health Alliance: oral health promotion

*Naranjito Youth Program: youth health promotion


*United Way: prevention and 211 line
CSHCN

The CSHCN Program has in place a collaborative agreement with the Lopez Family Foundation Telegenetics Clinic located at the University Pediatric Hospital since February 2015. The Clinic provides access to two geneticists from the Los Angeles Children Hospital, who are licensed to practice medicine in PR. As a result of the agreement, all children referred to the clinic are enrolled in the CSHCN Program in order to provide service coordination support that includes coordination of appointments and assistance for accessing recommended laboratory tests in or near the families’ communities. Once the Ponce and Arecibo RPC have internet access, additional clinics will be established in these two centers.

As part of a collaborative effort, APNI (PR Parent Training and Information Center) is financing the Services Coordinators for the Bayamón, Caguas, Mayaguez and Metropolitan Regions. CSHCN Program nurses at Arecibo, Fajardo and Ponce were identified to provide care coordination. All service coordinators are located at the RPCs.

The CSHCN Program and the DOE Special Education Program are working together to better coordinate services for CSHCN served by the two agencies. The CSHCN Program is working with the Mayor of Caguas and other stakeholders to identify the necessary funds or support for the improvements of the physical facilities of the Caguas RPC.

II.C. State Selected Priorities
<table>
<thead>
<tr>
<th>Priority Need</th>
<th>Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)</th>
<th>Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve health in women of reproductive age</td>
<td>Continued</td>
<td></td>
</tr>
<tr>
<td>2. Improve birth outcomes</td>
<td>Replaced</td>
<td></td>
</tr>
<tr>
<td>3. Decrease Infant Mortality</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>4. Improve Children Health and Wellbeing</td>
<td>Replaced</td>
<td></td>
</tr>
<tr>
<td>5. Improve adolescent health and wellbeing</td>
<td>Replaced</td>
<td></td>
</tr>
<tr>
<td>6. Increase the number of CSHCN who receive regular ongoing comprehensive health care within a medical home</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>7. Increase the number of CSHCN aged 12 to 17 years who receive adequate support and services for their transition to adult health care</td>
<td>Continued</td>
<td></td>
</tr>
<tr>
<td>8. Decrease the age when children at risk for Autism Spectrum Disorders (ASD) receive their first diagnostic evaluation</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>9. Reduce the prevalence at birth of neural tube defects</td>
<td>Continued</td>
<td>Since 2004, the NTD birth prevalence in PR has remained relatively stable, 9.8 per 10,000 live births. This is higher than in the US, where the prevalence is 7 per 10,000 live births. Hispanics consistently had a higher prevalence of NTDs compared to other racial/ethnic groups. There remain opportunities for prevention among women with lower folic acid intakes to further reduce the prevalence of NTDs in Puerto Rico, as well as the infant mortality related to this birth defect.</td>
</tr>
<tr>
<td>10. Improve CSHCN Program data capacity</td>
<td>New</td>
<td>This priority was chosen as the result of the needs assessment process itself. Data for Puerto Rico is not available from the National Survey of Children with Special Health Care Needs (NS-CSHCN) or the National Survey of Children’s Health (NSCH). Data systems support service delivery, facilitates performance and outcome monitoring, fosters quality improvement, and helps cultivate political support for services. Gaining an in-depth understanding of CSHCN through exploring existing data sources, identifying missing data, and developing new data sources will allow the DOH to identify gaps in services and to better assist the CSHCN community throughout the island.</td>
</tr>
</tbody>
</table>

**MCAH:**
The procedures for the needs assessment (NA) were discussed and selected in MCAH staff meetings. The chosen were used to select the priority needs based on categorization of the 5 population health domains (women/maternity health, perinatal and infant health, adolescent health, child health, cross cutting/life course). The Needs Prioritization Method Tool (used by Louisiana State in 2005) was culturally translated, adapted, and face validity performed to review the
Seventy-three potential needs priorities were identified (Table: Potential Priorities) after an analysis based on findings of the NA Survey, MCAH RB’s questionnaire, information provided by physicians through the PR Annual Convention Meeting of the PR College of Physicians and Surgeons, Health Dialogues and the Key Informant Interviews. The qualitative analyses (mainly from the health dialogues and key informant interviews) confirmed the majority of the health needs identified. Information based on the PM, SPM, OM, HP 2020, input from collaborators, state political priorities, and accessibility of resources to address documented needs was analyzed. To narrow potential priorities, MCAH convened a one day stakeholder meeting that included representatives from public agencies within and outside the DOH, professional organizations and community based organizations. Stakeholders (SH) who actively participated were representatives from: MCAH RB, MCAH Program Coordinators, ASES, HICO, Family Department, 4-H Club, Boys and Girls Club, Proyecto NACER, ACUDEN, Faculty of the UPR Social Work School, Faculty of the UPR School of Medicine Public Health, Highway Safety Commissioners Office, STD/HIV Prevention Agency, Health Promotion Agency, Primary Care Association, and OB/GYN Division of the PR College of Physicians and Surgeons, WIC Program, United Ways, Healthy Start, and a retired member of the MCAH staff.

At the consensus meeting EMRSDS staff gave two presentations: 1) the process used to select potential priorities and; 2) a description of the health status through statistical data of each one of the identified 73 possible needs contained in the instrument. The first and second parts of the instrument – containing the 73 potential priorities divided in the 5 population domains – were distributed among SH. Stakeholders were instructed to place a value from 1 to 5 on each of the following characteristics for each potential priority: the extent/magnitude of the health problem, severity of the consequences, resources availability, and level of public acceptability. For each domain the 5 priorities with the highest scores were selected. The two top potential priorities for each of the five domains (Table: Potential Priorities) were identified. SH proposed and evaluated strategies to address the 10 top chosen priorities using an instrument with specific criteria: period (short (1 year) vs. long (5 years) term), effectiveness and availability of resources. The SH identified at least 3 strategies for each top priority which complied best with the criteria.

A general MCAH Workgroup was organized to discuss the potential priorities and strategies identified by the SH. The Workgroup consisted of the MCAH Director, Pediatric Consult, Healthy Start Coordinator, Social Workers, Cultural Anthropologist, Health Educator Coordinator, Comprehensive Adolescent Program Director, and the EMRSDS team. After several meetings to discuss the allocation of resources, data sources availability and type of interventions, five main priorities were selected from the ten top priorities. All the top priorities are also included in the cross cutting / life course domain. The criteria to select the main priorities were: MCAH agency capacity, MCAH stakeholder’s collaborations, state priorities, data availability to monitor the priority. Those excluded did not fulfill the criteria. A brief discussion for why each priority by domain continues, replaced other priority or was added for this next year’s work plan follows:

**WOMEN/MATERNAL HEALTH**

**Improve WRA health and well-being (c)**

This priority continues as priority No. 1 from 2010 focusing in the women in a preconceptive or interconceptive period. Preconceptual health care, STD’s, use of folic acid, and domestic violence are amongst the issues that affect WRA. By improving WRA preconceptual health pregnant women health status will definitely improve.

**Improve birth outcomes (r)**

By improving WRA preconceptual and pregnant women health status, birth outcomes will definitely improve. This priority includes preterm births and other conditions and procedures that may affect the child health and survival. Efforts to decrease elective inductions are proven to decrease the prevalence of cesarean delivery with the morbidity associated to it. Early prenatal care, oral health of pregnant woman and nutrition evaluation help improve birth outcomes.

**PERINATAL/INFANT HEALTH**

**Decrease infant mortality (n)**

Decreasing IM is a new priority. A decrease in premature and LBW infants increases infant survival. The COINN and FIRM efforts represent public-private partnership initiatives with evidence based strategies to reduce the infant mortality. Promoting breastfeeding, baby-friendly hospital settings, early prenatal care, high risk babies born in appropriated hospitals, safe sleep, injury prevention, and forgotten baby prevention are also contributors to decreasing infant mortality.
CHILD HEALTH
Improve children health and well-being (1)

Improve children health and well-being replaces the previous needs priorities of 2010. It includes decreasing morbidity due to chronic conditions, reducing unintentional injuries, and strengthening the socio-emotional development in the pediatric population. Other issues included are immunizations, asthma, obesity and lack of physical activity. Emerging issues in this population such as abuse and neglect in children, mental health problems and other behavioral problems in children are also addressed. Promoting EPSDT increases the opportunities for effective interventions to optimize well-child care evaluation of development, nutritional habits, physical activities, immunization, injury prevention, perform screenings and provide anticipatory guidance.

ADOLESCENT HEALTH
Improve adolescent health and well-being (1)

Improve adolescent health and well-being replaces the 2010 priority need because it encompasses promoting healthy life styles in adolescents. Promoting a healthy life style reduces behavioral risk factors like use tobacco, alcohol and drugs, promotes the correct use of anti-conceptive methods, reduces interpersonal violence, suicides, and pregnancies. Improving adolescent health and well-being includes: decreasing morbidity due to chronic conditions, reducing unintentional and intentional injuries, and strengthening the socio-emotional development. Regular preventive care visits for adolescents provide opportunities for early identification, management and intervention for conditions and behaviors with consequences on health and well-being.

CROSS-CUTTING OR LIFE COURSE
Improve WRA health and well-being
Improve birth outcomes
Improve children health and well-being
Improve adolescent health and well-being

Although the life course – that focus on the complex ways in which biological factors interact with historical, social, cultural and economic factors over time - encompasses all health issues across populations, oral health is an important but often neglected marker of health cross-sectionally and longitudinally that addresses all the priorities under this domain.

Identifying WRA and Pregnant women with dental and gingival conditions with adequate care and prevention decreases the risk of premature labor. Identifying infants at higher risk for early childhood caries provides an opportunity for an early referral to a dental home for prevention. Identifying children and adolescent with high risk for caries or with dental conditions provides the opportunity for early referral to dental homes. Promotion of oral health in the community and participants of the various MCAH Programs provide opportunities to foster empowerment, improve the quality of life, and decrease the cost of care throughout the life course of generations.

CSHCN:

1. Increase the number of CSHCN who receive regular ongoing comprehensive health care within a medical home.
Several needs in relation to access to comprehensive health care were identified in the focus groups. There is a shortage of pediatric specialists, mainly neurologists, geneticists, ENTs, gastroenterologist and psychiatrists. These are mainly located in the San Juan Metropolitan Area and families need to travel long distances to receive services. Families identified delays in obtaining appointments and bureaucratic and slow administrative processes in obtaining referrals and approvals. Services are usually fragmented. Families need to frequently file complaints in order to obtain the services, laboratories and medications for their children. PCPs do not provide care coordination so families must coordinate services by themselves. The AAP defines “medical home” as health care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally sensitive – delivered by a physician who knows the child or adolescent and works with the family to develop a partnership of mutual responsibility and trust. Five of the six top needs are related to the components of the “medical home”. For this reason, these needs were merged into one priority. Data from the 2009 PRS-CSHCN revealed that only 24.7% of CSHCN ages 0 to 18 years receive coordinated, ongoing, comprehensive care within a medical home. This is a new priority. However, it merges priorities included in the 2010 and 2005 needs assessments.

2. Increase the number of CSHCN aged 12 to 17 years who receive adequate support and services for their transition to adult health care.
Youth and their families that participated in the focus groups, see the transition process to adult health care as a change in routine care and interruptions in services. PCP usually does not prepare and plan with youth or their families for the transition. Mi Salud ends the Special Coverage once youth attain 21 years of age. The Vocational Rehabilitation Administration is the only government agency that provides transition (work study) services to youth with special needs that are eligible under their regulations. An effective transition process from a pediatric to an adult health system should ensure continuity of developmental and age-appropriate care. In 2002, the AAP, the AAFP, and the ACP coauthored the following consensus statement: “The goal of transition in health care for young adults with special health care needs is to maximize lifelong functioning and potential through the provision of high-quality, developmentally appropriate health care services that continue uninterrupted as the individual moves from adolescence to adulthood”. This is a continued priority as it was one of the top 3 priorities identified in the 2010 and 2005 needs assessments.

3. Decrease the age when children at risk for Autism Spectrum Disorders (ASD) receive their first diagnostic evaluation.
Many children with autism miss out on early behavioral interventions and other benefits because health professionals are reluctant to diagnose autism early out of fear of labeling young children. Reliable diagnosis has been documented during infancy and toddlerhood, and evidence suggests that the earlier the onset of intervention, the greater likelihood of an improved developmental trajectory. In 2011, it was estimated in PR there were 2,890 children with ASD ages birth to three years old, the majority without a diagnosis. Given that a reliable diagnosis of ASD is possible by 24 months, and that about 90% of parents whose children are later diagnosed with ASD express documented concerns before age 2, the gap between best practice guidelines and community implementation is tangible. This is a new state priority.

4. Reduce the prevalence at birth of neural tube defects
After the mandatory fortification of enriched cereal grain products with folic acid, there was a 50% decrease in the prevalence of neural tube defects (NTD) in PR from 1998-2002. Other countries also reported a reduction in their number of neural tubes defects after fortification, such as Chile (50%), Canada (46%), US (36%), Costa Rica (35%), and South Africa (31%). Since 2004, the NTD birth prevalence in PR has remained relatively stable, 9.8 per 10,000 live births. This is higher than in the US, where the prevalence is 7 per 10,000 live births. Hispanics consistently had a higher prevalence of NTDs compared with the other racial/ethnic groups. Possible reasons could include differences in folic acid consumption and genetic factors affecting the metabolism of folic acid. There remain opportunities for prevention among women with lower folic acid intakes to further reduce the prevalence of NTDs in Puerto Rico. This is a continued state priority.

5. Improve CSHCN Program data capacity
Improving the CSHCN program data capacity to meet the Title V MCH Block Grant data collection and reporting requirements is a new state priority. This priority was chosen as the result of the needs assessment process itself. Data for Puerto Rico is not available from the National Survey of Children with Special Health Care Needs (NS-CSHCN) or the National Survey of Children’s Health (NSCH). Data systems support service delivery, facilitates performance and outcome monitoring, fosters quality improvement, and helps cultivate political support for services. Gaining an in-depth understanding of CSHCN through exploring existing data sources, identifying missing data, and developing new data sources will allow the DOH to identify gaps in services and to better assist the CSHCN community throughout the island.

Methodology used for ranking the identified needs
A body of stakeholders was convened on May 12, 2014 to present and discuss the needs identified by the focus groups. Opportunity was provided for the presentation and discussion of other needs. The stakeholders categorized the identified needs into eight groups and completed information on available resources to address each need. An instrument was used to rank the needs. The value assigned to each need was added to determine the top six needs.

Process for selecting the priorities
The top six CSHCN population needs determined by the stakeholders group, data collected from other state partners along with quantitative data were considered for the selection of the CSHCN domain priorities. Key criteria used for the prioritization process included: alignment with Title V mission and scope, federal requirements, state and local capacity, and ability to make a measurable impact in the short- and long-term.

II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures
**NPM 1-Percent of women with a past year preventive medical visit**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>74.5</td>
<td>75</td>
<td>75.4</td>
<td>75.8</td>
<td>76.2</td>
</tr>
</tbody>
</table>

**NPM 3-Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
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<tbody>
<tr>
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<td>72.3</td>
<td>76.1</td>
<td>80</td>
<td>84.2</td>
</tr>
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**NPM 4-A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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<tbody>
<tr>
<td>Annual Objective</td>
<td>82.1</td>
<td>83.3</td>
<td>83.3</td>
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<td>Annual Objective</td>
<td>19.7</td>
<td>21.2</td>
<td>22.8</td>
<td>24.3</td>
<td>25.9</td>
</tr>
</tbody>
</table>

**NPM 8-Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
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<th>2019</th>
<th>2020</th>
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<tbody>
<tr>
<td>Annual Objective</td>
<td>28.2</td>
<td>28.3</td>
<td>28.5</td>
<td>28.6</td>
<td>28.8</td>
</tr>
</tbody>
</table>

**NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
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</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
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</tbody>
</table>

**NPM 11-Percent of children with and without special health care needs having a medical home**

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>24.7</td>
<td>24.7</td>
<td>25.5</td>
<td>26.3</td>
<td>27.2</td>
</tr>
</tbody>
</table>
NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

<table>
<thead>
<tr>
<th>Annual Objective</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<th>2020</th>
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<tbody>
<tr>
<td></td>
<td>26</td>
<td>26</td>
<td>26.9</td>
<td>27.8</td>
<td>28.6</td>
</tr>
</tbody>
</table>

NPM 13-A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

<table>
<thead>
<tr>
<th>Annual Objective</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
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<td>NPM 12</td>
<td>43.9</td>
<td>44.8</td>
<td>44.8</td>
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<tr>
<td>NPM 13-A (A)</td>
<td>47.5</td>
<td>47.5</td>
<td>47.7</td>
<td>47.8</td>
<td>48.9</td>
</tr>
</tbody>
</table>

MCAH:

The priority needs identified as well as indicators used to monitor health status are based on the findings of the 2015 HNA. Following is a list of each national performance measure with the corresponding priority.

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>PRIORITIES 2015</th>
<th>NPM o SPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women/maternal health</td>
<td>Improve WRA health and well-being (c)</td>
<td>NPM 1-Percent of women with a past year preventive medical visit</td>
</tr>
<tr>
<td></td>
<td>Improve birth outcomes (i)</td>
<td>SPM 1-Percent of cesarean deliveries among low-risk first births</td>
</tr>
<tr>
<td>Perinatal/infant health</td>
<td>Decrease infant mortality (m)</td>
<td>NPM 3-Percent of VLBW infants born in a hospital with a Level III+ Neonatal Intensive Care Unit</td>
</tr>
<tr>
<td></td>
<td>NPM 4-(a) Percent of infants who are ever breastfed and (b) Percent of infants breastfed exclusively through 6 months</td>
<td></td>
</tr>
<tr>
<td>Child health</td>
<td>Improve children health and well-being (r)</td>
<td>NPM 8-Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day</td>
</tr>
<tr>
<td></td>
<td>SPM 2-Percent of children, ages 1 through 9, with a preventive medical visit in the past year</td>
<td></td>
</tr>
<tr>
<td>Adolescent health</td>
<td>Improve adolescent health and well-being (r)</td>
<td>NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year</td>
</tr>
<tr>
<td>Cross-cutting / Life</td>
<td>Improve WRA health and well-being</td>
<td>NPM 13-(a) Percent of women who had dental visit during pregnancy and (b) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year</td>
</tr>
<tr>
<td>Course</td>
<td>Improve birth outcomes (i)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improve children health and well-being</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improve adolescent health and well-being</td>
<td></td>
</tr>
</tbody>
</table>

The identification of indicators was done through a three-step analytical process. The first step involved the identification of indicators drawn from data on health needs gathered through questionnaires distributed to the population. These indicators were presented to stakeholders at the Stakeholders Meeting.
The second step was the selection procedure for main priorities in which one of the criteria used was data availability to monitor the priority.

In the final step, an instrument developed by EMRSOS was applied to select and linkage indicators to the priorities. This instrument classifies the potential indicators using a Likert scale to measure several characteristics of the indicator like pertinent, functionality, reliability, utilization, applicability, among others.

Because the instrument was extensive, one of the main criteria used to narrow the indicators and select the best measures was the evaluation of the data sources used to monitor the indicator (reliability criteria).

This criterion was very important since most of the national surveys in the mainland do not include Puerto Rico. To that end, Puerto Rico evaluated measures according to the availability of data sources suggested by MCHB.

Following is a description used by MCAH to link the priority needs with the national and outcomes measures.

**DOMAIN: WOMEN/MATERNAL HEALTH**

*Improve WRA health and well-being*

At-risk lifestyle, diabetes and obesity, STD, partner domestic violence, among others are public health problems that affect women’s well-being and their health, whether or not they plan to have a baby. These and other issues can be addressed by the preventive medical visits that support women to take control and choose healthy habits that ensure a better quality of life for them and their family. Increasing the number of women that receive a preventive medical visit, decrease the likelihood of maternal as well as infant mortality. In addition, the annual women preventive medical visit increment the probability of receive treatment or follow-up care as needed and reduce adverse of birth outcomes such as preterm birth and low birth weight, indirect causes of neonatal deaths. The percent of women with a past year preventive medical visit is a good indicator to measure WRA health and well-being (NPM 1).

*Improve birth outcomes*

Improving birth outcomes will improve the health of mothers and their children across their lifespans. A SPM will be developed to monitor this priority.

**DOMAIN: PERINATAL / INFANT HEALTH**

*Decrease infant mortality*

The maternal health status and other characteristics like age, education, marital status, family income, lifestyle and environmental factors may affect infant survival. Also, others characteristics related to the health system influence the infant health and best chance of survival. MCAH will continue empower women at every stage of their lifespan, emphasizing in pre-conceptive period. However, to reduce infant mortality, MCAH will focus attention on enhancing access to an adequate prenatal care and infants delivering at facilities equipped to handle high-risk deliveries and neonate in order to improve an adequate system of care for the mother and her baby. The percent of VLBW infants that born in a hospital with a Level III+ NICU (NPM 3) provide the measure to monitor the results of the perinatal regionalization strategies to aim the survival of the most fragile newborns.

On the other hand, advantages of breastfeeding are highlighted for the mother and her baby. Breastfeeding can reduce the stress level and the risk of postpartum depression meanwhile protects the baby from obesity, developing allergies, several illnesses, among other benefits. Also, breastfeeding may lower baby's risk of SIDS. The percent of infants who are ever breastfed and percent of infants breastfed through 6 months as a national performance measure (#4), can impact the priority of decrease that baby die before his or her first birthday.

**DOMAIN: CHILD HEALTH**

*Improve children health and well-being*

All children should have the opportunity to grow up healthy. There is growing awareness that preventable mortality and morbidity in PR such as obesity, unintentional injuries and mental disorders are significant factors affecting the health and well-being of child population.

On the other hand, physical activities improve coordination and balance. increase cardiovascular fitness. and contribute
On the other hand, physical activities improve coordination and balance, increase cardiovascular fitness, and contribute to better sleep and social skills. These activities can reduce the risk of obesity and emotional problems such as anxiety and depression. Physically active children are more likely to mature into physically active adults. The percent of children aged 6 to 17 years who are physically active at least 60 minutes per day (NPM 8) is a protective factor which promotes healthy child development and well-being.

A SPM will be developed to monitor this priority too.

**DOMAIN: ADOLESCENT HEALTH**
*Improve adolescent health and well-being.*

A healthy start in life helps adolescent to reach their full potential preventing diseases both in the short and long term. Focusing on healthcare for the adolescent has the potential to improving primary care to address adolescents’ physical, behavioral, and sexual health needs. Preventive medical visits provide the scenario to the adolescents to assume individual responsibility for their health habits and the basis to prepare adolescents for healthy future and well-being. The percent of adolescents aged 12 to 17 years with a preventive medical visit in the past year (NPM 10) can improve adolescent health and well-being.

**DOMAIN: CROSS CUTTING/LIFE COURSE**
Oral health (NPM 13) is an important protective factor across life course stages linked to the overall health of populations. It cuts across populations priorities: Improve birth outcomes, improve WRA, Children and Adolescent health and well-being.

Percent of women who had dental visits during pregnancy. Dental visits during pregnancy have important implications for birth outcomes as oral health status is linked to low-birth weight and prematurity. Preventive dental visits and healthy oral habits during pregnancy will lead to healthy birth outcomes that in turn, will have long lasting effects on subsequent life stages.

Percent of children, ages 1 through 17, who had a preventive dental visit in the past year. Oral diseases – like tooth decay and periodontal disease – affect the quality of life of children, adolescents and adult as they cause pain, disability, and lost productivity from missed school or work days. Optima oral health since early childhood throughout adolescence contributes to the quality of life during and in subsequent years and life stages.

**CSHCN:**

NPM #11 - Percent of children with and without special health care needs having a medical home.

This NPM is directly linked to Priority 1: Increase the number of CSHCN who receive regular ongoing comprehensive health care within a medical home. Data from the 2009 PRS-CSHCN revealed that only 24.7% of CSHCN ages 0 to 18 years receive coordinated, ongoing, comprehensive care within a medical home. Care coordination was the weakest of the medical home components. (Nationale: 43.0%, Source: 2009-10 National Survey of Children with Special Health Care Needs)

The Center for Medical Home Improvement (CMHI) defines the medical home as a community-based primary care setting which provides and coordinates high quality, planned, family-centered health promotion, acute illness care, and chronic condition management — across the lifespan. In 2008, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally sensitive care. As such, a medical home addresses and integrates high quality health promotion and chronic condition management in a planned, coordinated and family-centered manner.

NPM #12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.

This NPM is directly linked to Priority 2: Increase the number of CSHCN aged 12 to 17 years who receive adequate support and services for their transition to adult health care. The 2009 PRS-CSHCN data showed that only 26.0% of youth with special health care needs receive the necessary services and supports to make the transition to all aspects of adult life. (Nationale: 40%, Source: 2009-10 National Survey of Children with Special Health Care Needs)

The importance of transition planning has received increasing attention over the past several years. The Patient Protection and Affordable Care Act (ACA) recognized transition as an essential health home service. The National Committee on Quality Assurance, in its 2011 Patient-Centered Medical Home Standards, included a specific requirement to address care transitions for improving primary care. Also in 2011, the AAP, the AAFP, and the ACP published a
II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

CSHCN

SPM #3 - Percent of children diagnosed with Autism Spectrum Disorder at age 3 years or earlier.

This SPM is directly related to Priority 3: Decrease the age when children at risk for Autism Spectrum Disorders (ASD) receive their first diagnostic evaluation. In 2011, it was estimated that in PR there were 2,890 children with ASD form birth to three years old, the majority without a diagnosis. Research has shown the benefits of early intervention for children with developmental disabilities, especially autism. The sooner young children begin intervention, the greater the potential benefit. By acting at just the right time, while a young child's brain is still developing, early intervention can produce significant changes in the child's development. This is a new SPM.

SPM #4 - Percent of babies born with neural tube defects.

This SPM is directly related to Priority 4: Reduce the prevalence at birth of neural tube defects (NTDs). Birth defects are the leading cause of infant mortality and are responsible for substantial child and adult morbidity. Infants of Hispanic mothers have a higher birth prevalence of anencephaly, spina bifida and encephalocele. Since 2004, the NTD birth prevalence in PR has remained relatively stable, 9.8 per 10,000 live births. This is higher than in the US, where the prevalence is 7 per 10,000 live births. Tracking the prevalence at birth of NTDs provides valuable data on racial/ethnic patterns of birth defects and help plan for public health care and educational needs. This is a continued SPM.

SPM #5 – Degree to which CSHCN Program’s plan to increase information and data capacity is implemented.

This SPM is directly related to Priority 5: Improve CSHCN Program information and data system capacity. This SPM intends to address the need for improved capacity to meet data collection and reporting requirements; accurately analyze data and use these data to report on current improvement efforts and activities (e.g., state performance plans, annual performance reports). This is a new SPM.
II.F.1 State Action Plan and Strategies by MCH Population Domain

The MCAH goal is to assure MCA access to quality health care services and empowerment with accurate information to improve their well-being across the life course.

Priorities assure that MCAH’s objectives contribute to the preventive and primary health care services for all population. The state action plan translated the analysis of factors contributing to the MCA health in strategies delivered in similar systems of intervention at central and regional levels.

Improving the MCA well-being and quality of life and their families is a great challenge for the MCAH Program. To do so, it focus on health promotion and empowerment through education and intervention, referrals to appropriate services, accurate information share, and collaborative networks with health and social services and programs within and outside the PRDOH.

Regards accurate information, SPM #3 monitored a core of five research and surveillance initiatives, which produced essential information for MCA and CSHCN: BDSS, MIHS, MMSS, FIMR, and IIMH. Despite MCAH doesn’t continue with this measure, the MCH transformation and its emphasis on performance and accountability give the opportunity to enhance data accountability to show the MCAH contribution to the state public health system.

The accomplishments of the objectives are constantly evaluated with the support of the stakeholders for modifications in strategies to improve outcomes.
<table>
<thead>
<tr>
<th>State Priority Needs</th>
<th>Objectives</th>
<th>Strategies</th>
<th>National Outcome Measures</th>
<th>National Performance Measures</th>
<th>ESMs</th>
<th>SPMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve health in women of reproductive age</td>
<td>1. Increase the percent of women reporting a past year preventive visit by 2016.</td>
<td>1. Develop the Preventive Health Services Guidelines for women in reproductive age. 2. Establish the Preventive Health Services Guidelines for women in reproductive age as a Department of Health Public Policy. 3. Disseminate the Preventive Health Services Guidelines for women in reproductive age through diverse publishing media and forum. 4. Promote the preventive health services as required by Affordable Care Act among target population through PRMCH staff (community health workers, health educators, home visiting nurses). 5. Outreach and referral of uninsured women for Medicaid Program eligibility evaluation. 6. Develop a curricula regarding women’s preconceptive health. 7. Promote the inclusion of preventive and preconceptive health in the</td>
<td>Rate of severe maternal morbidity per 10,000 delivery hospitalizations Maternal mortality rate per 100,000 live births Percent of low birth weight deliveries (&lt;2,500 grams) Percent of very low birth weight deliveries (&lt;1,500 grams) Percent of moderately low birth weight deliveries (1,500-2,499 grams) Percent of preterm births (&lt;37 weeks) Percent of early preterm births (&lt;34 weeks) Percent of late preterm births (34-36 weeks) Percent of early term births (37, 38 weeks) Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Post neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births</td>
<td>Percent of women with a past year preventive medical visit</td>
<td></td>
<td></td>
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</tbody>
</table>
8. Promote the inclusion of preventive and preconceptive health in the continuous medical education activities of experienced health care providers.
Women/Maternal Health - Plan for the Application Year

Maternal (MH) and Women Preconception Health (WPH) are top priorities for the population served by the PR MCAH program. WPH focuses on the health of women, capable of reproducing since their first menses, and in between conceptions while MH focuses on a women’s health during pregnancy and immediately after birth. Both MH and WPH focus on improving health by promoting changes in attitudes and habits, taking in to account all the social, cultural and environmental factors, that have proven to increase the chance of improving pregnancy and birth outcomes, with subsequent improvement in the health of mothers and their newborn. Many women may not be aware they are pregnant until 8 to 12 weeks, therefore establishing healthy habits and optimal health condition prior to conception protects the embryo and fetus in a very vulnerable period (harmful effects of smoking, alcohol, drugs, stress, etc.). Promoting healthy lifestyles decreases the incidence of chronic diseases that complicate pregnancy and adversely affect birth outcomes and maternal health and morbidity (diabetes, hypertension, obesity, etc.).

The PR MCAH staff will focus on developing the Preventive Health Services Guidelines for Women in Reproductive Age (PHSGWRA) for Puerto Rico in collaboration with experts in women health care. The goal of the guidelines is to include health care since the first menses, and include inter-conception, pregnancy and post-partum health care. The guidelines will incorporate the PRDOH Guidelines for Preventive Perinatal Services. Once these guidelines are completed they will be established as the Department of Health Public Policy. The goal of establishing these guidelines is to promote optimum health in WRA by recommending periodic medical encounters for screening, physical exam, early diagnosis, treatment and preventive guidance for health care providers, health care providers training centers, community and WRA Preventive
physical exam, early diagnosis, treatment and preventive guidance for health care providers, health care providers training centers, community, and WRA. Preventive guidance strategies for promoting WPH include cessation of smoking or abusing alcohol prior to pregnancy, taking a daily folic acid, and maintaining a healthy weight among others. The program will develop a curricula regarding WPH directed to WRA in an effort to convey and promote healthy lifestyles. In an effort to improve pre-conceptive health the dissemination and implementation of the PHSGWRA in health services will be advocated by the MCAH program at all levels; health care providers (continuous medical education activities), health care providers training centers, community, and families.

The PHSGWRA will be used to promote preventive health services as required by Affordable Care Act among WPA population through MCAH staff (community health workers, health educators, home visiting nurses). They will also outreach to uninsured women and refer for Medicaid Program eligibility evaluation. Dissemination of the guidelines will also be through diverse publishing media and forums.

Prenatal health care providers are key components in efforts to increase the opportunities for women to begin prenatal care (PNC) in the first trimester of pregnancy. MCAH Program will continue reinforcing the awareness of their responsibility to provide PNC services to pregnant women as soon as requested. PNC health providers are also responsible for educating WRA under their care of the importance of family planning, birth spacing and the benefits of early PNC. The PNC visit is important for the early identification of high risk pregnancies for early interventions to protect the outcome of the mother and infant. MCAH staff across the island will continue pointing out the importance of early PNC to guarantee the best maternal and infant health outcomes during and after delivery. Through outreach activities women in need of prenatal services will be identified and channeled accordingly. This will in turn help improve the rates of PNC enrollment in the first trimester, maternal mortality and morbidity and infant outcome.

Maternal health care will continue to be a main feature of the HVP. All Home Visiting Program participants will continue to be screened for tobacco, alcohol and drug use and exposure to trauma and domestic violence. Management according to the level of risk will be provided. HVNs will continue to pay special attention to women who quit smoking during pregnancy to avoid a postpartum relapse. Nutrition and physical activity during pregnancy will be further emphasized in these interventions and the HVN staff will continue to receive trainings in how to deliver these messages in an effective way to the participants.

CHWs will also continue to include the topics of alcohol, tobacco and drug use in educational activities and individual orientations during their interventions in the community. These topics will be covered in depth during the prenatal and parenting courses and other educational activities.

The MCAH Program will continue collaborating in the Puerto Rico Collaborative Improvement and Innovation Network (CoIIN) for Infant Mortality reduction. Among the priorities selected for Puerto Rico are: preconception/inter-conception health, prevention of preterm and early term births and perinatal regionalization. Hard Stop policy is one of the chosen strategies aimed at decreasing induction prior to 39 weeks gestation and therefore decreasing the prevalence of cesarean sections and late premature births. MCAH Program will continue with educational activities with CME for Obstetricians presenting prematurity and infant mortality data; prevention, early detection, and treatment of premature labor; and the use of the Hard Stop Policy in hospitals with collaboration of the Hospital's Association. The Assistant Secretary for Regulation and Accreditation of Health Facilities (SARAF, Spanish acronym) from the PR Department of Health will required that all birthing hospitals establish the "Hard Stop Policy".

Women/Maternal Health - Annual Report
NPM 1 - Percent of women with a past year preventive medical visit

<table>
<thead>
<tr>
<th>Annual Objective</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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<td>75</td>
<td>75.4</td>
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<td>76.2</td>
</tr>
</tbody>
</table>

MH and WRA are top priorities of the PR MCAH Program in its goal to have an impact on the families, communities and health care system with the purpose to achieve the health and well-being of Puerto Rico’s pregnant women and their birth outcome. This requires ongoing assessment of the changing health needs of this population (as impacted by cultural, linguistic, demographic characteristics), identification of priorities and implementation of strategies to achieve equity in access and positive health outcomes. This is achieved by working in collaboration with multiple partners, including families, community based organization and other governmental agencies in promoting shared vision for leveraging resources, integrating and improving systems of care, promoting quality public health services and developing supportive policies.

The MCAH Program reaches these populations through various strategies. The HVP focuses on pregnant women at high risk which are voluntarily registered, and the CHW are promoters of health delivering educational activities at the community level. Efforts to improve pregnancy outcomes and the health of mothers and infants are most effective if they begin before a woman is pregnant, therefore it is important to establish healthy behaviors and achieve optimal health before pregnancy, as many women are not aware of their pregnancy until 10 to 12 weeks or more after conception. According to PR BRFSS, by 2013 around 73% of women had a past year preventive health care visit in Puerto Rico. During 2014, the HVP Program had a total of 64 HVN’s that visited 61 out of 78 municipalities. Another 4 municipalities were also impacted by the Healthy Families of America Program. Throughout this period, MCAH CHWs and HVN provided 211 educational activities at community level on prenatal health-related issues, including the importance of early entry into PNC, reaching 2,055 persons across the island; 57 of these were prenatal courses. The prenatal course “A Baby on its Way” main purpose is building knowledge and provide participants with tools to take care before pregnancy, maintain a healthy pregnancy, preventing risk behaviors, a healthy delivery and appropriate care for the baby. The target population is pregnant women and their companions. This course consists of four educational sessions that include accurate information and educational activities divided into the following topics: healthy lifestyles, prenatal care, risk behaviors, pregnancy stages, and changes in pregnancy, conditions affecting pregnancy, delivery planning, delivery process, premature birth, caesarean birth, postpartum care, baby care, breastfeeding, birth spacing and family planning. Participants also complete a socio-demographic profile and a pre and post-test. These educational forums offer an opportunity to identify pregnant women who lack PNC and to guide them to get these services. During this period, 2,638 participants of the HV Program in their inter-conception stage benefitted from one-on-one interventions by HVNs on matters about health care. Among them: family planning, recognizing when a pregnancy is in progress and particularly to get PNC as soon as pregnancy is suspected.

Preliminary, 2014 VS data for PR reveals that 99.8% women who had a live birth in 2014 received PNC at any time during their gestation. Eighty-five percent (85.5%) women with a live birth began PNC during their first trimester of pregnancy (NPM 18), a slight increase (0.7%) when compared to 2013 births (85%), and the 10 year Average Annual Percent Change (AAPC) shows an increase of 0.6% since 2005 (81.5%). PR does not have an established HP 2020 objective for PNC initiation in the first trimester, however when comparing VS data for 2014 with the annual performance objective set for 2014 (82.8%), the data reported above shows that the goal has been reached. An age-linked disparity is observed between women 10-19 years old and those 20 years or older. VS for 2012 revealed that 75.3% women in the 10-19 age range and 84.6% women 20 years or older began PNC during their first trimester of pregnancy. Low rates of early initiation to PNC by adolescents may be due to several causes, such as fear of notifying the pregnancy to their parents, and difficulty to get PNC coverage independent of their families’ health plan. The MCAH Program is continually on the lookout to identify, educate and help pregnant adolescents to obtain PNC services at once. HVN within the program are particularly responsible for visiting on a regular basis pregnant adolescents participating in the HV Program and for verifying that PNC offered follows the current PRDOH Guidelines for Preventive Perinatal Services.

In their intervention the Home Visiting Nurses (HVN) screen HVP participants for tobacco, alcohol, and drug use and provide management according to the level of risk. Registration and participation in the HVP is voluntary. The HVN counsel pregnant women to avoid behaviors that represent risks for their health and fetus such as: alcohol
Registration and participation in the HIV is voluntary. The HIV counselor pregnant women to avoid behaviors that represent risk for their health and those such as alcohol consumption, smoking, prescription and over-the-counter drug use, exposure to toxic substances, and stress. Smoking use during pregnancy has been associated with adverse birth outcomes, including preterm birth and low birth weight. In accordance with the FRAMES-like surveillance study (ESMIPR, Spanish acronym) carried out every two years by the MCAH Program, in 2012 the prevalence of tobacco use among pregnant women was 2%, with 0.07% of participants admitting smoking in the third trimester. **(NPM 15: Percentage of women who smoke in the last three months of pregnancy)**

In the HVP the "Perfil de la Participante" (Participant's Profile) is the instrument designed to collect information regarding smoking and other substance use status, to determine addiction severity, susceptibility to change and level of motivation and support. In 2014, the HVP screened for tobacco use 1,708 pregnant and postpartum participants. Eighty-four (84) participants (4.9%) answered a positive smoking history, 18 quit smoking before pregnancy, 46 quit smoking during pregnancy, 4 continue smoking the same amount of cigarettes and 9 significantly reduced their tobacco use. 7 participants didn’t respond. During pregnancy, emphasis is given to educate participants on adverse effects of high-risk behaviors as smoking in the Prenatal Course. The HVP experience throughout the years is that pregnant woman quit smoking as soon as they know they are pregnant, therefore not a common issue among program participants. In the other hand we had more pregnant woman and children exposed to second smoke. HVNs and CHWs point out the importance of avoiding environmental tobacco smoke (ETS) for women who, although not smokers themselves, live or spend time with smokers. Orientation and education are offered to these women on an individual basis, and educational materials reinforcing the information are distributed. Referrals to the Quit Line are made for participants and any other family member that smoke. Using the Smoke Free Home Initiative model, HVNs and CHWs conducted interventions on second and third hand smoke HVNs continue to implement the smoking cessation program with participants and family members who are interested in quit smoking. The effects of smoking on the fetus are covered in educational activities for pregnant women and in the prenatal course. Educational materials regarding both smoking and exposure to ETS are distributed in health fairs and other community education activities by the CHWs. In FY 2013-2014, a total of 95 educational activities on ETS and smoking prevention were carried out, reaching 1,422 participants.

Frequent use of alcohol, especially early in pregnancy, can cause fetal alcohol syndrome (FAS) and alcohol-related birth defects. In the HVP from 1,016 pregnant participants were screened for alcohol and other substances. Seventy-three (73) women admitted drinking the month prior to acknowledging they were pregnant, 11 used drugs, 17 reported risk for domestic’s violence and 14 reported their partner had problems with alcohol or drugs. These cases were referred for appropriate interventions and support during their participation in the HVP. The ESMIPR 2012 reported 5% of participants admitted drinking alcohol and 0.6% used drugs during pregnancy. The prenatal course emphasizes the negative effects of these habits on the outcome of the infant and on the overall health of the mother.

Immunization status and orientation to complete their immunization status following the ACIP recommendations for pregnant women are also pursued by the HVN. Yearly Influenza vaccination requires constant reminder to participants and to the community at large, with arguments on the need and safety of this vaccine for pregnant woman against the prevailing myths against immunization during pregnancy in the social media.

All participants of the HVP are screened for maternal depression using the Edinburg test at least in three occasions: during the third trimester of pregnancy, two months and six month postpartum. Cases with positive results are referred to their health care providers for identification of support services.

Neural tube defects - including spina bifida, anencephaly, and encephalocele– are serious birth defects that are important causes of infant mortality and disability. Women who have had a pregnancy resulting in an infant or fetus with a neural tube defect have an increased risk for having another pregnancy resulting in an infant or fetus with a neural tube defect. Besides the mortality and disability associated to these conditions there is a high cost in the treatment and care of this condition. It is estimated that the total lifetime cost of care for a child born with spina bifida is estimated to be $706,000. The CDC recommends the use of supplementation in a daily use of multi-vitamins containing folic acid to reduce the risk of neural tube defects in infants by two-thirds. **(SPM 1: The proportion of women of childbearing age consuming folic Acid)** In 2009-2010, only 30.1% of recent mothers reported daily multivitamin use in the month prior to pregnancy. In national surveys Hispanic Women have the highest rate among women having a child affected by these birth defects. In 2007 survey among all women of childbearing age: 40% reported taking folic acid daily, 81% reported awareness of folic acid and 12% reported knowing that folic acid should be taken before pregnancy. In Puerto Rico the prevalence of neural tube defect has decreased from 16 per 10,000 live births in 1996 to 9.8 per 10,000 in 2013 as reported by the Congenital Defect Vigilance System. The 2012 ESMIPR reported 84.7% of participants admitted consuming folic acid during pregnancy, and only 24.0% consumed folic acid in the previous three months to becoming pregnant. Eighty-five percent (85%) stated the reason for not consuming folic acid prior to pregnancy was because it was a non-planned pregnancy, and 14.2% did not take it because they believed it was not necessary.
Reason for not consuming folic acid prior to pregnancy was because it was a non-planned pregnancy, and 11.27% did not take it because they believed it was not necessary. Misconception referring to “the reason why providers recommended the use of folic acid” expressed by participants in the ESMIPR 2012 were, it was to make bones stronger (18.5%), and 1.0% to treat hypertension. Fourteen percent stated not knowing the purpose for consuming folic acid. Sixty-five percent (65%) of non-pregnant women older than 18 years old reported not taking vitamins in 2011 (Puerto Rico 2011 BRFSS survey). The WIC Program administered a brief questionnaire, based on the core questions of the BRFSS folic acid module, to all the non-pregnant participants of the WIC Program that visited the clinics during August and September 2014. Copies of the questionnaire were distributed among the 98 WIC centers throughout the island. A total of 3,718 women answered the questionnaire on knowledge and consumption of folic acid. Findings were as follows: 88% answered that folic acid is a vitamin, and 97% had heard about it; 43% answered currently taking any vitamins or supplements containing folic acid, and 33% take it daily; 55% answered that the time when women should take folic acid is from 10 years old, while 37% answered that it should be after learning she is pregnant; 60% answered that the reason why experts recommend taking folic acid is to avoid having babies with birth defects; 27.3% respondents who took multivitamins or folic acid, 7 days a week for at least one month before pregnancy, while 44.5% answered that they did not take folic acid. Promotion of the need to take folic acid in WRA prior to pregnancy requires multiple strategies and is part of the pre-conceptive preventive health plan. The use of folic acid as a preventive measure in WRA may be promoted as early as adolescence, for what developing effective campaigns to reach them require coordinating focus groups with adolescents for their input. Adolescents are most reachable in the school setting, for what the use of an Educational Module promoting the use of the Folic Acid by teachers covering health issues in public schools is another viable strategy that has been developed.

To reach the general public multiple activities with opportunities to educate and promote the preventive use of folic acid in WRA were delivered. The Birth Defects and Developmental Disabilities Surveillance and Prevention Section (BDSPS) under the CSMHCN division, participated in 206 community base health fairs/educational activities reaching 17,075 individuals, with the collaboration of the Maternal and Child Health Division (MCAH) regional staff and delivered the message of the need to take folic acid supplements in WRA in an effort to reduce neural tube birth defects.

During the Folic Acid Awareness Month multiple activities were held in local university campuses with media coverage helping disseminate the preventive message. During the month of October 2014, the folic acid educational material was disseminated in over 40 community base health fairs/educational activities reaching more than 4,500 individuals, thanks to the collaboration of the MCAH staff. The BDSPS had 3 articles published in national newspapers and gave three interviews, one on a local television show and two in a local radio show. The BDSPS started a collaborative agreement with the Puerto Rico Primary Health Care Association in order to work closely with Puerto Rico’s 330 Health Centers. An introductory teleconference presentation was given to the participating 330 Health Centers on October 9th, 2014.

Working and collaborating with other agencies and organizations provided additional opportunities to include promoting the preventive use of folic acid among their priorities and reaching a broader population. A short educational video was designed and produced in collaboration with the Metropolitan University, in which graduate nursing students deliver a message about the importance of consuming folic acid. The purpose is to promote the consumption of 400 mcg daily of folic acid to be distribute in universities, public schools and WIC clinics. The video will be played throughout the different campuses of the Metropolitan University in Puerto Rico during the 2015-2016 academic year, to promote knowledge and increase the consumption of folic acid among students.

The State Alliance for Birth Defects continued with meetings to develop strategies directed at promoting the increased daily use of folic acid among WRA. The State Alliance held 6 meetings in this reporting period, in which BDSPS data was shared for the development, execution and evaluation of the BDSPS data-driven action plan for birth defects surveillance, referral and prevention. A brochure and standing banner were created with information about the Alliance and its members, to be used during educational activities. Six (6) new partners joined the Alliance for Birth Defects Prevention: the PR Hereditary Diseases Detection, Diagnosis and Treatment Program; Somos Team Jarcho-Levin; APS Healthcare of PR; the Puerto Rico Commission on Civil Rights; SER de Puerto Rico; and one community member, mother of a child with developmental disabilities. The BDSPS maintains its collaboration with the Demographic Registry Office, which continues distributing to parents registering a baby the NBDP’s brochure “Congratulations Mom” (Spanish version), and to couples seeking a marriage certificate the CDC’s brochure “How to Prevent Birth Defects” (Spanish version) Island wide. The Alliance held its annual Health Fair, at the main campus of the Metropolitan University on October 13, 2014. These events were free and open to the public. Over 20 non-profit organizations and government agencies set up tables with educational material and provided information about birth defects prevention, services available in the community and general wellness to over 300 students. Concurrently, presentations were given in an auditorium by health professionals on various subjects, such as communicable diseases, spina bifida and hydrocephalus, importance of newborn screening, and sexual health. Based on the evaluation forms handed out during the event, 71.4% said that their experience visiting the information tables was excellent and 62% said their knowledge about birth defects and prevention had improved.
increased. Forty-one percent (41%) attended two or more of the educational presentations and 74.3% said that they found the presentations to be excellent. Eighty-five percent (85%) said that they would definitely like to participate in another activity like this one.

Facebook page: "Alianza para la Prevención de los Defectos de Nacimiento" (https://www.facebook.com/pages/Alianza-para-la-Prevenci%C3%B3n-de-los-Defectos-de-Nacimiento/360069500764637) continued as a social media portal with the purpose of providing information about birth defects incidence and prevention strategies, and to promote the health of women in reproductive age and other populations.
<table>
<thead>
<tr>
<th>State Priority Needs</th>
<th>Objectives</th>
<th>Strategies</th>
<th>National Outcome Measures</th>
<th>National Performance Measures</th>
<th>ESMs</th>
<th>SPMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease Infant Mortality</td>
<td>1. Increase the percent of very low birth weight infants (less than 1,500 grams) born in a hospital with a level III or higher NICU in Puerto Rico by 2016.</td>
<td>1. Perform continuous assessment of hospitals classification levels, according to the maternal and perinatal care capacities established by American College of Obstetrician Gynecology, and the American Academy of Pediatrics. 2. Disseminate findings regarding the hospitals classification levels assessment to support decision making in the Public and Private Health Systems. 3. Continue the current Fetal and Infant Mortality Review Advisory Committee activities in Puerto Rico (currently not supported by law). 4. Develop a Bill for the establishment of the Fetal and Infant Mortality Review Advisory Committee in Puerto Rico.</td>
<td>Perinatal mortality rate per 1,000 live births plus fetal deaths Infant mortality rate per 1,000 live births Neonatal mortality rate per 1,000 live births Preterm-related mortality rate per 100,000 live births</td>
<td>Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)</td>
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<td>Decrease Infant Mortality</td>
<td>Increase the percent of infants who were reported to ever breastfed in Puerto Rico by 2016.</td>
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<td>2. Increase the percent of infants who were reported as breastfed exclusively through 6 months in Puerto Rico by 2016.</td>
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<tr>
<td></td>
<td>1. Train the Home Visiting Program staff in breastfeeding.</td>
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<td></td>
<td>2. Provide breastfeeding training to Home Visiting Program participants in prenatal and postpartum periods.</td>
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<td>3. Provide breastfeeding support to participants in the postnatal period.</td>
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<td>4. Promote Law No. 79 regarding the requirement of informed consent to provide human milk substitutes in maternity service centers.</td>
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<td>5. Promote the Administrative Order No. 336 which requires hospitals to establish breastfeeding support policies.</td>
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<td>6. Continue the activities of the Breastfeeding Promotion Coalition.</td>
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<td>7. Continue collaboration with WIC Program (Peer Counselors).</td>
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<td>8. Increase collaboration with Community Based Organization providing breastfeeding support.</td>
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</tbody>
</table>

| | A) Percent of infants who are ever breastfed and |
| | B) Percent of infants breastfed exclusively through 6 months |

| | Post neonatal mortality rate per 1,000 live births |
| | Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births |
support.
9. Promote knowledge of existing laws that protect the rights of breastfeeding mothers.
10. Create a MOU with the Department of Education to provide a Prenatal Training Course (Spanish title: "Cursillo Prenatal").
11. Collaboration efforts with the Puerto Rico Hospitals Association to promote the Baby Friendly Hospitals Initiative, which implement a ten steps program to achieve a successful breastfeeding process.

**Perinatal/Infant Health - Plan for the Application Year**

The MCAH Program has identified decreasing Infant Mortality (IM) as one of the top priorities for what it will continue its strategies to decrease preterm births, increase percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates, and promote and support breastfeeding until infants reach at least 6 months of age.

The Program will perform continuous assessment of hospitals classification levels, according to the perinatal and maternal care levels as established by the American Academy of Pediatrics, American College of Obstetrician Gynecology and the Society for Maternal-Fetal Medicine, and disseminate the findings to support decision making in the Public and Private Health Systems. Once the classification of perinatal and maternal care services is completed, MCAH Program will promote the creation of inter-hospital agreements for high-risk patient referral. Thru legislation, MCAH Program will also promote de implementation of more teaching hospitals associated to the schools of medicine around the Island.

Puerto Rico’s CoIIN for Infant Mortality reduction strategies will continue to focus in the prevention of preterm and early term births. Prenatal care will be included in the Preventive Health Services Guidelines for women in reproductive age. With these guidelines Ob/Gyn’s should be able to identify among pregnant women those that have a previous premature birth and refer her for home services administration of the 17P (medroxyprogesterone). MCAH Program will also promote...
those that have a previous premature birth and refer her for home services administration of the 17P (hydroxy-progesterone). MCAH Program will also promote the use of the Hard Stop policy through a requirement to all birthing hospitals, which will be developed by the Assistant Secretary Office for Regulation and Accreditation of Health Facilities (SARAF, Spanish acronym) from the PRDOH. MCAH Program will continue to educate the public regarding premature birth through a media campaign and the distribution of a magnetic pad with information about signs and symptoms of preterm labor and the steps women should take once they become aware they are experiencing preterm labor. HVNs will continue to routinely evaluate their clients to identify the presence of risks related to premature and VLBW deliveries and provide education and individual orientations about the signs and symptoms associated with premature labor as well as information concerning the birthing facility with Level III perinatal services near to the client's residence. The MCAH Program will continue to promote the use of a prenatal card with pertinent information and to be carried at all times by pregnant women.

The FIMR Committee will keep studying cases and presenting the findings and recommendations to groups interested in reducing Infant Mortality and the regional boards for the development of preventive community actions. This next year the FIMR will undergo a reevaluation of its protocol with the purpose to overcome some of the difficulties, it had during the past years and be able to continue its evaluation processes without losing its initial purpose. The MCAH Program will continue the current Fetal and Infant Mortality Review Advisory Committee activities in Puerto Rico (currently not supported by law) and develop a Bill for the legal establishment of the FIMR Advisory Committee in Puerto Rico. This is with the intention of providing the FIMR with the legal tools to allow the evaluation of data pertaining to maternal care in the private Ob-Gyn offices necessary for a complete review.

The collection of data related to Breast Feeding practices is vital to assess the real status among WCBA in Puerto Rico and to develop and implement strategies aimed at increasing its acceptance. Accordingly, the MCAH will continue carrying out the ESMIPR biennially, with a change in the protocol to begin its next cycle in 2015 and offer the first survey to all post-partum women. They will be offered the self-administered survey to answer when they register their child in the Demographic Register. The protocol will continue with the second and third phase by telephone surveys of a randomly selected sample. The ESMIPR data collection and analysis will be continued and results, that include facts regarding BF practices in Puerto Rico, will be posted in the PRDOH web page for use by health providers and other individuals interested in the subject. The MCAH staff will continue to promote knowledge of existing laws that protects the rights of breastfeeding mothers. The Division will continue to provide training and updated information on the subject to its staff (HVN and HCW) to reinforce one-on-one orientations on BF-related issues to participants of the HV Program and to encourage the participants to adopt this traditional infant feeding practice, with special emphasis in following exclusive breastfeeding, at least during their offspring's first 6 months of life. The MCAH staff will provide follow-up on the compliance of the Administrative Order No. 336 which requires hospitals to establish breastfeeding support policies. The Breastfeeding Promotion Coalition (BPC) will organize and deliver workshops to help Hospitals identify strategies to comply with the Administrative Order, and promote BF in the hospital setting and establish effective referrals for BF support groups once discharged. The effort include promoting Law No. 79 regarding the requirement of informed consent from parents to provide human milk substitutes in maternity service centers emphasizing the risk implied upon allowing the use of substitutes of breast milk to feed infants.

The BPC will recruit the collaboration of Puerto Rico Hospitals Association to promote the Baby Friendly Hospitals Initiative, in implementing the ten steps proven to achieve a successful breastfeeding process. Efforts will continued to raise awareness among hospitals and maternity care facilities across the island of the opportunity to participate in national data collection surveys such as the mPINC that in turn provide information pinpointing areas in need of improvement to comply with the baby friendly steps. The Pediatric Consultant, of the MCAH program as presenting author, will be sharing “Working for Equity in Breastfeeding in the Maternity Services of Puerto Rican Hospitals” in a poster session which has been accepted for presentation during the 2015 American Academy of Pediatrics (AAP) National Conference & Exhibition to be held October 23-27, 2015 in Washington, DC.

The BPC will continue in close collaboration with WIC Program advocating for the Peer Counselors Program in Hospitals and the inclusion of Community Based
The BPC will continue in close collaboration with WIC Program advocating for the Peer Counselors Program in Hospitals and the inclusion of Community Based Organizations as strategies to support breastfeeding. During 2015 the BPC of Puerto Rico, leaded by the MCAH staff, will be promoting support for breastfeeding in the workplace and prolongation of breastfeeding beyond 6 months.

Perinatal/Infant Health - Annual Report

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>68.7</td>
<td>72.3</td>
<td>76.1</td>
<td>80</td>
<td>84.2</td>
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NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

<table>
<thead>
<tr>
<th>Annual Objectives</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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<tr>
<td>Annual Objective</td>
<td>82.1</td>
<td>83.3</td>
<td>83.3</td>
<td>84.6</td>
<td>84.6</td>
</tr>
<tr>
<td>Annual Objective</td>
<td>19.7</td>
<td>21.2</td>
<td>22.8</td>
<td>24.3</td>
<td>25.9</td>
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</table>

The MCAH Program has identified decreasing Infant Mortality (IM) as one of the top priorities. Preliminary data for 2014, suggest that IM rate is 7.0 per 1,000 Live Births (LB). Premature and low birth weight (disorders of prematurity and low birth weight) are among the first five causes of infant mortality on the island. Because PTB is a significant contributing factor to infant mortality decreasing its incidence will impact IM. Preliminary 2014 VS data revealed that 71% of the infants that died in their first year of life were premature babies. Among them, 85% were classified as early preterm and 15% as late preterm. The leading cause of death in the early preterm group was respiratory distress syndrome (13.5%) and congenital anomalies in the late preterm group (16.7%).

PR has one of the highest PTB rates in the nation. PR Healthy People 2020 has identified reducing late PTB as one of its objectives and has established the goal to reduce the rate to 12.1% by 2020. (State Performance Measure 4: The percent of late preterm births (34-36 weeks of gestation)) Preliminary 2014 VS reported a PTB rate of 15.2%. Most of these PTB occur when the pregnancy has reached between 34 to 36 weeks of gestation (10.4% in 2014). The Collaborative Improvement and Innovation Network (CoIIN), an initiative originated by HRSA and MCHB, main objectives is to reduce infant mortality in the US and its jurisdictions. On July of 2014 PR’s CoIIN Team met with the others states and jurisdictions teams in Arlington, Virginia, to develop a work plan that consisted of possible strategies and priorities according to each state and jurisdictions needs and that could help with the reduction of infant mortality. Out of the six final strategies selected after HRSA analyzed all states and territories input, the three strategies that the Puerto Rico’s team selected to work are: preconception/conception health, prevention of preterm and early term births and perinatal regionalization. MCAH Program has begun a series of educational activities with CREF for Obstetricians in Puerto Rico and midwives and will participate in the efforts of the local delivery of the Neonatal Quality Improvement Program.
activities with CME for Obstetricians presenting the prematurity and infant mortality data, the efforts to reduce both; the use of the Hard Stop Policy in hospitals with collaboration of the Hospitals Association and the coming requirement from the Health Department to all birthing hospitals; and early detection and standard of care of premature labor presented by a Peri-natologist.

The MCAH Program analyzed the results of the 2012 ESMIPR study in order to determine if factors that are not reported in vital statistics might be related to preterm births in PR. Univariate analyses were carried out to evaluate the effects of single factors on pregnancy duration and the risk of preterm delivery. Premature births are strongly related to maternal age of 25 to 34 years (OR=1.6; p=0.007), paternal age of 25 to 34 years (OR=1.7; p=0.00), paternal age of 35 years and older (OR=1.6; p=0.037), previous multiple births (OR=3.0; p=0.027), previous premature births (OR=10.0; p<0.001), previous low birth weight (OR=4.3; p<0.001), lack of family planning (OR=1.5; p=0.019), health conditions during pregnancy (OR=3.2; p<0.001), treatments for premature birth prevention (OR=4.1; p<0.001), visits to ER or hospitalizations during pregnancy (OR=2.9; p<0.001), and birth defects (OR=3.8; p=0.001). Premature births are moderately related to health conditions 3 months previous to pregnancy (OR=1.4; p=0.048), not visiting the dentist during pregnancy (OR=1.3; p=0.060) and consumption of prescription drugs during pregnancy (OR=1.3; p=0.054). Lastly there is a high probability for the baby to be low birth weight (OR=27.7; p<0.001), be admitted to NICU (OR=9.3; p<0.001) and be transferred to another hospital (OR=8.1; p<0.001) if born before 37 weeks of gestation.

(Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.) Low birth weight (LBW) is related to preterm birth, an increasing health concern and the first cause of death for early preterm babies. According to the most recent perinatal classification (Perinatal Care Guidelines Review Committee, 2012) of the 35 birthing hospitals evaluated during 2012, 20% were identified as basic perinatal services, 42.9% as specialized and 37.1% as subspecialized (34.3% IIIA and 2.9% IIIB). When compared to 2008 data (27.3%), subspecialized facilities increased 35.9%. Using this classification, preliminary Vital Statistic (VS) data for 2014 reveals that 69.1% of all VLBW were born at facilities adequately prepared to manage high-risk deliveries and neonates.

Since 2000, infant mortality (IM) has shown a marked reduction of 29.3% (9.9/1,000 live births vs. 7.0/1,000 live births). This decrease is also observed in neonatal and post-neonatal mortalities, with a reduction of 36.8% for neonatal mortality (7.6/1,000 live births vs. 4.8/1,000 live births) and a reduction of 23.1% for post-neonatal mortality (2.6/1,000 live births vs. 2.0/1,000 live births). Likewise, perinatal mortality decreased 27.6% since 2000 to 2014 (9.8/1,000 live births and fetal deaths vs. 7.1/1,000 live births and fetal deaths).

To raise awareness among clients and their relatives, MCAH HVN and HCW carried out a prenatal course that covered important health issues related to the prenatal, postpartum and pre and interconceptional stages. The HVP provides case management and care coordination services, health education and counseling to pregnant women with complex medical and social risk factors associated with LBW and VLBW infants. CHW hold outreach activities to identify and recruit pregnant women. Clients identified at risks related to premature and VLBW deliveries were individually oriented about the signs and symptoms associated with premature labor as well as information concerning the birthing facility with Level III perinatal services near to the client’s residence. The MCAH Program provides education to pregnant women on the signs and symptoms of preterm delivery, the importance of early prenatal care, healthy eating habits and adequate weight gain during pregnancy, physical activity, preconception health, oral health, health complications that may arise, labor and delivery processes, breastfeeding, newborn care, and family planning. HVN ensure that all HVP participants are evaluated in the WIC Program. The WIC Program also contributed toward reducing these rates by focusing on women with nutritional risk factors. During 2013-2014 MCAH Division staff provided orientation of prenatal care to 1,169 persons and 886 persons took part in 57 prenatal courses. HVNs contacted 3,508 families at community level across the island and identified 1,582 individual potential candidates to participate in the HV Program or referred them to other health programs according to their needs.
Also, in FY 2013-2014, the MCAH CHWs carried out 103 group activities regarding the signs and symptoms of preterm labor, and included orientation on where to seek for services in case an emergency arises. A total of 1,148 participants were reached across the island. Educational material on the subject was also distributed.

MCAH Program in collaboration with March of Dimes (MOD) focuses in prevention of preterm babies and the importance of completing at least 39 weeks of pregnancy. The MCAH Program staff continued providing educational activities to awareness of the IM to participants, providers and the general population. During the activities, staff encouraged women to abstain from high-risk behaviors such as smoking during pregnancy and offered recommendations to reduce this behavior as well as other factors that contribute to poor outcomes.

The MCAH Program first initiated a Fetal Infant Mortality Review (FIMR) in 2006, complementing local population-based fetal and IM data. Law No. 70, Aug 1997: Ordered the Secretary of Health to establish a committee responsible of developing studies and providing recommendations for the reduction of infant mortality. An interagency committee, comprised of nine members, public and private stakeholders including ASES. under the leadership of the MCH Director, was established to comply with the law. The committee became the components of the PR FIMR. The objective of the FIMR is to allow this Review Team to examine de-identified comprehensive information of infants who died in order to identify system-related risk factors that can be addressed. The Committee includes a wide array of concerned health stakeholders, including MCH and HS staff. Fetal and infant deaths are identified by the regional nurses. The data of the selected cases for review are then collected by nurses at regional level in the hospital and in a maternal interview which provides other social determinants of health that impact IM. Priority is given to providing the mother bereavement support. The MCH Program Pediatric Consultant (a pediatrician), and the HS social worker prepare together the case summaries that are then reviewed by the Committee. FIMR has identified critical community strengths and weaknesses as well as unique health/social issues associated with poor outcomes, and made recommendations in areas such as nutrition, prenatal care, pre-conceptive care, support system, education and hospital services. These recommendations have been shared with the MCAH regional boards promoting the development of community action by establishing and implementing strategies. These recommendations were also disseminated to relevant agencies and stakeholders with the objective of decreasing the IM rate in PR. The previous overall review was performed in 2010, and the cases were focused in the southeast region of the Island due to the higher prevalence of infant mortality in this region (Average infant mortality rate for this region was 11.4 for 2010-2013 versus 8.4 for Puerto Rico). Findings and recommendations were shared with the local boards of Mayaguez and Ponce. The Healthy Start staff developed a poster and a brochure about prevention of preterm labor; how to recognize the signs and where to look for services. These educational materials were distributed on WIC, providers’ office, Medicaid and other places where pregnant woman received services. Prenatal courses were used to provide education regarding the prevention, identification and management of signs of premature labor.

During FY 2013-14, the FIMR Committee has met a total of met on 11 occasions and continued to discuss 16 cases from the Mayaguez and Ponce Regions. Among the 11 cases the FIMR Committee reviewed, 87.5% of them were preterm infants (born prior to 37 weeks gestation; 50% were born prior to 28 weeks and 25% prior to 31 weeks). Fifty-six percent (56%) weighed less than 1 kg on birth. The most common maternal conditions reported were urinary infections. Forty-four percent (44%) of mothers were identified as overweight or obese, 56% reported stress during pregnancy, 44% had history of previous abortion or premature birth, and 88% had early prenatal care.

The MCAH Program staff continues to provide educational activities to participants, providers and the general population in an effort to make them aware of the preventable cause for Infant Mortality. The
HVP and CHW continued distributing the poster and the brochure: "Recognizing preterm labor: signs and symptoms". In addition, brochures have been distributed to participants in educational activities and health fairs, WIC and Medicaid offices and HVP.

(Performance Measure 11: The percent of mothers who breastfeed their infants at 6 months of age.) For many years BF practices have been promoted regularly by the PRDOH, its Breastfeeding Promotion Committee (BPC) at the MCAH Division, and other advocates, through public policies, laws, educational opportunities and other strategies. There is scientific evidence that Breastfeeding (BF) is a protective factor contributing against the development of acute infections such as diarrhea, ear and respiratory infections, and chronic problems such as asthma, allergies, and obesity. Increasing BF rates contributes to decreasing infant mortality. Breastfeeding confers benefits to infants, their mothers, their families and ultimately to the community and the environment. The Breastfeeding Promotion Coalition (BPC) with support from the MCAH staff continues to work to increase the ever BF rates and prolonging BF to beyond 6 months in PR by promoting the use of evidence-based practices for BF and collaborating closely with the WIC program.

BF rates are constantly monitored by the MCAH Division to evaluate its trend in PR. The PRAM's like, self-administered biennial survey, ESMIPR (Spanish acronym), and carried out by the Division since 2000, aims at women in their early post-partum period at hospital facilities, with follow up telephone interviews at 6 and 12 months after birth. In the 2012 study, telephone follow up, at 6 months reported prevalence of BF at 32.9% BF and at one year at 22.4%. Of the mothers who reported they were BF at 6 months, 54.6% reported they were exclusively BF, which represents 18% of the total women that participated. Analysis of ESMIPR 2012 data for BF at 6 months after birth showed that the rate rose 40% when comparing with 2010 results (23.5%). Preliminary data obtained from the birth certificate reported that in 2014, 79.6% of mothers were practicing BF at the moment of registering their babies, a 14.9% increase compared to 69.3% in 2011.

MCAH regional staff continued promoting BF at all population levels, to increase knowledge of the benefits of breastfeeding and the acceptance of this practice by the public. HVNs have provided individual BF orientations to participants of the HV Program; other staff has offered prenatal courses that include the topic of BF to pregnant women and their kin. The MCAH Program continued to disseminate posters and brochures, prepared by the program staff and via the regional offices, to Hospitals and other maternity care facilities on current laws about women’s and infants’ BF rights at these settings, particularly Law 156 of 2006 (assuring women can have a companion through labor and the pp period, rooming-in option, and BF rights, among others), and Law 79 of 2004 (banning hospital staff from giving breast milk substitutes to newborns without a doctor’s order and the mother’s informed consent).

The MCAH staff continued promoting knowledge of existing laws that protect the rights of breastfeeding mothers. The MCAH program efforts are directed at all levels to raise awareness of the importance of adopting breastfeeding as the best nutritional option for infants among WCBA in Puerto Rico. The Division has provided training and updated information on the subject to its staff. They in turn, particularly the MCAH CHWs, continue to offer educational opportunities and prenatal courses that include the topic of breastfeeding to pregnant women and family members at community level island wide to educate them on the benefits of this health practice. They also disseminate educational material for these purposes. During 2014 they conducted 127 educational activities on BF to 1,238 participants. HVNs continued providing one-on-one orientations on BF-related issues to participants of the HV Program within the MCAH Division to encourage them to adopt this traditional infant feeding practice, with special emphasis in following exclusive breastfeeding, at least during their offspring’s first 6 months of life. Their intervention provided breastfeeding training to HVP participants in prenatal and postpartum periods and breastfeeding support to participants in the postnatal period.

BF initiation begins at the hospital setting for what Baby-Friendly Hospitals, that provide the ten steps to promote BF, have been proven scientifically and are
promoted. In Puerto Rico there is no Baby-Friendly certified Hospital up to this date (2014). The mPINC (CDC Maternity Practices in Infant Nutrition and Care Survey) is an instrument for maternal institutions to self-evaluate their progress in improving maternal practices that support and promote breastfeeding. Although Maternal Hospitals (MH) in Puerto Rico have shown a gradual increase in the number of participants in the survey, limited participation in 2011 and 2013 mPINC was disappointing, and results were low national scores of 60 and 61. These findings raised concerns relating to the maternal practices affecting the promotion and support of BF. The Breastfeeding Promotion Committee (BPC) of the PR Health Department developed into a coalition and recruited further support from the local AAP chapter, WIC, Healthy Start, other government agencies and community based groups to address these concerns. A First Mother-Baby summits was delivered in January 2014 with the purpose to promote evidence based best practices that promote and support breastfeeding in maternity care facilities, and to obtain information on which practices were being implemented. This summit (sponsored By MCAH Healthy Start and supported by the BPC and MCAH staff) had the participation of 158 health professionals representing 20 hospitals with maternal wards. The summit invited key decision-making staff at maternity facilities to highlight the importance of evidence-based practices for BF and establish links among maternity facilities and community BF support networks in Puerto Rico. The need for hospitals to participate in the CDC mPINC Survey was emphasized. A second Mother-Baby Summit was coordinated in January 2015 with the participation of 240 health professionals representing 26 hospitals with maternal wards, emphasizing the laws that protect and support the right to breastfeed in the pp period in the hospital, and strategies to promote BF in the hospital. In response to the attention that the media gave this summit, and the poor mPINC scores PR has maintained, the PR Department of Health, assigned the MCAH division to collaborate with the office that regulates and certifies hospitals in PR (SARAFS), the task to prepare a ministerial order (Administrative Order 336) requiring Hospitals to implement a BF Program that includes 10 of the Baby-Friendly steps proven to promote and support BF. The BPC continued in close collaboration with WIC Program advocating for the Peer Counselors Program in Hospitals. The inclusion of Community Based Organizations (La Leche League PR, MAM, Muralla de Vida, Separe, Fondos Unidos) providing breastfeeding support in the BPC has been pursued as an effective strategy to support breastfeeding in the community. Efforts have continued to raise awareness among hospitals and maternity care facilities across the island of the opportunity to participate in national data collection surveys such as the mPINC that in turn provide information pinpointing areas in need of improvement, among them those related to the observance of local existing laws regarding BF rights.

The MCAH BPC continued to collaborate with advocates within and outside of the BPC in BF promotion efforts to educate people at all levels of the population on the numerous benefits provided by this natural feeding to infants, mothers, their families and their surroundings. In this coalition objectives and strategies were reevaluated based on data provided by the MCAH from the ESMIPR and birth certificates. The main goal was to identify and eliminate barriers and increase adoption of this practice among WCBA in the island. LACTA Project, WIC Program and the Coalition for the Promotion of BF in PR have been particularly engaged in this endeavor.
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<th>State Priority Needs</th>
<th>Objectives</th>
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1. Increase the percent of parent who report their children ages 6 through 11 years, are physically active at least 60 minutes per day in Puerto Rico by 2016.

1. Promote physical activity among Home Visiting Program participants.
2. Deliver Responsible Parenting Courses in communities by HCW.
3. Develop and include a section regarding physical activity and nutrition focused on 6 to 11 years old population into the Responsible Parenting Training curricula.
4. Identify curricula that provide training on improving physical fitness and/or healthy eating habits to train MCAH staff and develop interventional programs for this population.
5. Establish MOU’s with organizations and agencies identified that provide training on improving physical fitness and/or healthy eating habits.
6. Request proposals to community-based organizations aimed at increasing physical activity and healthy nutrition in

Percent of children in excellent or very good health
Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
**Improve Children Health and Wellbeing**

<table>
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<tr>
<th>Improve Children Health and Wellbeing</th>
<th>1. Increase the percent of children 0 to 9 years old with a preventive medical visit in Puerto Rico by 2016.</th>
<th>1. Promote Pediatric Preventive Health Care Guidelines among general public, academia, health professionals and health insurance companies.</th>
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**Child Health - Plan for the Application Year**

During 2014-2015, in an effort to improve child health and well-being the dissemination and implementation of the PR Pediatric Preventive Healthcare Guidelines (PR PPHG) in Pediatric Health services will be advocated by the MCAH program at all levels; health care providers, health care providers training centers, community, families and parents. The HVN and HCW will contribute in this process by educating parents on the schedule of preventive visits and the universal and selective screenings indicated according to age of the child, as recommended in the guide. The MCAH program will continue to evaluate use of clinical preventive services in an effort to identify strategies to promote and increase its use.

Because of the continued mis-information campaigns and myths throughout Social Media parents continue to resist immunizing their children on a timely manner, therefore MCAH workers require knowledgeable arguments to counteract them and change parents towards favoring on time complete scheduled immunization. During 2014-2015 further training of the HVN and HCW on how to Motivate Parents to Vaccinate will continue, providing them information and arguments as strategies to counteract these effects. HVN and HCW will continue to promote immunization on schedule, with emphasis on update schedules prior to 30 months of age.

The strategic plan to reduce obesity by improving nutrition and increasing the physical activity level in the population will take into consideration all available results from local investigations that shed light on the social, cultural, economic, ethnographic factors that contribute to the elevated overweight rate. Meanwhile the MCAH staff will actively collaborate with other PRDOH secretariats and agencies in their obesity prevention efforts and health promotion activities. The implementation will require a cooperation of government and public sectors, the Auxiliary Secretariat of Health Promotion and the MCAH staff support. Our staff will continue to promote physical activity, breastfeeding, healthy nutrition and compliance with the recently culturally and linguistically adapted My Plate recommendations during their home visits and community based activities. The Positive Responsible Parenting course includes messages directed towards adults with children between the ages of 2-5. As they adopt healthier habits they can become agents for change and can model healthy behaviors for the entire population.

The HVN and CHW will also be trained to use the history aspect of the “Caries Risk Assessment Questionnaire” (CRAQ) in an effort to identify high risk participants for an early referral for preventive dental services including sealants. The MNAH Program will collaborate with PR Headstart and WIC Program to promote the use of the history aspect of the CRAQ for the purpose to increase the identification of infants at risk for Early Childhood Caries and their early referral.

The HVN will continue to provide information and distribute educational materials directed at reducing unintentional injuries to the participants and at the community. The Prenatal course and the Positive Responsible Parenting course will include injury prevention and safety recommendations. Due to the tropical temperatures in Puerto Rico a baby forgotten in a car faces rapid dehydration and death if not promptly recognized. Therefore education and strategies to prevent
temperatures in Puerto Rico a baby forgotten in a car faces rapid dehydration and death if not promptly recognized, therefore education and strategies to prevent the forgotten baby syndrome are being developed for implementation in the HVP for next year by the MCAH staff. The MCAH staff will continue to collaborate with the Emergency Medical Services for Children (EMSC) Project and its Advisory Council working towards improving the emergency response infrastructure in Puerto Rico and establish a well-coordinated, well equipped and up to date Emergency Response System that complies with the latest recommendations of the National Pediatric Readiness Project (NPRP). Concerned with the deficiencies identified upon evaluation of ER providing services to the pediatric population, the Public Health Emergency Response and Coordination Office of the PRDOH and the EMSC will develop strategies and public policies to address deficiencies with the collaboration of the MCAH Program. In this process MCAH Program will collaborate in the revision of the PRDOH Hospital regulations and requirements, actualizing them and incorporating the AAP guidelines as a mandate for all institutions which provide pediatric emergency care.

The MCAH personnel will continue providing and disseminating through educational activities the latest NHSTA and AAP revised car seat guidelines and recommendations for adequate protective car seat selection and use according to the age and weight of the child to parents and communities. In addition staff will continue to promote compliance with local laws that besides requiring children be restrained while riding in a car, they must use safety approved helmets correctly when riding a bicycle, motorcycle or any other moving vehicle. These efforts will be directed at decreasing the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes.

HVN’s and CHW’s Staff will continue administering the Ages and Stages Questionnaires and ASQ-SE in an effort to identify delays, teach parents how to stimulate maximum development, and refer for further evaluation and early interventions. They will also carry out educational activities and distribute brochures on socio-emotional development, parenting skills and related topics. The Positive Responsible Parenting course training of CHW and HVP will be established and through them will be delivered and disseminated to the participants and community at large in an effort to promote the use of Nurturing and positive parenting skills. Trauma Informed Care training and a screening tool to identify trauma victims will be developed for the PR MCH Staff with the purpose to incorporate its use in the HVP in an effort to identify and offer referrals for help to participants identified as victims.

The Home Visiting Manual evaluation will be completed and implemented adding emphasis on increasing education on early stimulation at home and the use of pediatric preventive services for participating families with infants and children.

Child Health - Annual Report

NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

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<th>Annual Objective</th>
<th>2016</th>
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<td>Annual Objective</td>
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The MCAH program strives to have an impact on the families, communities and health care system with the purpose to achieve the health and well-being of Puerto Rico’s children and youth and their families. To accomplish these goals the Program continue to inform and educate the public and families about the unique needs of the pediatric population, conduct ongoing assessment of the changing health needs of the this population (as impacted by cultural, linguistic, demographic characteristics) to drive
During 2014 the MCAH Division reviewed the Puerto Rico’s Pediatric Preventive Health Care Services Guidelines (PR PPHCSG) in the context of the most recent Bright Futures (AAP) recommendations, statistics pertaining to the Puerto Rico pediatric population, and the Affordable Care Act (ACA). After discussion and consulting with a panel of experts on Pediatric Health Care, modifications were recommended and an actualized PR PPHCSG was published in a Public Policy statement from the Department of Health requiring its implementation in pediatric preventive health care visits. Besides the implementation of the PR PPHCSG in the GIP, the Insurance Commissioner Office (ICO) has adopted these guidelines as standard of care, and requires private health care insurance Companies in Puerto Rico to comply, as part of the ACA. Promoting the use of the PR PPHG is expected to impact and improve the health of infants, children, and adolescents by promoting healthy lifestyles that will enable them to achieve their full potential and the early identification of risk for evaluation and intervention. These guidelines emphasize the need to evaluate and screen nutritional habits, physical activity, BMI, oral health, development status, signs of depression and risky behavior and recommends specific validated screening instruments to help in an early identification and timely intervention. They also emphasize the role of anticipatory guidance for effective prevention. The HVN and HCW have contributed in the process of dissemination of the PR PPHCSG by educating parents on the schedule of preventive visits and the universal and selective screenings indicated according to age of the child, as recommended in the guides. These guidelines were also be used by the MNAH staff participating in the task force designated by the governor to develop an annual preventive pediatric visit certificate which will be required from students prior to beginning the school year 2015. The MNA staff advocated for inclusion in the certificate of evidence of the proper screenings indicated by age as recommended by the PR PPHCSG.

Data provided by the Administration of Health Care Services of Puerto Rico (ASES)(GIP) during 2013 reported 558,841 pediatric patients (between the age of 0 to 19 years old) were subscribed to the GIP, which represents a 60% of the population in that age range (936,270 children for 2013 estimated by US Census Bureau). Upon evaluation of the 10 most common diagnostic codes on health care bills, obtained through the ICO (GIP and Private Insurance Plans) only 108,250 visits were claimed during 2013 for preventive visits, excluding visits for immunization.

Among the priorities of the PRMCAH program is to continue to support on schedule immunization of the pediatric population. (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.) Law 25 of 1983 mandates children living in PR must be immunized according to the latest immunization schedule approved by the Secretary of Health in order to attend child care facilities, schools and universities. The PRDOH annually updates its immunization schedule in accordance to latest recommendations by ACIP and the CDC and publishes the PRDOH Manuel. The MCAH Program continued as a key collaborator with the Puerto Rico Immunization Program (PRIP) by supporting and promoting participation in the vaccination campaigns carried out throughout the Island. The MCAH Program staff continued to disseminate information on the importance of complying with the current immunization schedule. The HVN and HCW assessed and promoted adequate immunization for children participating in the Home Visiting Program (HVP) emphasizing immunizations topics in their home interventions by evaluating and providing guidance on immunization schedules, and clarifying myths and mis-conception relating to vaccines. Among challenges are the persistent reluctance of some parents to have their children receive multiple vaccines at once, parents concerned that vaccines may cause autism, toxic effects of mercury in vaccines and other mis- conceptions prevalent and spread by mass social medias. Another situation is that parents willing to immunize face difficulties to provide vaccines to children with ease in a timely fashion. Barriers identified relate to the mechanism in the system to obtain vaccination in their health care centers. These concerns were shared with the DP for their intervention and correction and the HVN personnel received instructions to strengthen their interventions to empower families in obtaining the immunization services in their area. Following the new regulations by the ACA, the DP with support from the MCAH staff have promoted that all insurance companies cover the cost of the recommended immunizations. A new format for the PRDOH web page has been published and is in constant editing to improve the information available to the population and health care professionals. In these pages the population has access to updated information on immunization and links to the CDC immunization information pages. Articles discussing science-based evidence on the safety of immunizations are available.
information on immunization and links to the CDC immunization information pages. Articles discussing science based evidence on the safety of immunizations are available with the purpose to educate and guide parents, promote vaccination on schedule and counteract the myths and misinformation they receive through mass communication media.

The HVN and CHW staff also used diverse community level interventions to disseminate the current immunization schedule and its safety by participating in the community at large, at school activities and health fairs. During CY 2014, 3,812 families were visited and received information on the importance of children’s immunizations. A total of 2,715 children from families in the HVP were evaluated for the adequacy of their immunization status, counseled and referred for vaccination, if needed. At the end of 2014 (December), 99.9% of HVP participants had an up to date immunization record at the time they were discharged from the program. A total of 138 activities with direct impact to 2,228 participants were carried out throughout the 7 MCAH regions in 2014. Beginning July 2014 PR was included in the National Immunization Survey that will provide additional information on the vaccine status of the population.

Another priority of the MCAH program is contributing to decrease the prevalence of obesity by promoting physical activity and healthy eating habits. (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) To help achieve this goal the MCAH staff continued participating and collaborating with the Pediatric Obesity Prevention Alliance Inc. (Alianza POP, non-profit organization) with the purpose of educating, designing and performing applied research and developing public policy to reduce the prevalence of childhood obesity in PR. Our staff, active members of the alliance, has collaborated in helping increase communication and collaboration among governmental, private and nonprofit agencies that are developing research and implementing interventions for the reduction of overweight in children.

The MCAH Division has been proactive helping to evaluate laws for implementation of public policies that integrates and coordinates local efforts to improve the early recognition of obesity in children with the appropriate referral for intervention. In May 2014 the proposed amendments to the Puerto Rico 296-2000 law, known as “The law of conservation of child and adolescent health of Puerto Rico”, Senate Project PS865, was extensively reviewed by the MCAH program. Emphasis on the need of an interdisciplinary intervention for identification and management of childhood obesity with non-punishable actions towards parents was advised. The approval of a Public Policy by the Puerto Rico government for the implementation of a strategic plan to stabilize and then reduce childhood obesity is a priority of the government and is in the process of evaluation by policy makers with multiple bills in different stages of evaluation and approval. Since no group or agency alone will be able to reduce or eliminate the problem particularly in these times of financial crisis, the policy will help identify organizations and agencies and assign roles and responsibilities, working together to maximize scarce resources and prevent duplicity. The MCAH staff actively collaborated with other PRDOH secretariats and agencies in their obesity prevention efforts and health promotion activities.

In September 2014 our staff collaborated actively in the Puerto Rico United Way campaign promoting the use of my plate as a nutritional guide for parents to feed their children and reduce obesity. This campaign included presentation in a press conference in an effort to educate journalists, communicators, media, community representatives and the public at large on issues related to pediatric obesity and encourage healthy eating and daily exercise.

Our HVN’s and CHW’s have promoted healthy eating and physical activity during their daily activities. During FY 2013-14, they offered 176 activities to promote physical activity and healthy eating with a total participation of 2,304 persons. Breastfeeding was promoted on 127 educational activities attended by 1,238 participants. There is scientific evidence that Breastfeeding (BF) is a protective factor contributing against the development of obesity in childhood. The Breastfeeding Promotion Coalition (BPC) with support from the MCAH staff continues to work to increase the BF rates in PR by promoting the use of evidence-based practices for BF as a preventive measure for childhood obesity and by collaborating with the WIC program to promote BF. Nutrition guidance and education during pregnancy and for infants was offered on 280 different occasions and reached 2615 persons.

The PR PPHCSG, actualized by the MCAH division, emphasizes calculating BMI and its percentile, history of physical activity and nutritional habits on all children during their preventive visits. It also reminds primary care providers the importance of including nutritional and physical activity advice when delivering anticipatory guidance.

Oral health care is another priority of the MCAH Division for promoting health in the pediatric population. The dissemination of the PR PPHG and its implementation further emphasize the need of using risk assessment at early infancy age, with focus nothing for an effective preventive intervention with referral to a dental home and use of dental
emphasizes the need of caries risk assessment at early infant age, with first teething, for an effective preventive intervention with referral to a dental home and use of dental varnish besides oral health care education among its recommendations. (Performance Measure 09: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.) Our MCAH staff promotes the messages directed at increasing the number of parents and children that adopt healthy oral habits. They continue to increase awareness among parents with elementary school children that dental sealants are covered by the GIP and encouraging them to request their application. The HVN and HCW disseminate educational materials concerning the importance of protective sealants to support their efforts. The Program acknowledges that promoting dental sealants particularly among parents of low income children is important since they are the group less likely to have had a dental sealant application and are at a higher risk for dental decay as previously reported in the medical literature.

In an effort to provide support for the promotion of oral health care the PR MCAH program kept close collaboration in the oral health alliance. We provided support to the Oral Health Workforce grant director promoting their strategies to build an optimal oral health workforce to ensure the access and availability of services in PR, enhance awareness of oral health policy and system change to augment the workforce island wide and enhance the public awareness of evidence based preventive strategies for improving oral health. The MCAH Program continued to advocate for the inclusion of oral health care for early childhood and pregnant female in the oral health care professional training and CME activities. PR Head Start reported dental cavities as a top prevalent health condition among their participants, 14.3% in 2014. Data provided by the Administration of Health Care Services of Puerto Rico (ASES)(GIP) reported 291,572 patients between the ages of 0 to 21 years old received dental services during 2014 (47% of the total population in that age group served by GIP (614,678)) and 813 children between 1 to 6 years had caries treated. The ICO reported that from a total of 89,485 children between the ages of 8 and 9 years with health insurance, only 7,024 (7.8%) received protective sealant at least in one molar. ASES reported a reduction of 43% of dentists that provide services to the GIP population in 2013, (2012: 1,193 dentists; 2013: 682 dentists) the ratio of 2,293 patients per dentist remaining. This reflects the crisis that PR is facing with the emigration of professional to the mainland due to economic deterioration on the Island. There continues to be reluctance of general dentist to give services to the early childhood population, and a concentration of pediatric dentist in the larger metropolitan areas limiting access to the population with limited transportation. This has prompted the need to advocate the inclusion of pediatric health care in the training of dental health care providers and CME of dentist by MCAH staff in the Oral Alliance. Collaboration has continue with the director of the Oral health Promotion Program to identify strategies to increase and promote referral for dental home since the first tooth (6 to 12 months of age) and the early identification of infants at high risk of dental caries for referral to dentist and for the administration of fluoride varnish. In Puerto Rico due to professional regulatory laws, the use of fluoride varnish by primary care practitioners is actually not allowed.

Direct actions taken to promote oral health care by the HVP and CHW included educational interventions to raise awareness among parents about the risk factors for caries, the importance of protective sealants, and to pregnant women on the importance of oral health in the outcome of pregnancy. They delivered 80 educational activities to a total of 1,416 participants during 2014. These activities emphasized the coverage of oral health care and procedures by the GIP.

Another area on which the PR MCAH program focuses is on the prevention of unintentional injuries. Unintentional injuries represent the first cause of death among the pediatric population aged 1 to 14 years. (State Performance Measure 5: The rate per 100,000 of emergency room visits (ERV) due to all unintentional injuries among children aged 1 to 14 years). According to VS preliminary data for 2014, death rate due to unintentional injuries was 1.1/100,000 in children 1 to 14 years of age, versus 3.1/100,000 in 2013. Despite the decrease in the death rate unintentional injuries are associated with significant morbidity. Survivors frequently have sequelas that impact their health and quality of life for the rest of their lives. Averages of 11.9 million visits annually were injury related in 2009-2010 in the US. Leading causes of injury related ERV in the US aged 18 and under are falls and striking or being struck by objects or persons, with 42% of patients under Medicaid Insurance. The PR MCAH Program continued to monitor non-fatal injuries and their causes in the pediatric population in an effort to define epidemiologically the children who receive emergency room services in PR. The purpose is to identify the most common causes and to evaluate, modify and develop further strategies in an effort to prevent their occurrence. The Insurance Commissioner Data (ICD) obtained from the local health insurance companies is used by the MCAH staff to conduct studies to define epidemiologically the children who receive emergency room services. The Insurance Commissioner reported 102,092 minors between the ages of 0-14 visited an emergency room due to an injury during CY 2013; and 90,506 during 2014. This represents a rate of 13,819.7 per 100,000, a decrease of 9.2%. ASES reported 1,620 hospitalized and 70, 476 ER visits of children minor than 14 years old, enrolled in the GIP, due to unintentional injury for 2014. Upon evaluation of the 10 most common diagnostic codes by insurance company on health care bills from emergency room visit, (obtained through the ICD (GIP and Private Insurance Plans)) by age group were as follows: less than 1 year old URTI (35%), viral infection (15%), fever (14%) bronchopneumonia and bronchitis(10%), injury (9%); 1 to 9 years old URTI (24%), viral infection (18%), fever (13%), pharyngitis and tonsillitis (12%), gastro intestinal disorders (10%), injury (10%); 10 to 19 years old viral infections (19%), gastrointestinal disorders (17%), URTI (15%), injury (11%). Among all age group, injury is on the top 10 identified. The MCAH Program gathered information regarding other nonfatal injuries in children aged 14 years and younger from sources
such as the PR Poison Control Center (PCC). The 2014 PCC report 2,427 (39%) of calls received were related to exposures to potentially toxic substances in children 14 years of age and under. Among the substances to which this group was most frequently exposed were: household cleaning products, analgesics, pesticides and insecticides, silica gel and preparations for cold and cough. No poison related deaths were reported in this age group. This requires the continued support to educational campaigns for the prevention of unintentional injuries. The HVN and HCW provided educational activities at the community level in order to promote the appropriate use of seat belt and car seats, promote purchase of safe toys, prevent poisonings and choking, and Shaken Baby Syndrome. During 2014 they delivered a total of 500 activities to 5,766 participants on various topics promoting non-intentional injury prevention. On the prenatal course protective car seat use is emphasized and parents are advised on the requirement of its use upon newborn discharge from hospital. In the HVP participants receive education on one to one intervention on accident prevention customized to the needs of the household depending on the composition of the family and the ages of their children. The HVN continued to provide information and distribute educational materials directed at reducing unintentional injuries.

The MCAH staff continued to collaborate with the Emergency Medical Services for Children (EMSC) Project and its Advisory Council working towards improving the emergency response infrastructure in Puerto Rico. The objective of this collaboration with EMSC Project is an effort to establish a well-coordinated, well equipped and up to date Emergency Response System that complies with the latest recommendations of the National Pediatric Readiness Project (NPRP). The NPRP is a multi-phase quality improvement initiative to ensure that all emergency departments (EDs) in the U.S. have the essentials and resources recommended by the American Academy of Pediatrics/American College of Emergency Physicians/Emergency Nurses Association (Guidelines for the Care of Children in the Emergency Department). Puerto Rico continued participating in the NPRP and in 2013 Emergency Room (ER) facilities and ambulances received a Broselow bag and training on how to implement its use to provide effective emergency care to children based on the guidelines and recommendations of the AAP, and using a color coded system. The objective was to improve the management and outcome of the pediatric population in emergency situations, using color coded equipment and medication doses to avoid errors. The development of the evaluation instrument was done with collaboration of the MCAH staff. This survey was used in onsite evaluations on the use of the Broselow bag, the presence and adequacy of equipment and medications in the bag, and overall knowledge of its purpose in the emergency rooms settings servicing pediatric population. It was also an opportunity to identify the number and professional qualifications of physicians that manage pediatric emergencies in island health care facilities and their distribution throughout PR. The study included evaluation of which guidelines these facilities follow when managing pediatric emergencies and if they have their medications and equipment color coded in order to appropriately manage patients according to their weight and height. The evaluation was aimed at identifying the barriers ER’s face when attempting to comply with current guidelines. In 2014 a total of 27 emergency rooms throughout the island were evaluated. Multiple deficiencies were identified, among them; absence of equipment, expired medications, wrong medications, lack of knowledge in the use of the equipment etc. During the visits, the ER staff received orientation and corrective measures were signaled out.

In the US an estimated 2,519,471 Emergency Department visits resulted from nonfatal crash injuries. According to CDC Vital Signs on child passenger safety released in February 2014 Motor vehicle crash deaths among children age 12 and younger decreased by 43% from 2002-2011; however, still more than 9,000 children died in crashes during that period. In terms of motor vehicle crash injuries, data released in October 2014, those crash injuries resulted in 188,833 hospitalizations and an estimated $18.4 billion in lifetime medical costs and $32.9 billion in lifetime work loss costs. Of children who died in a crash, one in three was not buckled up.

The major cause of death due unintentional injury in children in PR from 0 to 14 years by preliminary data for VS 2014 was motor vehicle crashes (MVC). (Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.) During 2013-2014, VS data reported 5 deaths and 2,728 non-fatal injuries related to MVC among children 0 to 14 years. According to the Puerto Rico Highway Safety Commission (PRHSC), the main causes for MVC fatalities in the general population are in descending order: speeding and aggressive driving impaired driving and non-occupant protection. Texting while driving has become increased as a cause for fatal accidents for which legislation to ban driving and texting or handheld mobile device use was passed.

For the last 5 years, PR has experienced a 20% reduction in the total number of MVC related fatalities. The PRHSC has been the entity in charge of leading local efforts to reduce MVC fatalities. They recognize that Driving While Intoxicated (DWI) is one of the main causes of fatal crashes in PR. To address this, PR is enforcing laws aimed at discouraging DWI. Among them are: zero tolerance law for those less than 18 years of age; reduction of permissible BAC to less than .02 for those between the ages of 18-21, and .08% for all drivers; mandatory jail time for a DWI drivers carrying passengers less than 15 years; vehicle confiscation and mandatory 48 hour jail time plus fines for repeat offenders; suspected DWI offenders cannot refuse a BAC sample. The PRTSC 2012 survey reported a 94.7 use of child restraint. Studies demonstrate 71% reduction in fatal injuries in infants with adequate restraint in a car seat and 54% decrease in toddlers. Infant and children protection are costly motor fitting stations...
reduction in fatal injury in infants with adequate seat restrain in < 1 y/o and 54% decrease in toddlers. Infant and children protective car seats restrain fitting stations, established by law in PR Fire Department firehouses and performed by firemen (certified child passenger safety technician) detected in 2013 that 3 of 4 were incorrectly installed. The MCAH staff in its effort to prevent MVC-related deaths continued disseminating information on the importance of correctly using the car seat in their educational interventions to mothers with young children. Families are oriented of Law 235, mandating adequate use and restraint of protective car seats in minors of 4 years. Families are oriented following the NHSTA and AAP recommendations which include maintaining children less than 2 years of age restrained in a forward facing car seat as long as possible, and the use of proper protective car seats until child reaches 80 lbs. A total of 94 educational activities were offered by MCAH staff to promote the correct use of car seats with the participation of 1,169 persons. These were done in collaboration with the EMSC Project, UPR Pediatric Residents and the Healthy Start Project throughout the Island. The prenatal course also emphasizes the requirement of an adequately placed protective car seat prior to newborn discharge from the hospital and compliance with Law 235 of PR. The CW promotes adequate use of child restraints as part of the anticipatory guidance given at the community level. Law 254, signed on September 15, 2012 increased the penalties associated with traveling with an unrestrained child under the age of four. On January 1, 2013, Law 201 signed on October 11, 2011 which prohibits the use of hand held cellular phones to generate, receive calls or text while driving, came into effect. Aware that many of the deaths that occur in children under the age of four are associated with improper installation of car seats, there have been increased efforts to provide the public with opportunities to have their installation inspected by certified officials. The PRHSC has an actualized website for the promotion of protective car seat use and orientation to parents with a contact number to identify the locations of the firehouses designated as official car seat inspection centers (http://www.minenevaseuro.com/) as part of the my child goes safe ongoing campaign. The MCAH program supports this effort by orienting parents how to contact and schedule an appointment for their protective car seat adequate restraint certification. The MCAH personnel has continued providing and disseminating through educational activities the latest NHSTA and AAP revised car seat guidelines and recommendations for adequate protective car seat selection and use according to the age and weight of the child. In addition staff continued to promote compliance with local laws that besides requiring children be restrained while riding in a car, they must use safety approved helmets correctly when riding a bicycle, motorcycle or any other moving vehicle.

(SPM 6: The number of preschool children who present behavioral problems.) ICO reported a total of 2,727 children between the ages 2 to 4 years were diagnosed with behavioral problems during the calendar year 2014. Behavioral problems diagnosis included; under-socialized conduct disorder aggressive and non-aggressive, overanxious disorder specific to childhood, attention deficit disorder and Hyperkinetic Syndrome of Childhood. They also identified 10,151 children between the ages of 0 to 4 with mental disorders during 2013-2014. Disorders requiring services included autism, pervasive developmental disorders, and developmental delay, among others. During the first semester of the school year 2014-2015, the Head Start Program identified 16,271 children with a variety of health related problems of which 2,595 (about 16 %) had behavioral or ADHD problems. Of these, 2,452 (95.5%) are children with behavioral problems while 143 (5.5%) are children with ADHD. The Head Start Program also reported having referred 3,886 for further evaluation after administering the ASQ. Other conditions and problems identified were 163 participants referred for evaluation for autism, 367 children evaluated for child abuse or negligence and 286 exposed to domestic violence.

The MCAH Program has continued to emphasize the need to monitor early childhood mental health status and identify early signs of developmental delay for early intervention and referral. During calendar year 2014 the Home Visiting Program Nurses screened 1,345 children between the ages of 4 months to 18 months with the ASQ and ASQ - 3. A total of 81 (6%) of them were referred to be evaluate by their pediatricians, Early Intervention Program or Pediatric Center. Most of them where referred by delay in speech and language and gross and fine motor delay. The intervention of the HVN emphasis parental skills for stimulating development at home on a daily basis and promote optimum development achievement in children. FY2013-2014, MCAH sponsored 729 educational activities reaching 11,151 people on the following topics: self-esteem, effective communication, growth and development, perinatal depression, and alcohol and drug abuse, dealing with conflict, dealing with emotions, appropriate toys according to the child age, baby shake syndrome, childbearing and responsible parenthood. Other topics covered were: Changes in childhood from birth to age three, 10 Parenting Tips, Being a Good Father, Child Discipline, Child Abuse, Parenting Skills.

A curriculum on Positive Responsible Parenting was completed. This curriculum includes developmental stages (physical, socio-emotional, cognitive), preventive services (screening, vaccines, etc.), prevention of unintentional injuries (use of car seat, position to sleep, sudden infant death prevention), and nurturing skills (abuse prevention, dealing with tantrums, etc.). This course was established by the collaborative work of all the MCAH staff (Health Educators, Cultural Anthropologist, Pediatrician, Social Worker, and Obstetric-gynecologist) and encompasses all aspects relating to the pediatric health care and overall wellbeing. The MCAH staff (HVN’s, CHWs, Health Educators and Social Workers) was trained about Motivational Interview (106), Neurobiology of Drugs (101) and Toxic Stress by a collaborative agreement with SAMHSA’s Region II and Central Caribe University (UCC) to increase their knowledge and provide the tools to empower the families.
Also, a Learning Community of Trauma was developed in ASSMCA with collaboration of the UCC and the National Child Traumatic Stress Network. This learning community is composed with delegates of PR Department of Health, PR Department of Family, Mental Health Administration (ASSMCA), and Carlos Albizu University. MCAH staff is a collaborator in this initiative. Training for Trauma identification and management has been implemented and identification of a screening tool to be used next year in the HVN program is in progress.

The Home Visiting Protocol Manual is being evaluated with emphasis on increasing education on early stimulation at home, the use of pediatric preventive services for participating families with infants and children, and positive responsible parenting skills.

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| Improve adolescent health and wellbeing | 1. Increase the percent of adolescents 10 to 19 years old with a preventive medical visit in Puerto Rico by 2016. | 1. Develop MOU’s and other written agreements with agencies providing services to youth to assure all adolescents receive the annual preventive health care visit.  
2. Educate, promote and disseminate the PR Pediatric Preventive Health Care Guidelines focused on adolescent health care to youth, parents/tutors and health care providers.  
3. Develop, promote and implement Puerto Rico Youth Friendly Health Services Guide with health care service facilities and providers.  
4. Develop partnerships with organizations serving adolescent population to promote the Pediatric Preventive Health Care Guidelines (PPHCG) and the Youth Friendly Health Services Guide developed.  
5. Educate youth and general public to promote adolescent health | Adolescent mortality rate ages 10 through 19 per 100,000  
Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000  
Adolescent suicide rate, ages 15 through 19 per 100,000  
Percent of children with a mental/behavioral condition who receive treatment or counseling  
Percent of children in excellent or very good health  
Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)  
Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza  
Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine  
Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine  
Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine  
Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. |
Adolescent Health - Plan for the Application Year

PR MCH Division became PR MCAH upon establishing the Comprehensive Adolescent Health Program (SISA, Spanish acronym) in 1992. Since then, adolescent health has been a consistent priority, stated in 2010 as to promote healthy lifestyles in adolescents. The five years needs assessment performed by MCAH for this new cycle provided findings related to the strengths and needs of the adolescent population of Puerto Rico as well as the capacity of the program, established partnerships and opportunities. Based on these findings, MCAH selected to continue working to improve adolescent health and wellbeing as one of its priorities.

Adolescence is a critical transitional period in life course’s journey that includes the biological changes of puberty and the need to negotiate key developmental tasks. It is a period of major physical, psychological and social development with bursting energy and an increasing surge to try new roles and behaviors. Although adolescence and young adulthood are generally healthy times of life and the majority of adolescents are thriving and developing to their optimum capacity, several important public health and social problems may start or peak during these years including alcohol, tobacco and other drugs use, early unprotected sex, mental illnesses, suicidal ideas and homicides. These leading causes of illnesses and death are largely preventable. Health outcomes are also grounded in youth’s social environments including peers, family, school, community and society levels that can either support or challenge their health and wellbeing. Nevertheless, the behavioral patterns established during this period help determine current and future youth health.

SISA adopted Positive Youth Development (PYD) in 2002 as the leading strategy for youth health promotion and prevention of risk behaviors. Addressing the positive development of young people facilitates their adoption of healthy behaviors and helps to ensure a healthy and productive future adult population. Focusing on PYD will continue in all MCAH adolescent health initiatives in FY 2015 while working towards National Performance Measure (NPM) 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year for the five-year period action plan. The annual preventive medical visit can provide the scenario for adolescents to understand and assume individual responsibility for their health habits and to prepare them to choose a healthy future and wellbeing. Data from the PR Insurance Commissioner’s Office (ICO) that include GHP and Private Health Insurance reveals that 25,160 visits at medical offices were claimed for preventive medical visit from a total amount of 503,974 adolescents 10-19 years of age in 2013. This data reflects an urgent need to educate and promote the annual preventive health care visit for all adolescents in PR.
The following eight strategies were identified and included in the PR Five-year Action Plan Table as interim general approaches until they are refined and completed to be submitted in the second Application/Annual Report Year:

1. Develop MOU’s and other written agreements with agencies providing services to youth to assure all adolescents receive the annual preventive health care visit.

2. Educate, promote and disseminate the PR Pediatric Preventive Health Care Guidelines focused on adolescent health care to youth, parents/tutors and health care providers.

3. Develop, promote and implement Puerto Rico Youth Friendly Health Services Guide with health care service facilities and providers.

4. Develop partnerships with organizations serving adolescent population to promote the Pediatric Preventive Health Care Guidelines (PPHC) and the Youth Friendly Health Services Guide developed.

5. Educate youth and general public to promote adolescent health care/wellbeing rights (laws) and services, including pregnant teens and childrearing teen moms and dads.

6. Develop, promote and disseminate a Guide to assist all youths and young adults as they transition from pediatric to adult-centered health care services in Puerto Rico.

7. Promote youth health literacy.

8. Promote the use of positive youth development.

**PR Pediatric Preventive Health Care Guidelines:** In 2014, MCAH reviewed, with a panel of experts, the PR Pediatric Preventive Health Care Guidelines (PRPHCG) in the context of the most recent Bright Futures (AAP) recommendations, statistics pertaining to the PR pediatric population, and the Affordable Care Act. These guidelines were modified and an actualized PR PPHCG was published as a DOH Public Policy requiring its implementation in GIP pediatric preventive health care visits. Also, the Insurance Commissioner Office (ICO) adopted them as standards of care and required all private insurance companies to comply. The new PRPHCG incorporates the use of specific validated instruments to evaluate and screen adolescents nutritional habits, physical activity, BMI, oral health, signs of depression (Patient Health Questionnaire 9- PHQ9) and risky behaviors (“CRAFFT”) for early identification, timely intervention and referral. It also includes testing for HIV, Syphilis, Gonorrhea and Chlamydia and emphasizes the role of anticipatory guidance for effective prevention. It recommends that adolescents have an annual checkup starting at age 11. MCAH will promote PPHCG knowledge to health professionals, parents and youths and will promote its use in the adolescent annual health care visit of all adolescents, including those in foster care and juvenile justice programs.

One of Puerto Rico’s current government program commitments is to assure each student receives an annual physical exam. In 2015, MCAH staff participated in the task force designated by the governor to develop an annual preventive pediatric visit certificate prior to beginning each school year; mechanisms for its implementation are yet to be decided. The MCAH staff advocated for the inclusion of the Guidelines in the certificate as evidence of proper screenings and quality health care by age as recommended by the PRPHCG.

These recent events represent an opportunity for MCAH to work collaboratively with other government agencies (DOE and Department of Family) to assure the provision of quality annual preventive health care visit to all adolescents. The challenge is promoting teen’s attendance to the annual visit by educating them and their parents/tutors about
quality annual preventive health care visit to all adolescents. The challenge is promoting teen’s attendance to the annual visit by educating them and their parents/tutors about the health/wellbeing benefits they will receive that will last for life. During 2014-2015, SISA’s Youth Health Promoters Project (YHPP) Action Guide was reviewed and a new section was included to be implemented in 2015-2016 school year to address the importance of annual health care visit. YHPP is a PYD peer to peer education project in collaboration with DOE middle schools. The MCAH staff will continue offering educational activities including annual preventive visit importance to parents, youth and health care professionals. Educating youths and parents about the PRPPHG and promoting its use by health care providers is expected to impact and improve the health of adolescents by the early identification of risk for evaluation and intervention and promoting healthy lifestyles that will enable them to achieve their full potential.

Youth-friendly health care services: Youth-friendly health care services are needed if young people are to be adequately provided with health care, including sexual and reproductive services. Such services are able to effectively attract young people, meet their needs comfortably and responsively, and succeed in retaining them as usual clients for continuing care. MCAH realized the need to develop a Youth-Friendly Health Services Guideline for Puerto Rico (PR-YFHSNG) to promote youth attendance to the annual preventive visit and all other health care visits. Dialogues and activities will be held with youths participating in SISA’s YHPP during 2015-2016 to hear their experiences and opinions about the health care visits and how better to serve their needs in order to incorporate them in the development of the Guide. The DOH Youth Advisory Group, that is in the process to be created and will start for the first time in 2015-16, will also be included as well as other interested youths. Health professionals from MCAH stakeholder Primary Health Care Association of PR expressed interest to be part in this process after receiving an Understanding Adolescent workshop by SISA in 2015. This Association gathers primary health care centers (330 law federal health centers) which at the present time are interested in increasing adolescent’s visits to their clinics. The Guide will be piloted and assessed as a tool to replicate in all youth serving health care centers.

Adolescent health/wellbeing rights and services: During 2014-2015 SISA and DOH legal advisory office began to compile PR laws about adolescent health and wellbeing in a document that could be used by youths, parents and professionals, including the DOH Youth Advisory Group in FY 2016. This document will include the laws and how they guarantee rights for all adolescents including: consent laws, privacy and confidentiality, mental health, sexual and reproductive health care among others. This tool will provide information to advocate for adolescents rights and to promote the annual health care visits to be shared through DOH webpage. A Directory of entities that provide health care services to teens and young adults will also be created and distributed through DOH webpage and other social media.

Youth Guide to Transitioning Health Care Services: Adolescents and young adults annual preventive health care visit will be maximized if youth are empowered with the information and skills they need to advocate for quality health care services as they move towards adulthood. The development of this tool will integrate youth and caring adults in the process of development.

Promote health literacy among youths: The Patient Protection and Affordable Care Act of 2010, defines health literacy as the degree to which an individual has the capacity to obtain, communicate, process and understand basic health information and services to make appropriate health decisions. Capacity is the potential a person has to do or accomplish something. Health literacy skills are those people use to realize their potential in health situations. Young people need to be empowered to make informed and appropriate decisions about health, including attending the preventive annual health care visit and participate in treatments. Promoting healthy literacy in young people will strengthen and support their ability to obtain and understand the information related to their health and take decisions. Youth health literacy and youth engagement activities will be included in 2016’s YHPP 2nd year implementation Guide to increase their basic skills and knowledge. MCAH staff will promote youth health literacy through different educational activities with youths in schools and community.

Promote positive youth development: The Comprehensive Adolescent Health Program (SISA, Spanish acronym) main approach to teen health promotion and risk behavior’s reduction continues to be Positive Youth Development (PYD) which is used by SISA’s Central staff and it’s Regional Coordinators (SISA RC) since 2002. The recruitment and training of two (2) SISA RC’s in 2014-2015 completed the staff of seven (7) SISA Coordinators, one for each DOE region to advocate for adolescent health and wellbeing through PYD initiatives. PYD can be briefly defined as the intentional process of providing all youths will the support, relationships, experiences, resources and opportunities to become successful and competent adults. SISA’s main PYD initiative is Youth Health Promoters Project (YHPP) in middle schools with the collaboration of the DOE. The YHPs are voluntary students from 7th through 9th grade (three years) that become peer mentors and active promoters of healthy lifestyles with SISA’s RC guidance. YHPP will continue in FY 2016 using the actualized Action Guides for 1st and 2nd year implementation. The 3rd year implementation module will be reviewed in FY 2016.
PYD will continue to be MCAH model towards youth health and development in 2016. In 2014-2015 MCAH contracted a PYD Specialist Coordinator in SISA Central staff to increase workforce capacity of the program promoting PYD. Her functions include to review and complete PYD PR Action Guide developed by PR Steering Committee of “Reto y Esperanza: Puertorriano Healthy Youth Development” (HRSA CE grant in 2008) to promote PYD knowledge and implementation in government and NGOs working with youths. She is also working towards the creation of DOH Youth Advisory Group (YAG). Although youths have been active participants and stakeholders to MCAH through YHPP, this will be the first time PRDOH will have a youth advisory group. The Secretary of DOH endorsed the YAG that will include youths from diverse sectors, interests and orientations as active participants in the development of health’s policies. Two meetings have been held to plan the development of YAG where youths and adults from government agencies and NGOs serving youths have exchanged their ideas to create it. In FY 2016 the first DOH YAG will be conformed and will begin its work actively using PYD.

MCAH Community PYD (CPYD) Project, for which the Naranjito Adolescent Program (PANI, Inc.) was contracted, will continue in 2015. This project was conceived to promote PYD and create implementation strategies in communities (Naranjito is a rural PR municipality). CPYD Coordinator is combining efforts with SISA recently contracted PYD Coordinator to complete the development of PR CPYD Implementation Guide for government and NGOs youth serving entities. Annual assessments to CPYD reveal a consistent increase in PANI, Inc. adoption of PYD. The experiences from the implementation of PYD in two community youth groups has been essential in the development of CPYD Guide. Evaluation with PANI, Inc. and youths will be repeated. This tool will be assessed for its inclusion in the Guide as a continuous assessment tool for entities adopting PYDM in their work with adolescents.

**Adolescent Health - Annual Report**

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

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<th>Annual Objective</th>
<th>2016</th>
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SISA’s Youth Health Promoters Project (YHPP) in middle schools continued to be active with collaboration of DOE during 2013-2014, with 477 active 12 to 15 y/o Promoters in 28 schools (27 public and 1 private) of which 110 YHP’s graduated in 9th grade. YHPs host peer to peer activities created by them to promote healthy lifestyles and reduce risk behaviors. During FY 2014 they offered 112 educational activities to 6,915 participants (6,062 students and 853 adults) about: bullying, suicide prevention, sexual-reproductive health, decision making, folic acid, seasonal flu, STIs, HIV/AIDS, tobacco, alcohol and other drugs, oral health, self-esteem, effective communication and healthy relationships including TPP. The SISA RCs guide YHP through an YHPP 5year Action Guide. The 1st year YHP guide was revised and was used with 1st year YHPP. The 2nd Year Guide revision is in progress (2014-2015) and includes a new section about annual teen preventive health visit’s importance and youth health literacy. The demonstration SISA YHPP in PR’s only JJ Girls Social Treatment Center in Ponce ended in 2013-2014 because the Center closed and girls were transferred to a JJ facility in another town (Bayamón) that houses boys. Communication with JJ administration is in progress to adapt curriculum guide and activities to resume YHPP in the new scenario.

SISA was PR representative along 6 selected states in the 2nd technical assistance meeting of the Comprehensive Adolescent Health System Collaboration and Innovation
CAH was PR representative along with selected states in the 2nd technical assistance meeting of the Comprehensive Adolescent Health System Collaboration and Innovation Network (CAHS-CoIn) by AMCHP/SAHRC in July, 2014. It had a dual purpose; to report the progress (challenges and achievements) of each jurisdiction towards establishing an adolescent health system and to offer the support for its development. PR report included the MCAH decision to contract a PYD specialist as part of the Comprehensive Adolescent Health Program to assist in the creation of the PR adolescent health care system and to develop the first Youth Advisory Group (YAG) to PRDOH, essential to engage youth’s voice and active participation in health public policies.

"Understanding Adolescence (UA)" is a workshop created by UMN State Adolescent Health Resource Center (SAHRC) and translated to Spanish and culturally adapted by SISA. UA continues to be an effective tool to address understanding adolescent development and promoting healthy youth development strategies in Puerto Rico. During 2013-14, five (5) SISA RC and Naranjito CPYD Coordinator completed UA TOF by SISA personnel and held 19 UA to 256 participants (197 health and education professionals, 52 parents/caregivers and 10 youth). Evaluations from the UA workshops to health and education professionals revealed they felt challenged to see adolescent behaviors through a different lens and to apply lessons learned while serving teens. Parents acknowledged UA helped them to understand the changes in adolescence and the need to be counselors instead of administrators of their teens. Youngsters comments included understanding the roller coaster changes they were going through and realizing they were not alone in the process. Participants suggested additional workshops about PYD implementation and tools to improve communication with teens. UA was also offered to eight (8) Down Syndrome Foundation (DSF) staff that provides support to DSF Working Youths. A partnership was established and an additional UA was planned for DSF Working Youths parents to address YSHCN transition to work and adult life. UA workshops continued in 2014-2015 and participant’s evaluations have been used to review the workshop and activities.

Efforts to promote PYD in communities included to contract again Adolescent Program of Naranjito (PANI, Inc.) a non for profit community based organization in a rural PR municipality to continue developing activities to promote PYD and collaborate in the development of Guide for PYD adoption in NGO’s and government agencies. During 2013-2014, the Community PYD (CPYD) Coordinator of PANI, Inc. multiple approach services oriented to increase knowledge on PYD and the inclusion of adolescents active participation in youth serving organization structures and delivery of services. The CPYD Coordinator reached 807 students and 386 adults through 46 activities including youth listening sessions and educational activities. UA was offered to PANI’s Board of Directors, school and public housing (PH) personnel, parents and youths.

The two PYD demonstration groups continued its 3rd year in two settings; one in public school setting (PSS) the other in a public housing setting (PHS). The PSS group had 15 youths and held 16 meetings with the CPYD Coordinator which included life skills capacity building, listening sessions and PYD activities. The PHS group of 8 members held 17 meetings to address similar themes but also included prevention of child abuse and neglect which was identified by the youths as the main health problem in their community. The experiences with both groups are being compiled for the development of PR Community PYD guide.

During FY 2013-2014 PANI, Inc. Director was interviewed and CYDP youths participated in a survey to assess the adoption of eight (8) Positive Youth Development Model fundamentals as part of State performance Measure 07: The degree to which selected organizations incorporate the PYD in the services provided to adolescents. Results of the evaluation suggested that youth perceived having high levels of participation opportunities, capacity development experiences, and acceptance within the group. However, when they were asked regarding experiences details, the evaluation concluded that youth have limited participation regarding PANI, Inc. work plans. The sum of scores of the 8 principles total 18 points out of a maximum of 24 or 75%, which was 8% short for the annual performance objective of 83% for year 2013 Title V objective. Nevertheless, there was a 6% increase in the degree the organization incorporated PYD since 2010 (from 70.9% in 2010 to 75% in 2013). During 2014-2015 the evaluation was repeated reflecting an increase in PYD incorporation to 87.5%, which represents a 24% increase in PYD incorporation by PANI, Inc. since the beginning of the Project in 2010.

Childbearing and parenting during adolescence are particularly challenging events that affect teens, their babies, the teen’s family and society. During the past years, MCAH has been working to decrease teen birth rates in Puerto Rico as part of National Performance Measure 08: The rate of birth (per 1,000) for teenagers aged 15 through 17. MCAH Monitoring & Evaluating Unit (MEU) annually updates female teen birth rates (FTBR), indicators and tendencies for each teen age group (10-14, 15-17 and 18-19) in PR and its municipalities. This information has provided useful insight to address teen sexual and reproductive health, including TPP at schools and other scenarios. The PR 15-17 y/o FTBR has declined almost continuously since its peak in 1997 (59.9/1,000). The 2014 rate for this age group is 20.6 per 1,000 births, a 66% decrease from 1997’s peak and a 20% decrease from 2013. Since research and data collection efforts about TP have tended to focus on female adolescents, during 2013-2014 SISA asked MEU to gather male teen birth rates (MTBR) for each teen age group including young adults (20-24 y/o) from 2008-2012. The results revealed that male young adults (20-24 y/o) fathered forty seven percent per cent (47%) of 2012’s teen mom’s babies. Similarly to FTBR, all MTBR have declined. The 15-19 y/o MTBR’s showed a
young adults (15-17 y/o) elevated forty-seven percent (47%) of 2012’s teen births rates. Similarly to PR, all MHC have declined. The 15-19 y/o SMR in PR showed a 14% reduction from 2008’s 21.5/1,000 to 18.4/1,000 in 2012. Although males 15-17 years old are less likely to father a baby (MTBR of 6.6/1,000 in 2012) compared to 15-17 females (FTBR of 27.9/1,000 in 2012) the impact of parenting a child at an early age also affect teen dads.

The interest to better understand teen male sexual and parenting behaviors led SISA to hold 38 listening sessions (“Conversatorios”) with 381 males, 12-18 years old, in schools of six DOH regions during school year 2013-2014. The purpose was to hear and collect teen male opinions about what it means to become a man and a fathering teen in PR. The listening session’s analysis by MCAH anthropologist is helping SISA develop new strategies to work with teen boys and sexuality, TPP and fathering. A four-part training on conducting culturally relevant Dialogues was designed by the Cultural Anthropologist and offered in 2014-2015 to SISA RC and CFPYD Coordinator who will be Dialogue Facilitators. This training emphasized listening, asking non-judgmental questions, cultural meanings and cultural reflexivity, important skills to develop to continue having conversations with youths, their parents and other adults in youth’s lives.

These listening sessions were important to organize a special DOH activity in May 2014 “Males and Teen Pregnancy” with the colloquium “My experiences as a dad…” A group of 66 adult representatives from 10 government agencies and 10 NGOs along with 18 teens from YHPP, schools and other teen entities, convened to hear firsthand experiences from eight (8) teen males that accepted the challenges and responsibilities of becoming teen dads. Teen dads came from two (2) teen parenting programs in PR, Proyecto NACER, Inc. and Nuestra Escuela, Inc. collaborators and stakeholders of MCAH. A panel of 6 experts on education, teen sexuality and parenting teen projects commented about the teen fathering experiences shared. They motivated the audience to reflect upon the need of including active participation of teen males in TPP efforts and teen parenting projects to help them achieve high education and career goals while in the childbearing process for their benefit, their children and society. Participants wrote down ideas to change policies in their work scenarios and suggested having additional activities about teen males. A summary of the event was shared with entities serving teens, students, general public, professionals serving youths and MCAH personnel including SISARC. In March 2015 a follow up work meeting about teen males, pregnancy and childbearing was held in the DOH.

Primary teen pregnancy prevention (TPP) efforts during 2013-2014 also included 233 educational activities by SISA RC with the attendance of 2,886’s 10-19 y/o and 2,473 adults with other groups in schools and other scenarios. Some of the themes were: conflict mediation and resolution, self-esteem, growth and development, STIs, abstinence, contraception, family planning, dating violence, folic acid use, teen sexuality, teen pregnancy prevention, safe internet use and personal hygiene among others. A total amount of 870 additional TPP educational activities were held by MCAH Community Health Workers (CHW) reaching 10,353 10-19 y/o in schools and communities about effective communication, managing emotions and decision making skills, peer pressure, personal relationships, violence prevention, responsible parenthood, teen pregnancy prevention, tobacco, alcohol and other drug effects, among others.

Secondary TPP efforts are held by the MCAH Home Visiting Nurses Program (HVNP) which use a coordinated management care model to offered coordination of services. During 2014 HVNP registered 461 unduplicated visits to pregnant teens (40 < 15 y/o; 421 were 15-17 y/o) and 1,658 follow up visits (161 to <15 y/o; 1,497 to 15-17 y/o) in the program. Efforts to space future babies in teen moms include the interconception period visits that totalized 2,342 follow up care visits (90 visits to <15 y/o and 2,252 to 15-17 y/o). In 2015 the HVN has continued offering services to support health/wellbeing of pregnant teens, their families and to space future babies.

Another issue of importance regarding teen health and wellbeing is prevention of suicide deaths that was addressed through National Performance Measure 16: The rate (per 100,000) of suicide deaths among youth aged 15 through 19). The strategy used by MCAH to address teen suicide prevention is to provide life-skills tools to the adolescent population in PR. The life skills tools serve as protective barrier to help teens face difficult and stressful life situations that may lead to suicidal behavior. The strategy has emphasized four areas: self-esteem, handling emotions, interpersonal relationships and conflict resolution. During FY 2013-2014 the PRMCAH staff in 7 DOH regions carried out educational activities related to these four life skills as follows: a) 120 presentations on self-esteem reaching 1,236 adolescents of which 841 were 10-14 y/o and 395 were 15-17 y/o; b) 46 activities about handling emotions with 345 adolescent participants (229 were 10-14 y/o, 116 were 15-17 y/o); c) 36 activities related to conflict resolution reaching a total of 285 adolescents (93 were 10-14 y/o, 192 were 15-17 y/o);d) 20 activities about interpersonal relationships reaching 201 youths (137 were 10-14 y/o, 64 were 15-17 y/o). The staff of one region (Fajardo) also carried out one activity about bullying reaching 19 teens, of which the majority were 10-14 y/o. Carrying out activities about bullying may help in preventing suicidal behavior. According to research there is a strong connection between peer victimization and adolescent suicide. MCAH also addresses these life skills through the SISA YHPP. The YHPPs offer peer to peer information, support and develop activities in their middle schools to celebrate life and promote healthy lifestyles including balancing mental, physical and social stressful events as bullying, violence and depression. (See above mentioned SISA
Suicide prevention efforts continued in PRMCAH during 2014-2015 and will be combined with promotion of the screening tool for depression during the annual visit to address pre-teen and teen population to reduce suicide ideation and suicide teen death rate that in 2013 was 1.9/100,000 for 15-19 y/o.

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<tr>
<th>State Priority Needs</th>
<th>Objectives</th>
<th>Strategies</th>
<th>National Outcome Measures</th>
<th>National Performance Measures</th>
<th>ESMs</th>
<th>SPMs</th>
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<tr>
<td>Increase the number of CSHCN who receive regular ongoing comprehensive care within a medical home</td>
<td>1. By 2020, increase by 10% the percentage of CYSHCN ages 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.*Baseline: 24.7%*Target: 27.2%<em>Data source: PRS-CSHCN</em>To be revised once 2015 PRS-CSHCN data is available.</td>
<td>1a. Establish a Medical Home Workgroup to share information, facilitate progress, and coordinate efforts to advance medical homes for children and youth with special health care needs. 1b. Develop and implement a Medical Home strategic plan with measurable goals. 1c. Develop and disseminate CSHCN medical home tools, best practices and timely information through multiple communication strategies. 1d. Develop and implement a successful model of CSHCN Services Coordination to increase access to medical homes.</td>
<td>Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system Percent of children in excellent or very good health Percent of children ages 19 through 35 months, who have received the 4:3:1:3 (4):3:1:4 series of routine vaccinations Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</td>
<td>Percent of children with and without special health care needs having a medical home</td>
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<td>Increase the number of CSHCN aged 12 to 17 years who receive adequate support and services for their transition to adult health care</td>
<td>2. By 2020, increase by 10% the number of YSHCN who have a transition readiness assessment and comprehensive plan of care beginning by age 14.*Baseline: 26%*Target: 28.6%*To be revised once 2015 PRS-CSHCN data is available.</td>
<td>2a. Establish a Health Care Transition Workgroup to share information, facilitate progress, and coordinate efforts to advance an effective transition process from a pediatric to an adult health system. 2b. Develop and implement a Transition to Adult Health Services strategic plan with measurable goals. 2c. Develop and disseminate CSHCN transition to adult health care tools, best practices and timely information through multiple communication strategies. 2d. Develop and implement a successful model of CSHCN Coordinator to increase access to adequate support and services for YSHCN transition to adult health care.</td>
<td>Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system  Percent of children in excellent or very good health</td>
<td>Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care</td>
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<td>Decrease the age when children at risk for Autism Spectrum Disorders (ASD) receive their first diagnostic evaluation</td>
<td>3. By 2020, increase by 10% the proportion of children with ASD having a first evaluation by 36 months of age. Baseline: To be established. (Data Source: PR Autism Registry)</td>
<td>3a. Increase awareness of the early warning signs of ASD. 3b. Screening for ASD at 18 and 24 months of age. 3c. Increase access to diagnostic services in a timely matter. 3d. Implementation of the Autism Registry to have valid data on ASD prevalence and age of diagnosis.</td>
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<td>Reduce the prevalence at birth of neural tube defects</td>
<td>4. By 2020, decrease by 10% the prevalence at birth of anencephaly and spina bifida. (Anencephaly Baseline: 2.7/10,000) (Target: 2.4/10,000) (Spina Bifida Baseline: 4.36/10,000) (Target: 3.92/10,000) (Data Source: PR-BDSPS)</td>
<td>4a. Raise the awareness of families affected by a NTD on the optimal dosage of folic acid for reducing the risk of recurrence of NTDs. 4b. Develop and disseminate NTDs prevention health care tools, best practices educational tools and timely information through multiple communication strategies. 4c. Build partnerships with other government agencies, non-profit and private organizations to reach new target populations.</td>
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<td>Improve CSHCN Program data capacity</td>
<td>5.1 Increase CSHCN Program data capacity though the implementation of an Electronic Health Record (EHR) at the Regional Pediatric Centers by 2020.</td>
<td>5.1a Provide the RPCs the hardware &amp; communication infrastructure for the EHR implementation and operation. 5.1b Configuration of an EHR module based on CSHCN Program uniform clinical forms. 5.1c Design and implement custom statistical and data reports. 5.1d Design and Implement an EHR Training Plan for CSHCN Program Staff.</td>
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<td>Improve CSHCN Program data capacity</td>
<td>5.2 Increase CSHCN Program data capacity to meet new reporting requirements for performance measurements by 2020.</td>
<td>5.2a Identify data sources for CSHCN in PR and analyze existing data. 5.2b Identify data gaps, assess capacity to address data gaps, and develop a plan.</td>
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**Children with Special Health Care Needs - Plan for the Application Year**

*Priority #1: Increase the number of CSHCN who receive regular ongoing comprehensive health care within a medical home*

Studies have shown that having a medical home is associated with improved health care among CSHCN. The concept of a medical home has been proposed to ensure consistency and continuity of care for CSHCN. Although it seems to be an easy solution in theory, implementation is complicated especially for the child residing in a rural area as geography, transportation, and financial barriers are usually present. There is also a subgroup of children with complex chronic health problems that make up a small but vulnerable population. These children are characterized by their dependence on multiple pediatric subspecialists and often on medical technology; they are medically fragile and are particularly dependent on care coordination to maintain stable health.

A Medical Home Workgroup will be established to share information, facilitate progress, and coordinate efforts to advance medical homes for CSHCN. The workgroup will include parents, representatives from private and group practices, health care plans, hospital and university systems, local community organizations, and the Title V MCH/CSHCN programs. The workgroup will develop a Medical Home Strategic Plan with measurable goals including, but not limited to, increasing the public awareness and understanding regarding the Medical Home concept among providers, families, and other stakeholders; increasing the overall number of health care practitioners providing a medical home through work with pediatric and family practices to increase care coordination and other medical home characteristics, expanding the community...
providing a medical home through work with pediatric and family practices to increase care coordination and other medical home characteristics, expanding the community-based health care infrastructure, increasing access to services in rural areas; partnering with medical and nursing schools; exploring alternative approaches to maximizing compensation for operating comprehensive Medical Homes; increasing continuity of health care for CSHCN in the foster care system; increase partnerships with families, providers, and other stakeholders; strengthening transition programs for adolescents; and understanding how children with complex chronic conditions are currently receiving health care, what ideal health care might look like, and what the barriers to obtaining optimal care might be. CSHCN medical home tools and best practices information will be adapted and timely disseminated through multiple communication strategies to primary care providers, medical specialists, community service providers, family organizations and statewide partners who impact care for families with CSHCN.

A successful CSHCN Services Coordination Model will be developed and implemented to ensure that families receive needed services. The core competencies needed for this role include a basic understanding of the ways that having a child with a special health care needs affects a family. The coordinator should also have knowledge of insurance coverage for CSHCN. Their work should help families build their general advocacy skills and assist in developing family leaders in the community. These professionals should be linked to medical homes and have a formalized way to document visits and develop benchmarks of success. For children who receive services from many providers, CSHCN Coordinators can support their families to feel more comfortable when accessing services by modeling how to make appointments and receive needed services by phone. The coordinator can explore transportation options to medical appointments for families who do not have their own transportation or need special transportation. Coordinators can problem solve situations with families that many doctors’ offices do not have time or knowledge to do. They can link families with support organizations, help them find low cost or free adaptive equipment, and educate families about early intervention and school services.

Priority #2: Increase the number of CSHCN aged 12 to 17 years who receive adequate support and services for their transition to adult health care

The number of CSHCN reaching adulthood is increasing, and the diversity of their clinical conditions is expanding. An effective transition process from a pediatric to an adult health system should ensure continuity of developmental and age-appropriate care. At some point, most pediatric patients should and do move into the adult care system. The challenge is to improve the system that serves youth with special health care needs while simultaneously preparing youth and their families with the knowledge and skills necessary to promote self-determination, wellness, and successful navigation of the adult service system.

A Transition to Adult Health Services Workgroup will be established to share information, facilitate progress, and coordinate efforts to advance the transition to adult health services for CSHCN. The workgroup will include parents, representatives from private and group practices, health care plans, hospital and university systems, local community organizations, and the Title V MCH/CSHCN programs. The workgroup will develop a Transition to Adult Health Services Strategic Plan with measurable goals including, but not limited to, increasing the public awareness and understanding regarding the Transition to Adult Health Services concept among providers, families, and other stakeholders; increasing the overall number of health care practitioners providing transition to adult health services through work with pediatric and family practices in the implementation of the core elements, or components, of health care transition: transition policy, transitioning tracking and monitoring, transition readiness or preparation, transition planning, transition and transfer of care, and transition completion (Got Transitions); identifying opportunities to educate providers of adult care on treating young adults with chronic conditions; and working with medical associations, primary care associations, and others to identify medical providers trained in adolescent health and special health care needs. CSHCN transition to adult health care tools and best practices information will be adapted and timely disseminated through multiple communication strategies to primary care providers, medical specialists, community service providers, family organizations and statewide partners who impact care for families with CSHCN. The CSHCN Services Coordination Model will address the services coordinator role in helping the families to understand their child’s future health care needs and how to navigate the adult health services to ensure YSHCN receive the services necessary to make transitions to all aspects of adult life.

3. Decrease the age when children at risk for Autism Spectrum Disorders (ASD) receive their first diagnostic evaluation

ASD can sometimes be detected at 18 months or younger. By age 2, a diagnosis by an experienced professional can be considered reliable. However, many children do not receive a final diagnosis until much older. An accurate and early autism diagnosis can provide the basis for an appropriate educational and treatment program.

Increasing awareness of the early warning signs of ASD among physicians and parents is a key aspect for the early diagnosis of ASD. Early warning signs of ASD tools and best practices information will be adapted and disseminated through multiple communication strategies to primary care providers, medical specialists, community service...
best practices information will be adapted and disseminated through multiple communication strategies to primary care providers, medical specialists, community service providers, family organizations and statewide partners. A booklet with information on developmental milestones from birth to five years of age and early warning sign for ASD will be distributed to families by birthing hospitals, pediatricians and other early childhood service providers.

A best practice protocol for the developmental surveillance and early screening of young children for ASD was developed by the PR Autism Committee and approved by the Secretary of Health in January 2015. The protocol incorporates the standards and guidelines issued by the American Academy of Pediatrics (AAP). The protocol will be disseminated through multiple communication strategies to primary care providers, medical specialists, community service providers, family organizations and statewide partners. A Certificate of Developmental and ASD Screening will be implemented and will be required for all children entering day care and preschool.

To increase access to diagnostic services in a timely matter at least one Autism Team will be set up at the CSHCN RPCs with the exception of the Metropolitan RPC. The CSHCN Autism Center will host the Autism teams for the Metropolitan Health Region. The teams will follow the best practice protocol for the diagnosis of ASD developed by the PR Autism Committee and approved by the Secretary of Health in January 2015.

The implementation of the PR Autism Registry will provide baseline data on ASD prevalence and age at diagnosis. As recommended by New Jersey's Autism Registry staff, initial education efforts about the Registry will be directed to the most likely reporters: diagnosticians and autism centers, followed by professional groups (attending conferences, writing articles for their newsletters, developing a webpage) and lastly doing in-office education.

4. Reduce the prevalence at birth of neural tube defects

After the mandatory fortification of enriched cereal grain products with folic acid, there was a 50% decrease in the prevalence of neural tube defects (NTD) in PR from 1998-2002. Since 2004, the NTD birth prevalence in PR has remained relatively stable, 9.8 per 10,000 live births. Studies have shown that Hispanics consistently had a higher prevalence of NTDs compared with the other racial/ethnic groups. A common genetic polymorphism in Hispanics, the methylenetetrahydrofolate reductase T allele, has been associated with relatively lower plasma folate and RBC folate concentrations compared with those without this polymorphism. Also, many women who have had an NTD-affected pregnancy and are planning a subsequent pregnancy do not take a folic acid supplement. (Morbidity and Mortality Weekly Report Weekly / Vol. 64 / No. 1 January 16, 2015). Among 3,718 Puerto Rico WIC participants’ women that completed a folic acid questionnaire in 2014, 33% reported taking a folic acid supplement daily, 27.3% reported taking it at least one month before getting pregnant and 44.5% reported not taking folic acid.

The BDSPS will continue the active population based surveillance for 47 birth defects, including NTDs (anencephaly, spina bifida and encephalocele) to track their prevalence at birth.

The BDSPS social worker will continue contacting by phone families with NTD-affected pregnancies to provide counseling and orientation on the optimal dosage of folic acid for reducing the risk of recurrence of NTDs under a physician’s supervision, as well as, coordination of services with health specialists and community support groups.

The BDSPS will continue the distribution of the brochure "Congratulations Mom" (Spanish version) to parents registering a baby, and to couples seeking a marriage certificate the CDC’s brochure "How to Prevent Birth Defects" (Spanish version) at the Demographic Registry Office Island wide.

The Folic Acid Awareness Month will be celebrated in October 2015, and the BDSPS will provide educational presentations to raise awareness in the population, especially women of childbearing age, on the importance of taking 400 micrograms of folic acid daily. Also, educational materials and incentives will be distributed at health centers, public schools, colleges and universities. The National Birth Defects Prevention Month will be held in January 2016. The BDSS will continue supporting the PR Alliance for Birth Defects Prevention in their collaborative efforts with other agencies and stakeholders to develop additional strategies to prevent NTD’s.

5. Improve CSHCN Program data capacity
An electronic health record can be used to improve developmental tracking and service provision to CSHCN and their families. It can also serve as an integrating healthcare tool for improving individual access to the medical home, allowing primary providers to monitor patient improvements and treatments over time regardless of the location of service provision.

A secure, Web-based electronic health record (EHR) will be developed and implemented to provide comprehensive information on CSHCN. The specific aims are: making available to health care providers a secure Web access to a comprehensive EHR of CSHCN to ensure current information and continuity of care; improving the coordination and quality of care provided to CSHCN in ambulatory settings by the use of health information technology; and providing accurate, comprehensive health care information for developmental tracking of children. A long term goal is to link data on newborn screening (NBS) and newborn hearing screening (NHS) with data on diagnosis, treatment, and follows up from the CSHCN program services.

The first step is to designate an EHR team to conduct an assessment of the CSHCN program goals, needs, and financial and technical readiness. The second step is developing an EHR implementation plan that includes the correct tasks to perform, the order of those tasks, and clear communication of tasks to the team involved with the change process. The third step is choosing the right EHR system (hardware, software, maintenance and upgrade costs, interfaces, cost to connect to health information exchange (HIE), customized quality reports). The fourth step involves the installation of the EHR system and associated activities, such as training, mock “go-live,” and pilot testing. The final phase includes successfully testing to demonstrating meaningful use of EHRs.

To increase CSHCN Program data capacity to meet new reporting requirements for performance measurements, a health services planner/evaluator will be contracted. This professional will be responsible for providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst on an evaluation, responsible for all data analysis, and will coordinate the analyses of data, assuring quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of an evaluation, including planning, data collection, data analysis, and report writing.
NPM 11 - Percent of children with and without special health care needs having a medical home

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<tr>
<th>Annual Objective</th>
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<td>24.7</td>
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NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

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<th>Annual Objective</th>
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NPM1: 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.

During 2013, there were 36,580 live births in Puerto Rico, as reported by Vital Statistics. The percentage of newborns receiving at least one screen was 99.9% (36,573/36,580). Thirty-six (36) cases were confirmed and all (100%) were timely referred for treatment. The percentage of newborns that received the screening test for hearing loss was 98.3% (35,962/36,580). Fifty nine (59) cases with hearing loss were confirmed. The UNHSP has documentation of referral for treatment for 34 (57.6%) of the confirmed cases. Of these, 19 (55.9%) were timely referred before 6 months of age, 11 (32.3%) were referred after 6 months of age, and 4 (11.8%) were referred but age at time of referral is not available. The other 25 cases were lost to follow up.

Under the Title V CSHCN program leadership, the Puerto Rico Hereditary Diseases Council (PRHDC) has held regular monthly meetings since September 2013. The CSHCN program is paying a per diem and travel expenses to facilitate and support the participation of the member who is representing families and services consumers since February 2015.

In 2014, the Council revised the regulations of PR Law #84 of 1987, to mandate the universal newborn screening for all live infants born in Puerto Rico for all Core Conditions included in the Recommended Uniform Screening Panel (RUSP) as of April 2013 with the exceptions of Hearing Loss, which is mandatory under PR Law # 311 of 2003, (PR Universal Newborn Hearing Screening Law) and Critical Congenital Heart Defects. The new regulations are in effect since January 2015. Screening for Glycogen Storage Disease Type II (Pompe) was not included as it was added to the RUSP in March 2015. The Title V CSHCN Program financed the reproduction of a new brochure for families on the expanded mandated conditions included in the newborn screening to be distributed at the birthing facilities.

A collaboration agreement was established between the PR Newborn Screening Program Laboratory (PR-NSPL), the PR Hereditary Diseases Detection, Diagnosis and Treatment Program (PR-HDDTP) and the Title V CSHCN Program Regional Pediatric Centers. The purpose of this initiative is to have a better capacity of tracking positive cases and arranging for referral and appropriate follow-up care in a timely manner. The PR-NSPL is also referring confirmed cases of inborn errors to the Title V PR-HDDTP Coordinator who, with prior family consent, refers the child to the CSHCN Program at the Regional Pediatric Center closest to their home.
The Title V PR-HDDTP Coordinator is also responsible for maintaining a data base of confirmed newborn screening cases. For each of the confirmed cases, the Coordinator makes a request for additional information to the Title V PR-BDSPS nurse abstractors, so they can obtain demographic and other data from the birthing hospitals records needed to populate the data base. The nurse abstractors also report to the Coordinator all cases that they identify at the birthing hospitals diagnosed with any of the mandatory conditions included in the newborn screening, to ensure they were not missed by the newborn screening.

The Title V CSHCN Program is currently working with the PRHDC, the PR Newborn Screening Program Laboratory and the PR Association of Allergists to develop the guidelines for management of newborns with a positive screening for Severe Combined Immunodeficiency (SCID). The purpose of the guidelines are to establish the recommended confirmatory tests for presumed positive results, ensure capacity and resources for tracking positive cases and arrange for referral and appropriate follow-up care in a timely manner.

In July 2015, the WIC and CSHCN Programs will be piloting a new way to provide children diagnosed at the University Pediatric Hospital with the special formulas or medical foods needed for the management of their condition. Instead of families leaving the hospital with a payment in form of a check, they will be provided a package with the special formulas or medical foods given at the CSHCN Nutrition Clinic facilities of the Metropolitan RPC. As part of the project, the WIC Program will provide a nutritionist and an administrative assistant that will offer support to the CSHCN Nutrition Clinic.

The CSHCN Program contracted Nutrition Specialists for the Caguas, Mayaguez and Ponce RPCs. These specialists will be trained in the nutritional management of confirmed diagnosis of inborn errors of metabolism. Training began in May 2015 and initially will be provided by the University Pediatric Hospital Genetics staff. Once the RPPCs have Internet access, coordination with the Lopez Family Foundation for continuing education of these personnel by the LA Children Hospital staff will be pursued.

In November 2014, the Title V CSHCN Program provided leadership in the approval of PR Law # 192 (November 20, 2014) which mandates newborn screening for Critical Congenital Heart Defects (CCHD). Title V CSHCH staff, with the technical assistance of the New Jersey CCHD Screening Program staff, developed the regulations for the implementation of the PR CCHD Screening Program. The regulations will be in effect in June 2015. The regulations require each birthing facility licensed by the DOH to perform a pulse oximetry screening, a minimum of 24 hours after birth, on every newborn in its care, and to report all failed CCHD screenings to the PR-BDSPS. Birthing facilities and health care professionals are required by Law 351 of 2004 (PR Birth Defects Surveillance System Law) to report infants with CCHD (and other congenital defects) who are Puerto Rico residents to the PR-BDSPS. As the Electronic Birth Certificate was not yet final, it was possible to include CCHD screening results for all births. The PR-BDSPS health educator and social worker are adapting a CCHD screening brochure for families. The PR-BDSPS nurse abstractors will receive training on the background and significance of screening, screening methods and recommendations so they can provide support to staff of the birthing hospitals they visit.

**NPM2:** 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. (CSCHN survey)

To measure family-centeredness of care, the 2009 PRS-CSCHN asked parents whether their child’s providers spend enough time with the family, listen carefully to parents, make parents feel like a partner in their child’s care, are sensitive to family’s customs and values, and provide the specific information that parents needs. Close to 82% (81.7%) of families reported that physicians usually or always spent enough time with them; 88.1% reported that physicians usually or always listened carefully; 87.7% that the physician made them feel as partners; 82.3% reported that physicians were usually or always sensitive to their values and customs; and 83.2% reported that physicians usually or always provided needed information. These percentages will be compared to the results of the 2015 PRS-CSCHN currently in progress to assess changes in the past six years.

The CSHCN Program Families Representative continued as a paid staff participating in staff training, parent focus groups, family conferences and activities at RPCs. She also assisted with outreach activities, partnership development with other agencies, development and review of resource materials and other publications, mentoring new parents, identification of resources, supporting parents, writing grants, helping with surveys, and disseminating materials. Having a Families Representative as part of the CSHCN program staff has increased awareness and understanding of family issues and needs, improved planning and policies resulting in more responsive services, and improved the overall program goals.
increased availability of families able to participate in the program activities. The CSHCN Program Families Representative was selected as one of 6 Scholars and 2 Mentors to participate in the AMCHP 2014-2015 Family Scholar Program. She was also appointed as the PR AMCHP Family Delegate. These opportunities have provided her with the knowledge, tools and resources to enhance her development as family leader.

**NPM3: 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)**

The presence of a medical home was evaluated using a series of questions from the 2009 PRS-CSHCN: whether the child has a personal doctor or nurse, he or she has a usual source of sick and well-child care; the child has had problems obtaining needed referrals; the family is satisfied with doctors’ communication with each other and with the child’s school and other systems; the family gets help coordinating the child’s care if needed; the doctor spends enough time with the child, the doctor listens carefully to the parent; the doctor is sensitive to the family’s customs; the doctor provides the family with enough information; and whether the parent feels like a partner in the child’s care. A child was defined as having a medical home if his or her care is reported to meet all of these criteria. Twenty-four point seven percent (24.7%) of CSHCN received care that met this standard. Care coordination was the weakest of the medical home components with 41.4% of families reporting benefiting from effective care coordination; 95% of families reported having a personal doctor who knows him or her well; 77.8% of families reported having a usual source of sick and well care; 53.1% of families reported having problems to get needed referrals; 54% of families reported to be very satisfied with physician-to-physician communication; 49.4% of families reported to be very satisfied with physician communication with other programs; 41.4% of families benefit from effective care coordination; 81.7% of families reported that physicians usually or always spent enough time with them; 88.1% reported that physicians usually or always listened carefully; 82.3% reported that physicians were usually or always sensitive to their values and customs; 83.2% reported that physicians usually or always provided needed information; and 87.7% that the physician made them feel as partner. These percentages will be compared to the results of the 2015 PRS-CSHCN currently in progress to assess changes in the past six years.

As part of a collaborative effort, APNI (PR Parents Training and Information Center) is financing the Services Coordinators for the Bayamón, Caguas, Mayagüez and Metropolitan Regions. CSHCN Programs nurses at Arecibo, Fajardo and Ponce were identified to provide care coordination. All service coordinators are located at the Regional Pediatric Centers.

The CSHCN Program Families Representative continues providing orientation and supporting CSHCN families that need health, educational and other types of services for their children. The BDSPS Social Worker also continued providing counseling and orientation to families of children with birth defects, including children with congenital heart defects, as well as, coordination of services with health specialists and community support groups. The HDDDTC Program Services Coordinator is also referring, with prior family consent, confirmed cases of inborn errors of metabolism to the CSHCN Program at the Regional Pediatric Center closest to their home.

**NPM4: 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)**

The 2009 PRS-CSHCN asked parents of CSHCN whether their child had insurance in the past 12 months and what kind of insurance they had. For children with insurance, the survey also assessed parents’ perceptions of the adequacy of that coverage. To do this, the survey measured whether the plan offers benefits and services that meet the child’s needs, whether the family considers any costs not covered by the plan to be reasonable, and whether the plan allows the child to see the providers that he or she needs; 97% of CSHCN were insured at the survey time; 10% were uninsured at some time in the previous 12 months; 40.8% of families feel that their insurance coverage was adequate for their child’s needs; 33% of families under the GIP reported satisfaction with the services versus 48% of families with private insurance, a statistically significant difference; 48.2% of parents reported that out of pocket costs are never or sometimes reasonable; 25.2% reported that child’s insurance plan never or sometimes covered their child’s needs; 25.1% reported that the insurance never or sometimes allowed child to see needed providers. These percentages will be compared to the results of the 2015 PRS-CSHCN currently in progress to assess changes in the past six years.

The CSHCN Program continued covering hearing aids for children with hearing loss as these are not covered by private insurance or the GIP. The Program is covering special formulas and medical foods for children 6 years – 21 years old with some inborn errors of metabolism (example: PKU).
NPM5: 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)

A community-based system of services is an infrastructure that operates across service sectors. Multiple service programs, each with its own funding streams, eligibility requirements, policies, procedures, and service sites, serve CSHCN. Communities and their resources affect the way families of children with special health needs find and use services. This outcome was assessed using a single question asking parents whether they had had difficulties trying to use the range of services their children had needed over the past year. Based on 2009 PRS-CSHCN, 81.8% of families reported the community-based service systems are organized so families can use them easily. This percentage will be compared to the results of the 2015 PRS-CSHCN currently in progress to assess changes in the past six years.

NPM6: 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.

Few coordinated services have been available to YSHCN in their transition to adult-oriented care. Transition planning must begin early in order to move children and families along in a developmentally appropriate fashion. The standard for transition outcome was evaluated for YSHCN aged 12 to 17 using two questions: whether a child’s doctors usually or always encourage adolescents to take increasing responsibility for their care, and whether doctors had provided anticipatory guidance for the transition to adult health care. The 2009 PRS-CSHCN data showed that 26% of YSHCN received the necessary services necessary to make transitions to adult life, including adult health care, work, and independence. This percentage will be compared to the results of the 2015 PRS-CSHCN currently in progress to assess changes in the past six years.

NPM12: Percentage of newborns who have been screened for hearing before hospital discharge

During 2013, there were 36,580 live births in Puerto Rico, as reported by Vital Statistics. The percentage of newborns that received the screening test for hearing loss was 98.3% (35,962/36,580). Fifty-nine (59) cases with hearing loss were confirmed. The Newborn Hearing Screening Program has documentation of referral for treatment for 34 (57.6%) of the confirmed cases. Of these, 19 (55.9%) were timely referred before 6 months of age, 11 (32.3%) were referred after 6 months of age, and 4 (11.8%) were referred but age at time of referral is not available. The other 25 cases were lost to follow up.

The UNHSP Service Coordinator and the Family Advocate contacted 558 of 753 (74.1%) babies with a “refer” result to assist in obtaining appointments for diagnostic audiological evaluations, necessary referrals and health insurance coverage. Families of infants with documented hearing loss were referred to early hearing intervention programs to receive needed services.

In April 2014 the UNHSP implemented the Plan-Do-Study-Act (PDSA) model for quality improvement. PDSAs implemented include: 1) a template to collect two points of contact of families of referred babies to reduce the loss to follow up and 2) contacting the families of babies with a “refer” result through text messages. A “report card” was developed to track the reporting data of all birthing hospitals to assure that all infants are screened for hearing loss at birth. This report card will be sent to each birthing hospitals to let them know how many babies obtained a “refer” result according to their monthly statistical data report, how many referred babies were reported through the CANU-Online tracking system, and how many referred babies were reported to the UNHSP by other means.

In July 2014, Dr. Ines Cuebas was appointed as Puerto Rico AAP EHDI Chapter Champion and became a member of the UNHS Program’ Advisory Committee.

In September 2014, an Evaluation Specialist was contracted. As one of the UNHS Program PDSAs, the Specialist edited the statistical data report form used by the birthing hospitals to provide a monthly report to UNHSP which now includes the number of babies screened before one (1) month of age and babies screened after one (1) month of age, number and demographic information of babies transferred to others hospitals and to which hospitals, babies screened and born during the reporting month, babies screened during the reporting month but born in another month, among others.
In November 2014, the UNHSP Program Coordinator and Service Coordinator participated in a Neonatology Symposium organized by the Society of Pediatricians of Puerto Rico. Orientation and educational materials were provided to the participants.

In February 2015, the Program Coordinator presented at the Annual Convention of the Puerto Rico Audiology Academy on the neonatal hearing screening protocol, the responsibilities of the birthing hospitals, the role of audiologists and pediatricians, the importance of reporting statistical data to the UNHSP, the complete demographic information of the babies that obtain a “refer” result in the hearing screening and the results of the diagnostic audiological evaluations of the referred babies in a timely manner, and the rule 1-3-6, among others. The single page template for audiologist to report (via email or fax) diagnostic evaluation results of referred babies to UNHSP was distributed.

In March 2015, the UNHSP held the first focal group with the participation of five (5) of the eighteen (18) audiologists’ coordinators contracted by the birthing hospitals to monitor the neonatal hearing screening. The second focal group was held on April 2015 with the participation of the others thirteen (13) audiologists’ coordinators. The purpose of these focal groups was to know how they are conducting the neonatal hearing screening in their respective birthing hospitals and to share ideas on how the UNHSP can be improved.

The UNHSP established a collaborative relationship with the CSHCN Program (Title V) and the BDSPS to support tracking of all infants diagnosed with permanent hearing loss that need to receive early intervention services by six months of age.

The Directory of Audiologists that evaluate newborns and infants was updated. The Service Coordinator created a list of medical specialists that evaluate newborns and infants, including ENTs, geneticists, pediatric neurologists, among others.

The UNHS Program Coordinator and Service Coordinator visited 8 birthing hospitals to monitor the newborn hearing screening protocol and to provide educational materials on neonatal hearing screening.

The Parent Support Group, "Victoria", continued its meetings every two (2) months and the UNHS Advisory Committee monthly. Periodic conversations were held with UNHSP coordinators, nursery’ supervisors at birthing hospitals and audiologists to monitor data reporting, troubleshoot reporting issues and to increase stakeholder’s data entry in CANU online tracking system.

SPM2: The prevalence at birth of neural tube defects

The BDSPS conducts active surveillance for 47 birth defects, including NTDs (anencephalia, spina bifida and encephalocoele).

During January 2014, the BDSPS celebrated the National Birth Defects Prevention Month, where 16 community educational activities were carried out reaching 443 individuals. Additionally, the BDSPS published two articles in national newspapers and gave two interviews, one on a local television program and the other on a local radio program.

The BDSPS 2014 Annual Report was completed and additional relevant data was included, such as demographic information and prevalence maps. Also, information about the UNHSP was included for the first time.

As part of the efforts to reach at risk populations, the BDSPS offered 30 presentations on folic acid and birth defects prevention strategies, throughout elementary and high schools, universities and community activities, reaching a total of 1,144 individuals. Humana and Triple-S Health Insurance companies continued educating about birth defects prevention and distributing BDSPS educational materials in their activities. Also, 7 articles were published in national newspapers. BDSPS staff was interviewed in one local television program and two local radio program. and 1.570 copies of the BDSPS educational module “Birth Defects. a Holistic Approach” with continuing
one local television program and two local radio program, and 1,370 copies of the BDSPS educational module “Birth Defects, a Heuristic Approach” with containing education credits for health professionals were distributed.

The BDSPS and the PR Department of Education (DOE) developed a new teacher’s module on folic acid and healthy lifestyles, and are providing continuing education training to teachers of all grades. On November 4th, 2014, the BDSPS and PR Spina Bifida and Hydrocephalus Association presented to eighty five (85) public school teachers on the importance of folic acid consumption for the prevention of birth defects, specifically neural tube defects.

The Alliance for Birth Defects Prevention held 8 meetings in which BDSPS data was shared with stakeholders for the development, execution and evaluation of the BDSPS data-driven action plan for birth defects surveillance, referral and prevention. The Alliance held its annual Health Fair, at the main campus of the Metropolitan University on October 13, 2014. This event was free, open to the public, and featured over 20 non-profit organizations and government agencies that set up tables with educational material and provided information to over 300 students, about birth defects prevention, services available in the community and general wellness. Concurrently, presentations were given in an auditorium by health professionals on various subjects, such as communicable diseases, spina bifida and hydrocephalus, importance of newborn screening, and sexual health.

During January 2015, the BDSPS celebrated the National Birth Defects Prevention Month, where 11 community educational activities were carried out reaching 458 individuals. Additionally, the BDSPS had 2 articles published in national newspapers.

The BDSPS initiated a collaborative agreement with the Puerto Rico Primary Health Care Association in order to work closely with Puerto Rico’s 330 health centers. An introductory teleconference presentation was offered to the participating 330 health centers and for 2015 several educational activities are planned with various health centers and the Primary Health Care Association.

The BDSPS, the Chronic Disease Division of the PRDOH, and the DOE have joined efforts to develop a new and more comprehensive health and acid folic module called, “Folic Acid: A Vitamin for Life”. Two modules have been completed, one for elementary grades (4th-6th grade) and another for intermediate and high school grades (7th to 12th grade). During September, 2015, 80 health teachers from public schools across the Island will receive training on how to include the folic acid module in their curriculum.

The BDSPS maintains its collaboration with the Demographic Registry Offices island wide, which continue distributing to parents registering a baby the NBDPN’s brochure, “Congratulations Mom” (Spanish version), and to couples seeking a marriage certificate the CDC’s brochure, “How to Prevent Birth Defects” (Spanish version).

The Alliance for the Prevention of Birth Defects continues its bi-monthly meetings and identifying agencies to recruit in this effort. An evaluator will be hired to develop the Alliance for the Prevention of Birth Defects Strategic Plan.

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**State Action Plan Table**

**Cross-Cutting/Life Course**
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<tr>
<th>State Priority Needs</th>
<th>Objectives</th>
<th>Strategies</th>
<th>National Outcome Measures</th>
<th>National Performance Measures</th>
<th>ESMs</th>
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<tr>
<td>Improve health in women of reproductive age</td>
<td>1. To increase the number of pregnant women who have a dental visit during pregnancy in Puerto Rico by 2016.</td>
<td>1. Promote preventive oral health evaluation in all pregnant women. 2. Promote the inclusion of preventive oral health care of pregnant women and early childhood in the educational curriculum of dental care providers in training. 3. Promote the inclusion of preventive oral health care of pregnant women and early childhood in the continuous medical education activities of experienced dental health care providers. 4. Promote healthy habits that protect oral health in communities.</td>
<td>Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good health</td>
<td>A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year</td>
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<td>Improve Children Health and Wellbeing</td>
<td>1. To increase the number of children, ages 1 through 17, who had a preventive dental visit in Puerto Rico by 2016.</td>
<td>1. Promote the use of caries risk assessment for the early identification of infants at high risk as recommended in the pediatric preventive guidelines.</td>
<td>Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months. Percent of children in excellent or very good health.</td>
<td>A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year.</td>
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<tr>
<td>Improve adolescent health and wellbeing</td>
<td>1. To increase the number of children, ages 1 through 17, who had a preventive dental visit in Puerto Rico by 2016.</td>
<td>1. Promote preventive oral health evaluation in all adolescents. 2. Promote healthy habits that protect oral health in communities.</td>
<td>Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months Percent of children in excellent or very good health</td>
<td>A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year</td>
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<tr>
<td>Improve birth outcomes</td>
<td>1. To increase the number of pregnant women who have a dental visit during pregnancy in Puerto Rico by 2016.</td>
<td>1. Promote preventive oral health evaluation in all pregnant women. 2. Promote the inclusion of preventive oral health care of pregnant women and early childhood in the educational curriculum of dental care providers in training. 3. Promote the inclusion of preventive oral health care of pregnant women and early childhood in the continuous medical education activities of experienced dental health care providers. 4. Promote healthy habits that protect oral health in communities.</td>
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Cross-Cutting/Life Course - Plan for the Application Year

Oral health is an important protective factor for health birth outcomes and overall health in subsequent life stages that has been neglected in PR society among populations and health professionals alike. As it was indicated in the Needs Assessment, a very low percent of children between 8 and 9 years of age had dental sealants for 2014. Similarly, the percentage of pregnant women receiving oral health services is very low (16.2%). For this reason, oral health (NPM # 13) has been selected as the health issue to be addressed in the Cross-Cutting/Life Course domain. This domain intersects health and related work across populations and across life stages – infants, children, adolescents and adults (reproductive age women up to 44 years of age) – as well as improving birth outcomes (pregnancy/fetal stage).

The NPM #13 objectives are:

a. To increase the number of pregnant women who have a dental visit during pregnancy in PR during 2016.

b. To increase the number of children, ages 1 through 17, who had a preventive dental visit in Puerto Rico during 2016.

PRMCAH work on oral health will be done through the promotion of preventive dental visits and oral health education and literacy.

PRMCAH will promote Pediatric Preventive Health Guidelines that include oral health for children and adolescents. Work in oral health since infancy will contribute to a person’s development in subsequent years and life stages (school years, adolescence, early adulthood, adulthood and old age).

To improve oral health during pregnancy, PRMCAH will develop and promote WRA Health Guidelines that will include oral health for pregnant women. It is of extreme importance to work towards increasing dental visits during pregnancy as oral health status is linked to birth outcomes like low-birth weight and prematurity.

The health education involves a two-prong oral health overall action. One is information and education to families, children, adolescents, pregnant women and the public about risks, healthy oral habits, GIP coverage, preventive dentist visits and use of sealants. All educational activities will be done through the dissemination of print materials, workshops, presentations, work group and one-on-one education. PRMCAH will promote oral health literacy so that populations understand its relation to the overall health and well-being across the life course stages.

The second tier is training and education to health professionals. PRMCAH will advocate for the inclusion of oral health care for pregnant women and children in their early years in the educational curriculum of dental care providers in training as well as its inclusion into continuous medical education for experienced dental health care providers. PRMCAH will also train and promote the use of caries risk assessment for the early identification of infants at high risk among the staff of HVP, Early Head Start/Head Start and WIC programs.

PRMCAH will strengthen work in the area of oral health with existing partners to better coordinate educational, oral care services and referrals. More importantly, it will propitiate the involvement of families in promoting healthy oral habits, preventive dentist visits, and oral health literacy in communities.
Cross-Cutting/Life Course - Annual Report

NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

<table>
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<th>Annual Objective</th>
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The main strategy used by PRMCAH to address oral health was to provide information and education on the importance of sealants, risks for dental caries, healthy oral habits, GIP coverage for visits and procedures, and oral health during pregnancy.

During FY 2013-2014, the PRMCAH staff in the seven Health Regions carried out a total of 80 educational activities related to oral health for children and adolescents. Through these activities the staff reached a total of 1,416 people of which the reported age groups are as follows: 1,075 children under 10 years of age; 93 children aged 10-14; 49 adolescents 15-19 years of age; 129 adults aged 20-54; and 7 over 55 years of age. Parents involved in the educational activities were strongly advised to instill healthy oral habits in their children since early childhood, assure dental visits for their children and GIP coverage for sealants and how to request these (Performance Measure 09: Percent of third grade children who have receive protective sealants on at least one permanent molar tooth).

The PRMCAH staff also carried out 18 educational activities around oral health and pregnancy. A total of 154 people participated in these activities of which 38 were in the 15-19 age group; 111 in the 20-54 age group and; 5 over 55 years of age. These activities revolve around topics of birth outcomes in relation to oral health, GIP coverage for oral health during pregnancy, and the importance of dental visits for pregnant women.

The HVN’s offered one-on-one education to 1,016 enrolled pregnant women on oral health, GIP coverage, and birth outcomes. They also provided one-on-one education to mothers of 2,717 infants and children (aged 1-2 years) that were participating in the program. In educating mothers, HVN’s emphasized the avoidance of sugary foods for children since it is customary in PR society to put sugar in children’s milk and/or give sodas to infants and children.

Other Programmatic Activities

PR MCAH program continues sustaining critical partnership to advance maternal and child health with other MCHB-supported programs such as MIECHV and MCHB supported Collaborative for Innovation and Improvement Network (CoIN to reduce infant mortality in the US and its jurisdictions). For this purpose the PR MCAH Program selected preconception/inter-conception health, prevention of preterm and early term births and perinatal regionalization as strategies to achieve the goal. To achieve improvement of preconception/inter-conception women health the MCAH program will develop and promote guidelines for healthcare of women of reproductive age, promote preventive health visit in woman of reproductive age, and will continue to promote proper birth spacing through education regarding family planning. Early identification of women with previous preterm birth for the use of the 17-P, implementation of the “Hard Stop Policy” at birthing hospitals and campaigns targeting pregnant women on signs and symptoms of premature labor are strategies that will be continued in an effort aimed at prevention of preterm and early term births. Hard Stop Policy is aimed at decreasing induction prior to 39 weeks gestation and therefore decreasing the prevalence
of cesarean sections and late premature births. The evaluation and the classification of hospitals by levels of neonatal and obstetric services, promoting the creation of inter-hospital agreements for the referral of high-risk pregnant women and promoting the implementation of "hospitals training sites" associated with schools of medicine (which may require a bill) are other strategies the MCAH Program will continue to use to achieve perinatal regionalization and decrease infant mortality. MCAH Program will continue with educational activities with CME for Obstetricians presenting prematurity and infant mortality data; prevention, early detection, and treatment of premature labor; and the use of the Hard Stop Policy in hospitals with collaboration of the Hospitals Association and March of Dimes.

The MCAH program will continue to support and provide staff training for the MIECHV program (MCHB-supported) to advance maternal and child health, and which specifically targets pregnant adolescent population in specific geographical areas. Both programs share similar priorities: to improve children health & well-being, (MIECHV’s main goal is to reduce child abuse and neglect) and, improve maternal health care (by promoting early pregnant adolescent prenatal care). MIECHV, "Familias Saludables" (FS) serve <21 y/o pregnant females and their families. The Federal Qualified Health Center named “Salud Integral de la Montaña, Inc.” had its 2nd year implementing EBPs Healthy Families America and Growing Great Kids and two new sites (Maunabo and Patillas) were added. Staff was hired and trained in the new sites. The original sites (Barranquitas and Orocovis) offered services to 63 families through a total amount of 1,009 home visits. Challenges and achievements has been assessed during 2014-2015 and the Program continue in 2015.

In 2013-2014 PRMCAH continued the administration of PR Abstinence Education Grant (AEG) and Personal Responsibility Education Program (PREP) funds for additional TPP efforts with teens, parents and communities. PRAEG implemented 4th year PEP (parents EB) to 633 parents and tutors of 10-12 y/o with an 85% participation rate. This program included art lesson to 349 kids while their parents attended PEP. A total of 1,038 home visits (1-2hrs) to PEP families gave additional tools. A total of 24 parent support groups gave parents PEP follow up. Teen EBP’ AIM had 853 preteens (10-12) in its 3rd year of implementation. AEG evaluation gathered data from parents and teens to assess’ fidelity and impact of EBPs as implementation continues in 2015. An increase of funds for FY 2015 will allow to serve approximately 1,200 early teens and 895 parents or tutors. The PRDOH expects these interventions will delay sexual onset in adolescents and improve parent-teen communication skills and problem-solving techniques in order to promote their healthy and positive development.

During 2013-2014, PRPREP implementation phase began with 10 health promoters hired and trained to offer EBPs Cuidate (12-14 y/o) and Cuidalos (12-14 y/o parents) in 5 selected municipalities. With the approval of developer, both EBPs were culturally adapted and Cuidate sessions shortened to comply with 50 min. class period in schools. Pilot phase was completed in 10 public housings and 1st year implementation in middle schools included 393 youth aged 12-14 and 26 parents/caregivers. An external evaluator was hired to evaluate pilot and 1st year implementation. Entry/exit and satisfaction surveys were done to evaluate PREP. AE and PREP staff attended 3rd TPP Conference. AEG and PREP has continued during 2014-2015 and will continue on 2015-2016. Pro-Youth Committees will be constituted on each PREP municipality or implementation site to identify issues affecting youths, discuss strategies and sustainability. All these strategies seek to increase youth knowledge and responsibility for their sexual and reproductive health and rights.

The DOH also addresses suicidal behavior through ASSMCA Mental Health Support Line PAS (Spanish acronym for First Psychosocial AID), a crisis toll free number. The PAS hotline receives calls for crisis intervention, information and suicide prevention for both adults and adolescents. The PAS program reported having given service (FY 2014-2014) to a total of 15,024 suicidal behavior cases (ideas and attempts) of which 1,113 were children and adolescents (0-17 and 18-20 y/o). Of this group, 689 were females and 424 were males. Of the 689 female cases, 596 were suicidal ideas and 93 were attempts. Of the 424 male cases, 383 were suicidal ideas while 41 were attempts. The PAS offered educational activities on suicide prevention in school settings to 3,250 students and 289 teachers. It also distributed 7,290 educational materials on Suicide Prevention in a variety of activities (e.g. health fairs, workshops and presentations.
CShCN

The Children with Special Medical Needs Division is responsible for overall leadership of the PR Autism Law (2012) activities. The law establishes, among others, the following responsibilities of PRDOH: the identification, diagnosis, assessment, intervention and coordination of services for the population under 22 years old with Autism Spectrum Disorder (ASD) through the RPCs; and the implementation of an Autism Registry. To meet the needs of the ASD population under 22 years old, the CShCN program has increased its workforce at the RPCs and Central Office. New staff includes highly experienced professionals in ASD from the fields of clinical and school psychology, speech-language pathology, occupational therapy and special education. In collaboration with the Autism Center and the Ponce Autism Center, RPCs staff has received training on ASD screening and diagnosis. Next steps include staff training on conducting early, interdisciplinary, evaluations to confirm or rule out ASD and other developmental disorders following the best practice protocol for the developmental surveillance and early screening of young children for ASD that was developed by the PR Autism Steering Committee and approved by the Secretary of Health in January 2015. Effective July 1st, 2015, the Autism Center will be administered by the CShCN Program to provide a unified collaborative and administrative structure designed to ensure the successful execution of plans and strategies that support the implementation of the PR Autism Law. This center will provide ongoing training and technical assistance to students, families and staff at the RPCs.

As part of a collaborative effort to address the care coordination needs of CSHCN, APNI (PR Parents Training and Information Center) is financing the Services Coordinators for the Bayamón, Caguas, Mayaguez and Metropolitan Regions. CSHCN Program nurses at Arecibo, Fajardo and Ponce were identified to provide services coordination. All service coordinators are located at the Regional Pediatric Centers. As previously identified, these personnel training needs include: working with the primary care physicians and family advocates to facilitate access to services, promoting continuity of care, provide family support, improving functional outcomes and maximizing efficient and effective use of resources, and assuring transition services for CYSHCN.

Other workforce development and training needs of the CSHCN RPCs and Central Office staff include: understanding system realignments and scopes of service as a result of the transition from a direct service delivery orientation to population health assurance role; incorporating the perspectives of families and family representatives into the MCH workforce, and becoming skilled in collecting appropriate data for accountability documentation as a result of the paradigm shift toward results-based accountability. Technical assistance is also needed for the implementation of a successful Care Coordination Program, the Medical Home Concept and the transition of YSCHN to adult care services.
II.F.3. Family Consumer Partnership

CSHCN

The CSHCN Program has a Families’ Representative as a paid staff participating in staff training, parent focus groups, family conferences and activities at RPCs. She also assists with outreach activities, partnership development with other agencies, development and review of resource materials and other publications, mentoring of new parents, identification of resources, supporting parents, writing grants, helping with surveys, and disseminating materials. Having a Families’ Representative as part of the CSHCN program staff has increased awareness and understanding of family issues and needs, and improved planning and policies; resulting in more responsive services, and increased availability of families able to participate in the CSHCN program activities.

The CSHCN Program Families Representative was selected as one of 6 Scholars and 2 Mentors to participate in the AMCHIP 2014-2015 Family Scholar Program. She was also appointed as the PR AMCHIP Family Delegate. These opportunities have provided her with knowledge, tools and resources to enhance her development as family leader.

The CSHCN Program Families Representative was a key leader in the focus groups study for the 2016—2020 needs assessment, as well as, for the selection of the CSHCN domain priorities.

The CSHCN program is paying per diem and travel expenses to facilitate and support the participation of the Puerto Rico Hereditary Diseases Council member who has represented families and services consumers since February 2015.
II.F.4. Health Reform

MCAH

The Affordable Care Act (ACA) require that health plans cover a series of preventive health services without charging copayment or coinsurance that benefits our target population. Education on prevention at the community level has been one of the main activities of the MCAH staff that includes the importance of the preventive health services and where to look for them, to all population groups. Breastfeeding comprehensive support and counseling, and contraception are two areas addressed by our HVNs that will add to the ACA requirement. The coverage of contraceptives methods by the GHP has release TV funds previously used to cover that service and will allow to increase the delivery of our Prenatal and the Positive Parenting courses in the community.

CSHCN

Not all Affordable Care Act (ACA) dispositions apply to Puerto Rico. One of the most significant dispositions of the ACA implementation that does not apply to Puerto Rico is the individual mandate. Contrary to other jurisdictions, individuals are not required by law, nor will they be subject to fines if do not have a medical plan. As a result, Puerto Rico does not have a Health Insurance Marketplace and a navigator program to help consumers learn about and enroll in coverage.

The CSHCN Program gap-filling health services include covering hearing aids for children with hearing loss as these are not covered by private insurance or the GHP. The Program is also covering special formulas and medical foods for children 6 years – 21 years old with some inborn errors of metabolism (example: PKU).

To facilitate access to pediatric subspecialty providers, the CSHCN Program is covering the pediatric neurosurgeon and the plastic surgery services for the Neural Tube Defects and the Cranio-Facial Disorders Interdisciplinary Clinics at the Metropolitan RPC; and the pediatric orthopedists services for the Complex Orthopedic Conditions Clinics at the Metropolitan and Mayaguez RPCs. These services are billed to child’s insurance plan.

II.F.5. Emerging Issues

CSHCN

Greater collaboration with the Education Department in the coordination of health related services to children eligible for Special Education.
II.F.6. Public Input
II.F.7. Technical Assistance

The MCH/CSHCN Programs requested a Phase II Family Engagement TA to enhance family engagement and build family leadership across Title V MCH/CSHCN block grant programs. The objectives include: (a) building the capacity of Title V professionals to identify, recruit, support, and partner with parent leaders across Title V, and (b) building the capacity of parents receiving Title V services to serve in leadership roles in partnership with Title V professionals. The activities include (1) facilitating an on-site “train the trainer” workshop for teams of Title V professionals and identified parents with the potential for leadership, recruiting teams from MCH/CSHCN Divisions, and home visiting among other Title V programs; (2) providing peer-to-peer support to enhance the knowledge, skills and capacity of Title V leadership and Title V parent engagement leaders so as to sustain parent engagement and leadership efforts; and (3) establishing ongoing parent/professional development learning opportunities via a series of targeted webinars, conference calls, and development and sharing of needed resources, based on feedback and input from Title V leadership as well as the trained teams and the family engagement team leads. The request was approved by the MCHB.
### III. Budget Narrative

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<td>Expended</td>
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III.A. Expenditures

III.B. Budget
IV. Title V-Medicaid IAA/MOU
V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.
## Form 2
### MCH Budget/Expenditure Details
**State: Puerto Rico**

### FY16 Application Budgeted

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<td>2. UNOBLIGATED BALANCE</td>
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<td>3. STATE MCH FUNDS</td>
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<td>4. LOCAL MCH FUNDS</td>
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<tr>
<td>5. OTHER FUNDS</td>
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</tr>
<tr>
<td>6. PROGRAM INCOME</td>
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<td>7. TOTAL STATE MATCH</td>
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<td>9. OTHER FEDERAL FUNDS</td>
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<td>10. OTHER FEDERAL FUNDS</td>
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<td>11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL</td>
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### FY14 Annual Report Expended

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<tr>
<td>2. UNOBLIGATED BALANCE</td>
<td>$656,748</td>
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<tr>
<td>3. STATE MCH FUNDS</td>
<td>$12,240,731</td>
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<tr>
<td>4. LOCAL MCH FUNDS</td>
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</tr>
<tr>
<td>5. OTHER FUNDS</td>
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<tr>
<td>6. PROGRAM INCOME</td>
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<tr>
<td>7. TOTAL STATE MATCH</td>
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<td>8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL</td>
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<tr>
<td>9. OTHER FEDERAL FUNDS</td>
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<td>11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL</td>
<td>$28,734,964</td>
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Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.
9. OTHER FEDERAL FUNDS

Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)  $633,803

Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program $1,802,460

Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program $1,000,000

Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration $140,000

Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI) $95,374

Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention $250,000

US Department of Education > Office of Special Education Programs > Early Identification and Intervention Infants/Toddlers $4,291,178

Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities $175,000
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<td>B. Children with Special Health Care Needs</td>
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<td>C. Title V Administrative Costs</td>
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<td><strong>2. UNOBLIGATED BALANCE</strong></td>
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<td><strong>3. STATE MCH FUNDS</strong></td>
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<td><strong>5. OTHER FUNDS</strong></td>
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<td><strong>6. PROGRAM INCOME</strong></td>
<td>$173,258</td>
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<tr>
<td><strong>7. TOTAL STATE MATCH</strong></td>
<td>$12,413,989</td>
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Form Notes For Form 2:
None

Data Alerts for Form 2:

1. The value in Line 1A, Preventive and Primary Care for Children, Annual Report Expended is less than 30% of the Federal Allocation, Annual Report Expended. Please add a field level note indicating the reason for the discrepancy.

2. The value in Line 1B, Children with Special Health Care Needs, Annual Report Expended is less than 30% of the Federal Allocation, Annual Report Expended. Please add a field level note indicating the reason for the discrepancy.
## I. TYPES OF INDIVIDUALS SERVED

### IA. Federal MCH Block Grant

1. Pregnant Women
2. Infants < 1 year
3. Children 1-22 years
4. CSHCN
5. All Others

<table>
<thead>
<tr>
<th></th>
<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
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<td>$0</td>
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### IB. Non Federal MCH Block Grant

1. Pregnant Women
2. Infants < 1 year
3. Children 1-22 years
4. CSHCN
5. All Others

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<th>FY16 Application Budgeted</th>
<th>FY14 Annual Report Expended</th>
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<td><strong>Non Federal Total of Individuals Served</strong></td>
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**Federal State MCH Block Grant Partnership Total**

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Form Notes for Form 3a:
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Data Alert for Form 3a:

1. Children 1 to 22 Years, Application Budgeted does not equal Form 2, Line 1A, preventive and Primary Care for Children Application Budgeted. Please add a field level note to explain.

2. CSHCN, Application Budgeted does not equal Form 2, Line 1B, Children with Special Health Care Needs, Application Budgeted. Please add a field level note to explain.

3. Children 1 to 22 Years, Annual Report Expended does not equal Form 2, Line 1A, preventive and Primary Care for Children, Annual Report Expended. Please add a field level note to explain.

I. TYPES OF SERVICES

IIA. Federal MCH Block Grant

1. Direct Services
   A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One
   B. Preventive and Primary Care Services for Children
   C. Services for CSHCN

2. Enabling Services

3. Public Health Services and Systems

4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service

   Pharmacy
   Physician/Office Services
   Hospital Charges (Includes Inpatient and Outpatient Services)
   Dental Care (Does Not Include Orthodontic Services)
   Durable Medical Equipment and Supplies
   Laboratory Services

   Direct Services Total $0

   Federal Total
IIB. Non-Federal MCH Block Grant

1. Direct Services
   A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One
   B. Preventive and Primary Care Services for Children
   C. Services for CSHCN

2. Enabling Services

3. Public Health Services and Systems

4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service

   Pharmacy
   Physician/Office Services
   Hospital Charges (Includes Inpatient and Outpatient Services)
   Dental Care (Does Not Include Orthodontic Services)
   Durable Medical Equipment and Supplies
   Laboratory Services

   Direct Services Total

Non-Federal Total
Form Notes for Form 3b:
None

Field Level Notes for Form 3b:
Form 4
Number and Percentage of Newborns and Others Screened, Cases Confirmed and Treated
State: Puerto Rico

Total Births by Occurrence 36,580

1a. Core RUSP Conditions

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<tr>
<th>Program Name</th>
<th>(A) Number Receiving at Least One Screen</th>
<th>(B) Number Presumptive Positive Screens</th>
<th>(C) Number Confirmed Cases</th>
<th>(D) Number Referred for Treatment</th>
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<td>Primary congenital hypothyroidism</td>
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<td>Biotinidase deficiency</td>
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<td>Classic galactosemia</td>
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<td>Congenital adrenal hyperplasia</td>
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1b. Secondary RUSP Conditions

2. Other Newborn Screening Tests

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<td>Newborn Hearing</td>
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3. Screening Programs for Older Children & Women

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<th>(C) Number Confirmed Cases</th>
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4. Long-Term Follow-Up

The newborn screening program did not monitor infants with confirmed diagnosis after referral for treatment in 2013 and 2014. The PR-HDDTP is currently developing guidelines for monitoring infants with confirmed diagnoses after referral for treatment. The UNHSP provides long-term follow to infants with confirmed hearing loss up to age three. The program creates a record of the infant that includes: demographic information, name of the birthing hospital, date the infant was referred to the Early Intervention Services System, results of the diagnostic audiological evaluations, name of health insurance provider, name of primary care physician, and name of the professional that provided the treatment and type of treatment (ex. hearing aids, cochlear implant, medical treatment).
Form Notes for Form 4:
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Field Level Notes for Form 4:
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<th>(C) Title XXI %</th>
<th>(D) Private/Other %</th>
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<td>43.6</td>
<td>0</td>
<td>56.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Infants &lt;1 year of Age</td>
<td>50,724</td>
<td>43.6</td>
<td>7</td>
<td>49.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. Children 1 to 22 Years of Age</td>
<td>524,687</td>
<td>43.6</td>
<td>7</td>
<td>49.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4. Children with Special Health Care Needs</td>
<td>8,797</td>
<td>43.6</td>
<td>7</td>
<td>49.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Others</td>
<td>20,933</td>
<td>43.6</td>
<td>7</td>
<td>49.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>648,248</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Form Notes for Form 5a:
None

Field Level Notes for Form 5a:
### Form 5b

**Total Recipient Count of Individuals Served by Title V**

**State: Puerto Rico**

**Reporting Year 2014**

<table>
<thead>
<tr>
<th>Types Of Individuals Served</th>
<th>Total Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Women</td>
<td>59,218</td>
</tr>
<tr>
<td>2. Infants &lt; 1 Year of Age</td>
<td>88,722</td>
</tr>
<tr>
<td>3. Children 1 to 22 Years of Age</td>
<td>560,241</td>
</tr>
<tr>
<td>4. Children with Special Health Care Needs</td>
<td>14,192</td>
</tr>
<tr>
<td>5. Others</td>
<td>32,487</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>754,860</strong></td>
</tr>
</tbody>
</table>
Form Notes for Form 5b:
None

Field Level Notes for Form 5b:
1. Field Name: Infants Less Than One Year
   Fiscal Year: 2014
   Column Name:
   Field Note:
   Infants means child that haven't reach 1 year old, that means that children born the year before could be served during this reporting year and will add to the total child born during this reporting year. Therefore it is impossible that it would be only 10% more than the total birth by occurrence reported in Form 4.
I. Unduplicated Count by Race

<table>
<thead>
<tr>
<th></th>
<th>(A) Total All Races</th>
<th>(B) White</th>
<th>(C) Black or African American</th>
<th>(D) American Indian or Native Alaskan</th>
<th>(E) Asian</th>
<th>(F) Native Hawaiian or Other Pacific Islander</th>
<th>(G) More than One Race Reported</th>
<th>(H) Other &amp; Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total Deliveries in State</td>
<td>36,580</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>36,580</td>
</tr>
<tr>
<td>Title V Served</td>
<td>36,573</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>36,573</td>
</tr>
<tr>
<td>Eligible for Title XIX</td>
<td>16,936</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16,936</td>
</tr>
<tr>
<td>2. Total Infants in State</td>
<td>38,884</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>38,884</td>
</tr>
<tr>
<td>Title V Served</td>
<td>35,780</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>35,780</td>
</tr>
<tr>
<td>Eligible for Title XIX</td>
<td>16,953</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>16,953</td>
</tr>
</tbody>
</table>
## II. Unduplicated Count by Ethnicity

<table>
<thead>
<tr>
<th></th>
<th>(A) Total Not Hispanic or Latino</th>
<th>(B) Total Hispanic or Latino</th>
<th>(C) Ethnicity Not Reported</th>
<th>(D) Total All Ethnicities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Total Deliveries in State</strong></td>
<td>0</td>
<td>0</td>
<td>36,580</td>
<td>36,580</td>
</tr>
<tr>
<td>Title V Served</td>
<td>0</td>
<td>0</td>
<td>36,573</td>
<td>36,573</td>
</tr>
<tr>
<td>Eligible for Title XIX</td>
<td>0</td>
<td>0</td>
<td>16,936</td>
<td>16,936</td>
</tr>
<tr>
<td><strong>2. Total Infants in State</strong></td>
<td>0</td>
<td>0</td>
<td>38,884</td>
<td>38,884</td>
</tr>
<tr>
<td>Title V Served</td>
<td>0</td>
<td>0</td>
<td>35,780</td>
<td>35,780</td>
</tr>
<tr>
<td>Eligible for Title XIX</td>
<td>0</td>
<td>0</td>
<td>16,953</td>
<td>16,953</td>
</tr>
</tbody>
</table>
Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data
State: Puerto Rico

A. State MCH Toll-Free Telephone Lines

<table>
<thead>
<tr>
<th>Application Year 2016</th>
<th>Reporting Year 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. State MCH Toll-Free &quot;Hotline&quot; Telephone Number</td>
<td>(787) 764-5915</td>
</tr>
<tr>
<td>2. State MCH Toll-Free &quot;Hotline&quot; Name</td>
<td>Línea Informativa Madres, Niños y Adolescentes</td>
</tr>
<tr>
<td>3. Name of Contact Person for State MCH &quot;Hotline&quot;</td>
<td>Dr. Manuel I. Vargas Bernal</td>
</tr>
<tr>
<td>4. Contact Person's Telephone Number</td>
<td>(787) 765-2929 x4550</td>
</tr>
<tr>
<td>5. Number of Calls Received on the State MCH &quot;Hotline&quot;</td>
<td>1,125</td>
</tr>
</tbody>
</table>

B. Other Appropriate Methods

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Other Toll-Free &quot;Hotline&quot; Names</td>
<td>Línea Pas</td>
</tr>
<tr>
<td>2. Number of Calls on Other Toll-Free &quot;Hotlines&quot;</td>
<td></td>
</tr>
<tr>
<td>3. State Title V Program Website Address</td>
<td><a href="http://www.salud.gov.pr">www.salud.gov.pr</a></td>
</tr>
<tr>
<td>4. Number of Hits to the State Title V Program Website</td>
<td></td>
</tr>
<tr>
<td>5. State Title V Social Media Websites</td>
<td>Unidos por la Niñez Temprana on Facebook</td>
</tr>
<tr>
<td>6. Number of Hits to the State Title V Program Social Media Websites</td>
<td></td>
</tr>
</tbody>
</table>
Form Notes for Form 7:
None
1. Title V Maternal and Child Health (MCH) Director

Name: Manuel I. Vargas Bernal
Title: MD, MPH
Address 1: PO Box 70184
City / State / Zip Code: San Juan PR 00936
Telephone: (787) 765-2929 x4550
Email: mivargas@salud.pr.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name: Miguel Valencia Prado
Title: MD
Address 1: PO Box 70184
City / State / Zip Code: San Juan PR 00936
Telephone: (787) 765-2929 x4572
Email: mvalencia@salud.pr.gov

3. State Family or Youth Leader (Optional)

Name: Gloria I. Montalvo Ortega
Title: MD
Address 1: PO Box 70184
City / State / Zip Code: San Juan PR 00936
Telephone: (787) 765-2929 x4565
Email: gmontalvo@salud.pr.gov
Form Notes for Form 8:
None
### Application Year 2016

<table>
<thead>
<tr>
<th>Priority Need</th>
<th>Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)</th>
<th>Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve health in women of reproductive age</td>
<td>Continued</td>
<td></td>
</tr>
<tr>
<td>2. Improve birth outcomes</td>
<td>Replaced</td>
<td></td>
</tr>
<tr>
<td>3. Decrease Infant Mortality</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>4. Improve Children Health and Wellbeing</td>
<td>Replaced</td>
<td></td>
</tr>
<tr>
<td>5. Improve adolescent health and wellbeing</td>
<td>Replaced</td>
<td></td>
</tr>
<tr>
<td>6. Increase the number of CSHCN who receive regular ongoing comprehensive health care within a medical home</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>7. Increase the number of CSHCN aged 12 to 17 years who receive adequate support and services for their transition to adult health care</td>
<td>Continued</td>
<td></td>
</tr>
<tr>
<td>8. Decrease the age when children at risk for Autism Spectrum Disorders (ASD) receive their first diagnostic evaluation</td>
<td>New</td>
<td></td>
</tr>
<tr>
<td>9. Reduce the prevalence at birth of neural tube defects</td>
<td>Continued</td>
<td>Since 2004, the NTD birth prevalence in PR has remained relatively stable, 9.8 per 10,000 live births. This is higher than in the US, where the prevalence is 7 per 10,000 live births. Hispanics consistently had a higher prevalence of NTDs compared to other racial/ethnic groups. There remain opportunities for prevention among women with lower folic acid intakes to further reduce the prevalence of NTDs in Puerto Rico, as well as the infant mortality related to this birth defect.</td>
</tr>
<tr>
<td>10. Improve CSHCN Program data capacity</td>
<td>New</td>
<td>This priority was chosen as the result of the needs assessment process itself. Data for Puerto Rico is not available from the National Survey of Children with Special Health Care Needs (NS- CSHCN) or the National Survey of Children’s Health (NSCH). Data systems support service delivery, facilitates performance and outcome monitoring, fosters quality improvement, and helps cultivate political support for services. Gaining an in-depth understanding of CSHCN through exploring existing data sources, identifying missing data, and developing new data sources will allow the DOH to identify gaps in services and to better assist the CSHCN community throughout the island.</td>
</tr>
</tbody>
</table>
None
Form Note for Form 10a NPMs and NOMs:
NPM 1:
Average Annual Percent Change (AAPC) from 2009 to 2013 was calculated to estimate Annual Performance objectives 2016 to 2020.
Source: BRFSS 2009 to 2013.

NPM 3:
AAPC from 2012 to 2014 was calculated to estimate Annual Performance objectives 2016 to 2020.
Source: Vital Statistics
Classification according to Perinatal Care Guidelines Review Committee, 2011.

NPM 4A:
AAPC from 2005 to 2014 was calculated to estimate Annual Performance objectives 2016 to 2020.
Source: Vital Statistics.

As of July 2014 PR was incorporated at the National Immunization Survey (NIS). This indicator will be reported later on using NIS data.

NPM 4B:
AAPC from 2002 to 2012 was calculated to estimate Annual Performance objectives 2016 to 2020.
Source: ESMIPR (PRAMS like survey) from the MCAH Program of the Department of Health.

As of July 2014 PR was incorporated at NIS. This indicator will be reported later on using NIS data.

NPM 8:
Data for children physically active in PR is not available. 2012 NCHS national data was considered for baseline and upper 95% Confidence Interval were considered as 2020 annual objective.

PR MCAH Program will incorporate this indicator as one of the state added questions in the PR Behavioral Risk Factor Surveillance System (BRFSS). This indicator will be reported later on using BRFSS data.

NPM 10:
Annual Performance objectives 2016 to 2020 estimation considered data from 2012 to 2013.
Source: PR Health Insurance Administration (PRHIA) and the Insurance Commissioner (ICO).

PR MCAH Program will incorporate this indicator as one of the state added questions in the PR BRFSS. This indicator will be reported later on using BRFSS data.

NPM 11:
The first two years objectives are equal to the "baseline" data. It is expected that the efforts made over the last years will impact the results of the last three years of the five-year period (2018 to 2020)]. The objectives will be revised once the results of the 2015-PRS-CSHCN are available.

NPM 12:
The first two years objectives are equal to the "baseline" data. It is expected that the efforts made over the last years will impact the results of the last three years of the five-year period (2018 to 2020)]. The objectives will be revised once the results of the 2015-PRS-CSHCN are available.

NPM 13A:
AAPC from 2002 to 2012 was calculated to estimate Annual Performance objectives 2016 to 2020.
Source: ESMIPR (PRAMS like survey) from the MCAH Program of the Department of Health.

NPM 13B:
Annual Performance objectives 2016 to 2020 estimation considered data from 2012 to 2013.
Source: PRHIA and ICO.

PR MCAH Program will incorporate this indicator as one of the state added questions in the PR BRFSS. This indicator will be reported later on using BRFSS data.
NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

NOM-1 Notes:
None

Data Alerts:
None

NOM-2 Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM-2 Notes:
PR does not participate in the State Inpatient Database. Data will be requested next year to the PR Health Insurance Administration (PRHIA) and the Insurance Commissioner Office (ICO) according to the ICD – 9 codes published on the CDC webpage by January 22, 2014: “Severe Maternal Morbidity in the United States”.

Data Alerts:

1. Data has not been entered for NOM #2. This outcome measure is linked to the selected NPM 1,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM-3 Maternal mortality rate per 100,000 live births

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Indicator</td>
<td>8.7</td>
</tr>
<tr>
<td>Numerator</td>
<td>3</td>
</tr>
<tr>
<td>Denominator</td>
<td>34,493</td>
</tr>
<tr>
<td>Data Source</td>
<td>Death and Birth Certificates</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-3 Notes:
Numerator and Denominator: Provided by the Office of Demographic Registry

Data Alerts:
None
NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

NOM-4.1 Notes:
None

Data Alerts:
None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

NOM-4.2 Notes:
None

Data Alerts:
None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM-4.3 Notes:
None

Data Alerts:
None

NOM-5.1 Percent of preterm births (<37 weeks)

NOM-5.1 Notes:
None

Data Alerts:
None
NOM-5.2 Percent of early preterm births (<34 weeks)

NOM-5.2 Notes:
None

Data Alerts :
None

NOM-5.3 Percent of late preterm births (34-36 weeks)

NOM-5.3 Notes:
None

Data Alerts :
None

NOM-6 Percent of early term births (37, 38 weeks)

NOM-6 Notes:
None

Data Alerts :
None

NOM-7 Percent of non-medically indicated early elective deliveries

NOM-7 Notes:
None

Data Alerts :
None
NOM-8  Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM-8 Notes:
None

Data Alerts :
None

NOM-9.1  Infant mortality rate per 1,000 live births

NOM-9.1 Notes:
None

Data Alerts :
None

NOM-9.2  Neonatal mortality rate per 1,000 live births

NOM-9.2 Notes:
None

Data Alerts :
None

NOM-9.3  Post neonatal mortality rate per 1,000 live births

NOM-9.3 Notes:
None

Data Alerts :
None
NOM-9.4 Preterm-related mortality rate per 100,000 live births

NOM-9.4 Notes:
None

Data Alerts:
None

NOM-9.5 Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM-9.5 Notes:
None

Data Alerts:
None

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM-10 Notes:
None

Data Alerts:
None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

NOM-11 Notes:
None

Data Alerts:
None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Data Alerts:
None
NOM-13  Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Data Alerts :
None

NOM-14  Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

NOM-14 Notes:
PR does not participate in the National Survey of Children’s Health. Data will be requested next year to the PR Health Insurance Administration (PRHIA) and the Insurance Commissioner Office (ICO) according to the ICD – 9 codes for decayed teeth.

Data Alerts :

1. Data has not been entered for NOM #14. This outcome measure is linked to the selected NPM 13,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM-15  Child Mortality rate, ages 1 through 9 per 100,000

NOM-15 Notes:
None

Data Alerts :
None

NOM-16.1  Adolescent mortality rate ages 10 through 19 per 100,000

NOM-16.1 Notes:
None

Data Alerts :
None
NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM-16.2 Notes:
None

Data Alerts :
None

NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000

NOM-16.3 Notes:
None

Data Alerts :
None

NOM-17.1 Percent of children with special health care needs

NOM-17.1 Notes:
None

Data Alerts :
None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM-17.2 Notes:
Data is not available at this time. The 2015 Puerto Rico Survey of Children with Special Health Care Needs, now in progress, will be used as a baseline.

Data Alerts :

1. Data has not been entered for NOM #17.2. This outcome measure is linked to the selected NPM 11,12,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.
NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

NOM-17.3 Notes:

Data Alerts:
None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

NOM-17.4 Notes:
None

Data Alerts:
None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

NOM-18 Notes:
PR does not participate in the National Survey of Children's Health. PR MCAH Program will incorporate this indicator as one of the state added questions in the PR BRFSS. This indicator will be reported later on using BRFSS data.

Data Alerts:

1. Data has not been entered for NOM #18. This outcome measure is linked to the selected NPM 10,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.

NOM-19 Percent of children in excellent or very good health

NOM-19 Notes:
PR does not participate in the National Survey of Children's Health. PR MCAH Program will incorporate this indicator as one of the state added questions in the PR BRFSS. This indicator will be reported later on using BRFSS data.

Data Alerts:

1. Data has not been entered for NOM #19. This outcome measure is linked to the selected NPM 8,10,13,11,12,. Please add a field level note to explain when and how data will be available for tracking this outcome measure.
NOM-20  Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Indicator</td>
<td>24.1</td>
</tr>
<tr>
<td>Numerator</td>
<td>465</td>
</tr>
<tr>
<td>Denominator</td>
<td>1,928</td>
</tr>
<tr>
<td>Data Source</td>
<td>2013</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>PR YRBSS</td>
</tr>
</tbody>
</table>

**NOM-20 Notes:**
Numerator and Denominator: Provided by PR YRBSS 2013.
PR does not participate in the National Survey of Children’s Health. PR MCAH Program will incorporate this indicator as one of the state added questions in the PR BRFSS. This indicator will be reported later on using BRFSS data.

**Data Alerts:**
None

**NOM-21  Percent of children without health insurance**

**NOM-21 Notes:**
None

**Data Alerts:**
None
NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Indicator</td>
<td>43.5</td>
</tr>
<tr>
<td>Numerator</td>
<td>23,943</td>
</tr>
<tr>
<td>Denominator</td>
<td>55,000</td>
</tr>
<tr>
<td>Data Source</td>
<td>PRIR</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-22.1 Notes:
Numerator and Denominator: Provided by PR Immunization Registry (PRIR).

As of July 2014 PR was incorporated at NIS. This indicator will be reported later on using NIS data.

Data Alerts:
None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Indicator</td>
<td>9.2</td>
</tr>
<tr>
<td>Numerator</td>
<td>80,523</td>
</tr>
<tr>
<td>Denominator</td>
<td>879,411</td>
</tr>
<tr>
<td>Data Source</td>
<td>PRIR</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-22.2 Notes:
Numerator and Denominator: Provided by PR Immunization Registry (PRIR).

As of July 2014 PR was incorporated at NIS. This indicator will be reported later on using NIS data.

Data Alerts:
None
NOM-22.3  Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Indicator</td>
<td>52.4</td>
</tr>
<tr>
<td>Numerator</td>
<td>154,263</td>
</tr>
<tr>
<td>Denominator</td>
<td>294,417</td>
</tr>
<tr>
<td>Data Source</td>
<td>PRIR</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-22.3 Notes:
Numerator and Denominator: Provided by PR Immunization Registry (PRIR).
As of July 2014 PR was incorporated at NIS. This indicator will be reported later on using NIS data.
Data Alerts:
None

NOM-22.4  Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Indicator</td>
<td>74.7</td>
</tr>
<tr>
<td>Numerator</td>
<td>219,938</td>
</tr>
<tr>
<td>Denominator</td>
<td>294,417</td>
</tr>
<tr>
<td>Data Source</td>
<td>PRIR</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

NOM-22.4 Notes:
Numerator and Denominator: Provided by PR Immunization Registry (PRIR).
As of July 2014 PR was incorporated at NIS. This indicator will be reported later on using NIS data.
Data Alerts:
None
NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

<table>
<thead>
<tr>
<th>State Provided Data</th>
<th>2014</th>
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<tbody>
<tr>
<td>Annual Indicator</td>
<td>70.3</td>
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<tr>
<td>Numerator</td>
<td>206,896</td>
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<tr>
<td>Denominator</td>
<td>294,417</td>
</tr>
<tr>
<td>Data Source</td>
<td>PRIR</td>
</tr>
<tr>
<td>Data Source Year</td>
<td>2014</td>
</tr>
</tbody>
</table>

**NOM-22.5 Notes:**
 Numerator and Denominator: Provided by PR Immunization Registry (PRIR).

As of July 2014 PR was incorporated at NIS. This indicator will be reported later on using NIS data.

**Data Alerts :**
None
### NPM 1-Percent of women with a past year preventive medical visit

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
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<td>75</td>
<td>75.4</td>
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<td>76.2</td>
</tr>
</tbody>
</table>

### NPM 3-Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>68.7</td>
<td>72.3</td>
<td>76.1</td>
<td>80</td>
<td>84.2</td>
</tr>
</tbody>
</table>

### NPM 4-A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

<table>
<thead>
<tr>
<th></th>
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<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>82.1</td>
<td>83.3</td>
<td>83.3</td>
<td>84.6</td>
<td>84.6</td>
</tr>
<tr>
<td>Annual Objective</td>
<td>19.7</td>
<td>21.2</td>
<td>22.8</td>
<td>24.3</td>
<td>25.9</td>
</tr>
</tbody>
</table>

### NPM 8-Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>28.2</td>
<td>28.3</td>
<td>28.5</td>
<td>28.6</td>
<td>28.8</td>
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</tbody>
</table>

### NPM 10-Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<thead>
<tr>
<th></th>
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<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>
### NPM 11-Percent of children with and without special health care needs having a medical home

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>24.7</td>
<td>24.7</td>
<td>25.5</td>
<td>26.3</td>
<td>27.2</td>
</tr>
</tbody>
</table>

### NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Objective</td>
<td>26</td>
<td>26</td>
<td>26.9</td>
<td>27.8</td>
<td>28.6</td>
</tr>
</tbody>
</table>

### NPM 13-A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
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<td>44.8</td>
<td>45.7</td>
<td>45.7</td>
</tr>
<tr>
<td>Annual Objective</td>
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<td>47.5</td>
<td>47.7</td>
<td>47.8</td>
<td>48.9</td>
</tr>
</tbody>
</table>
States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.
States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.
Form 10d
National Performance Measures (Reporting Year 2014 & 2015)
State: Puerto Rico

Form Notes for Form 10d:
None

NPM 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.

<table>
<thead>
<tr>
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<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
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<td>100.0</td>
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<td>100.0</td>
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<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
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<td>19</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
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<td>28</td>
<td>19</td>
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<td>PR Newborn Screening</td>
<td>PR Center for Inherited Diseases</td>
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</tr>
<tr>
<td>Provisional Or Final?</td>
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<td></td>
<td>Final</td>
<td></td>
</tr>
</tbody>
</table>

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   **Field Note:**
   Data for reporting year January 1, 2013-December 31, 2013 as data for the July-December 2014 was not available.

2. **Field Name:** 2013
   **Field Note:**
   FY 2012-2013 data provided by the PR Center for Inherited Diseases. Conditions mandated by Law 84, 1987: Hypothyroidism, PKU and Hemoglobinopathies.

3. **Field Name:** 2012
   **Field Note:**
   FY 2011-2012 data provided by the PR Hereditary Disease and Newborn Screening Program.

4. **Field Name:** 2011
   **Field Note:**
   FY 2010-2011 data provided by the PR Hereditary Diseases and Newborn Screening Program.

   The annual performance objectives for 2012-2016 were revised.

Data Alerts:
None
### NPM 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)

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
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<td><strong>Annual Indicator</strong></td>
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<td>37.4</td>
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<td><strong>Numerator</strong></td>
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<td>63,011</td>
<td>63,011</td>
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</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>168,665</td>
<td>168,665</td>
<td>168,665</td>
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<tr>
<td><strong>Data Source</strong></td>
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<td>PR Survey of CSHCN</td>
<td>PR Survey of CSHCN</td>
<td>PR Survey of CSHCN</td>
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<td><strong>Provisional Or Final ?</strong></td>
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</table>

### Field Level Notes for Form 10d NPMs:

1. **Field Name**: 2014  
   **Field Note**:
   
   2009 data is being reported as the 2015 PR Survey of CSHCN is currently in progress.

2. **Field Name**: 2013  
   **Field Note**:
   
   Data from the first PR Survey of CSHCN conducted by the PR Department of Health in 2009. The second PR-CSHCN study is currently in progress to provide updated data to this performance measure.

3. **Field Name**: 2012  
   **Field Note**:
   
   See notes for 2010.

4. **Field Name**: 2011  
   **Field Note**:
   
   See notes for 2010.

### Data Alerts:

None
NPM 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)

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
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<td>23.0</td>
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<td>23.5</td>
</tr>
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<td>29,640</td>
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<td><strong>Data Source</strong></td>
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<td>PR Survey of CSHCN</td>
<td>PR Survey of CSHCN</td>
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<td><strong>Provisional Or Final ?</strong></td>
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</table>

Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   
   **Field Note:**
   
   2009 data is being reported as the 2015 PR Survey of CSHCN is currently in progress.

2. **Field Name:** 2013
   
   **Field Note:**
   
   Data from the first PR Survey of CSHCN conducted by the PR Department of Health in 2009. The second PR-CSHCN study is currently in progress to provide updated data to this performance measure.

3. **Field Name:** 2012
   
   **Field Note:**
   
   See notes for 2010.

4. **Field Name:** 2011
   
   **Field Note:**
   
   See notes for 2010.

Data Alerts:

None
### NPM 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)

<table>
<thead>
<tr>
<th></th>
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<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
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<td>38.8</td>
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<td>37.7</td>
<td>38.6</td>
<td>38.8</td>
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<tr>
<td>Denominator</td>
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<td>109,335</td>
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<td>Data Source</td>
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<td>Provisional Or Final?</td>
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#### Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014  
   **Field Note:**  
   2009 data is being reported as the 2015 PR Survey of CSHCN is currently in progress.

2. **Field Name:** 2013  
   **Field Note:**  
   Data from the first PR Survey of CSHCN conducted by the PR Department of Health in 2009. The second PR-CSHCN study is currently in progress to provide updated data to this performance measure.

3. **Field Name:** 2012  
   **Field Note:**  
   See notes for 2010.

4. **Field Name:** 2011  
   **Field Note:**  
   See notes for 2010.

#### Data Alerts:

None
### NPM 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)

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Objective</strong></td>
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<td>83.4</td>
<td>84.2</td>
<td>85.0</td>
<td>85.8</td>
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<tr>
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<td><strong>Numerator</strong></td>
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<tr>
<td><strong>Denominator</strong></td>
<td>174,345</td>
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<td>174,345</td>
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<td><strong>Data Source</strong></td>
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#### Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   - **Field Note:**
     - 2009 data is being reported as the 2015 PR Survey of CSHCN is currently in progress.

2. **Field Name:** 2013
   - **Field Note:**
     - Data from the first PR Survey of CSHCN conducted by the PR Department of Health in 2009. The second PR-CSHCN study is currently in progress to provide updated data to this performance measure.

3. **Field Name:** 2012
   - **Field Note:**
     - See notes for 2010.

4. **Field Name:** 2011
   - **Field Note:**
     - See notes for 2010.

#### Data Alerts:

None
NPM 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.

<table>
<thead>
<tr>
<th></th>
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<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
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<td>25.1</td>
<td>25.3</td>
<td>25.7</td>
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<tr>
<td>Denominator</td>
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<td>66,144</td>
<td>66,144</td>
<td>66,144</td>
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<td>Data Source</td>
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<td>PR Survey of CSHCN</td>
<td>PR Survey of CSHCN</td>
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<td>Provisional Or Final ?</td>
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Field Level Notes for Form 10d NPMs:

1. **Field Name**: 2014
   
   **Field Note**:
   
   2009 data is being reported as the 2015 PR Survey of CSHCN is currently in progress.

2. **Field Name**: 2013
   
   **Field Note**:
   
   Data from the first PR Survey of CSHCN conducted by the PR Department of Health in 2009. The second PR-CSHCN study is currently in progress to provide updated data to this performance measure.

3. **Field Name**: 2012
   
   **Field Note**:
   
   See notes for 2010.

4. **Field Name**: 2011
   
   **Field Note**:
   
   See notes for 2010.

**Data Alerts:**

None
NPM 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.

<table>
<thead>
<tr>
<th></th>
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<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
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<tr>
<td>Annual Indicator</td>
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<td>90.0</td>
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<td>Numerator</td>
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<td>314</td>
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<tr>
<td>Denominator</td>
<td>305</td>
<td>349</td>
<td>335</td>
<td>1,368</td>
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<td>PR Immunization Program</td>
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<td>Provisional Or Final?</td>
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<td></td>
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</tbody>
</table>

Field Level Notes for Form 10d NPMs:

1. **Field Name**: 2014  
   **Field Note**:  
   Data from the Immunization Coverage Evaluation provided by the Immunization Program of the PR Department of Health corresponding to 2014.

2. **Field Name**: 2013  
   **Field Note**:  
   Data from the Immunization Coverage Evaluation provided by the Immunization Program of the PR Department of Health corresponding to 2013.  
   The annual performance objectives for 2014-2018 were revised.

3. **Field Name**: 2012  
   **Field Note**:  
   Data from the Immunization Coverage Evaluation provided by the Immunization Program of the PR Department of Health corresponding to 2012. Evaluation conducted August 2012 following 2011 methodology.  
   The annual performance objectives for 2013-2017 were revised.

4. **Field Name**: 2011  
   **Field Note**:  
   Data from the Immunization Program August 2011 coverage study. The methodology is different from previous reported year.

**Data Alerts:**

None
NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

<table>
<thead>
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<td>24.3</td>
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<tr>
<td>Denominator</td>
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<td>75,593</td>
<td>74,495</td>
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Field Level Notes for Form 10d NPMs:

1. Field Name: 2014
   Field Note:
   Numerator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.
   Denominator: US Census Bureau, 2014 International Database.

2. Field Name: 2013
   Field Note:
   Numerator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.

3. Field Name: 2012
   Field Note:
   Updated data for 2010 and 2011.
   Numerator: Provided by the Office of Informatics and Technology Advances (OITA) of the Puerto Rico Department of Health.
   Denominator: Population Estimates provide by the US Census.
   Average Annual Percent Change (AAPC) between 2000 and 2011 was calculated to estimate 2012 data, Vital Statistics (VS) data was not available for this year, see Appendix 5.
   The annual performance objectives for 2013-2017 were revised.

4. Field Name: 2011
   Field Note:
   Updated data for 2009 and 2010.
   Numerator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.
   Denominator: Population Estimates provide by the US Census.
   Average Annual Percent Change (AAPC) between 2000 and 2010 was calculated to estimate 2011 data, Vital Statistics (VS) data was not available for this year, see Appendix 5.

Data Alerts:
None
NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

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<td>89,485</td>
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Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014

   **Field Note:**
   Numerator: Data regarding the grade in which children are enrolled is not available in the billing forms. The reported number is an estimation based on the information provided the Insurance Commissioner (ICO) that reflects the number of 8 to 9 year old children who received protective sealants on at least one permanent molar tooth during the last year.
   Denominator: Estimated Population of children 8 and 9 years old in PR according to the US Census.

2. **Field Name:** 2013

   **Field Note:**
   Numerator: Data regarding the grade in which children are enrolled is not available in the billing forms. The reported number is an estimation based on the information provided the Insurance Commissioner (ICO) that reflects the number of 8 to 9 year old children who received protective sealants on at least one permanent molar tooth during the last year (2012).
   Denominator: Estimated Population of children 8 and 9 years old in PR according to the US Census.

   The annual performance objectives for 2014-2018 were revised.

3. **Field Name:** 2012

   **Field Note:**
   Numerator: Data regarding the grade in which children are enrolled is not available in the billing forms. The reported number is an estimation based on the information provided the Health Insurance Commissioner (HICO) that reflects the number of 8 to 9 year old children who received protective sealants on at least one permanent molar tooth during the last year (2012).
   Denominator: Estimated Population of children 8 and 9 years old in PR according to the US Census.

   The annual performance objectives for 2013-2017 were revised.

4. **Field Name:** 2011

   **Field Note:**
   Numerator: Data regarding the grade in which children are enrolled is not available in the billing forms. The reported number is an estimation based on the information provided by the Health Insurance Commissioner (HICO) that reflects the number of 8 to 9 year old children who received protective sealants on at least one permanent molar tooth during the last year (2011).

   The annual performance objectives for 2012-2016 were revised.

   Denominator: Estimated Population of children 8 and 9 years old in PR according to the US Census.

Data Alerts:
NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

<table>
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<tr>
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<td>0.7</td>
<td>2.1</td>
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<tr>
<td>Numerator</td>
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Field Level Notes for Form 10d NPMs:

1. **Field Name**: 2014  
   **Field Note**:  
   Numerator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.  
   Denominator: US Census Bureau, 2014 International Database.

2. **Field Name**: 2013  
   **Field Note**:  
   Numerator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.  

3. **Field Name**: 2012  
   **Field Note**:  
   Updated data for 2010 and 2011.  
   Numerator: Provided by the Office of Informatics and Technology Advances (OITA) of the Puerto Rico Department of Health.  
   Denominator: Population Estimates provide by the US Census.  
   Average Annual Percent Change (AAPC) between 2000 and 2011 was calculated to estimate 2012 data, Vital Statistics (VS) data was not available for this year, see Appendix 5.  
   The annual performance objectives for 2013-2017 were revised.

4. **Field Name**: 2011  
   **Field Note**:  
   Updated data for 2009 and 2010.  
   Numerator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.  
   Denominator: Population Estimates provided by the US Census.  
   Average Annual Percent Change (AAPC) between 2000 and 2010 was calculated to estimate 2011 data, Vital Statistics (VS) data was not available for this year, see Appendix 5.  
   The annual performance objectives for 2012-2016 were revised and adjusted.

**Data Alerts:** None
**NPM 11 - The percent of mothers who breastfeed their infants at 6 months of age.**

<table>
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<td><strong>Numerator</strong></td>
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<td><strong>Denominator</strong></td>
<td>982</td>
<td>956</td>
<td>956</td>
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**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2014
   **Field Note:**
   Data provided by the 2012 ESMIPR (PRAMS like survey) from the MCH Program of the PR Department of Health.

2. **Field Name:** 2013
   **Field Note:**
   Data provided by the 2012 ESMIPR (PRAMS like survey) from the MCH Program of the PR Department of Health.
   The annual performance objectives for 2014-2018 were revised.

3. **Field Name:** 2012
   **Field Note:**
   Data provided by the 2012 ESMIPR (PRAMS like survey) form the MCH Program, of the Puerto Rico Department of Health.
   The annual performance objectives for 2013-2017 were revised.

4. **Field Name:** 2011
   **Field Note:**
   Data provided by the 2010 ESMIPR (PRAMS like survey) form the MCH Program, of the PR Department of Health.

**Data Alerts:**

None
### NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

<table>
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**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2014
   
   **Field Note:**
   Data for reporting year January 1, 2013-December 31, 2013 as data for the January-December 2014 was not available. The numerator is the number of newborns screened at the 37 birthing hospitals in PR, while the denominator is the number of live births reported by the PR Vital Statistics Office.

2. **Field Name:** 2013
   
   **Field Note:**
   Data for 2013 were provided by the Universal Newborn Hearing Screening Program from the PR Department of Health. Denominator was obtained from the number of births reported by 37 birthing hospitals in PR.

3. **Field Name:** 2012
   
   **Field Note:**
   Data for 2012 were provided by the Hearing Screening Program from the PR Department of Health.

4. **Field Name:** 2011
   
   **Field Note:**
   Data for 2011 were provided by the Hearing Screening Program form the PR Department of Health.

**Data Alerts:**

None
NPM 13 - Percent of children without health insurance.

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<td>14.3</td>
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<tr>
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Field Level Notes for Form 10d NPMs:

1. **Field Name**: 2014
   
   **Field Note**:
   
   Numerator: PR Health Insurance Administration (PRHIA) and the Insurance Commissioner (ICO).
   Denominator: US Census Bureau, 2014 International Database.
   
   Calculation: PRHIA and ICO provide data of insured children in PR for current year. Considering the population estimates by the US Census and the insured children, uninsured children are estimated.

2. **Field Name**: 2013
   
   **Field Note**:
   
   Numerator: PR Health Insurance Administration (PRHIA) and the Insurance Commissioner (ICO).
   Denominator: US Census Bureau, 2013 International Database.
   
   Calculation: PRHIA and ICO provide data of insured children in PR for current year. Considering the population estimates by the US Census and the insured children, uninsured children are estimated.

The annual performance objectives for 2014-2018 were revised.

3. **Field Name**: 2012
   
   **Field Note**:
   
   Numerator: Health Insurance Administration (ASES) and the Health Insurance Commissioner (HICO).
   Denominator: US Census Bureau, 2012 International Database.
   
   Calculation: ASES and HICO provide data of insured children in PR for current year. Considering the population estimates by the US Census and the insured children, uninsured children are estimated.

The annual performance objectives for 2013-2017 were revised.

4. **Field Name**: 2011
   
   **Field Note**:
   
   Numerator: Health Insurance Administration (ASES) and the Health Insurance Commissioner (HICO).
   
   Calculation: ASES and HICO provide data of insured children in PR for current year. Considering the population estimates by the US Census and the insured children, uninsured children are estimated.

Data Alerts:
NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

<table>
<thead>
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<tbody>
<tr>
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Field Level Notes for Form 10d NPMs:

1. Field Name: 2014
   Field Note:
   Data for 2014 calculated based on data provided by the WIC Program of the PR Department of Health for the period of July 2013 to June 2014.

2. Field Name: 2013
   Field Note:
   Data for 2013 calculated based on data provided by the WIC Program of the PR Department of Health for the period of July 2012 to June 2013.

   The annual performance objectives for 2014-2018 were revised.

3. Field Name: 2012
   Field Note:
   Data for 2012 calculated based on data provided by the WIC Program of the PR Department of Health for the period of January to December 2011.

   The annual performance objectives for 2013-2017 were revised.

4. Field Name: 2011
   Field Note:
   Data for 2011 calculated based on data provided by the PR WIC Program of the PR Department of Health for the period of January to December 2010.

   The annual performance objectives for 2012-2016 were revised.

Data Alerts:

None
### NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

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<td>0.5</td>
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**Field Level Notes for Form 10d NPMs:**

1. **Field Name:** 2014  
   **Field Note:**  
   Data provided by the 2012 ESMIPR (PRAMS like survey) from the MCH Program of the PR Department of Health.

2. **Field Name:** 2013  
   **Field Note:**  
   Data provided by the 2012 ESMIPR (PRAMS like survey) from the MCH Program of the PR Department of Health.
   
   The annual performance objectives for 2014-2018 were revised.

3. **Field Name:** 2012  
   **Field Note:**  
   Data provided by the 2012 ESMIPR (PRAMS like survey) from the MCH Program of the PR Department of Health.
   
   The annual performance objectives for 2013-2017 were revised.

4. **Field Name:** 2011  
   **Field Note:**  
   Data for 2009 was updated.
   
   Data provided by the 2010 ESMIPR (PRAMS like survey) from the MCH Program of the PR Department of Health.

**Data Alerts:**

None
NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

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<tr>
<td>Denominator</td>
<td>276,565</td>
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Data Source
- Death Certificate OITA

Provisional Or Final ? Final

Field Level Notes for Form 10d NPMs:

1. Field Name: 2014
   Field Note:
   Numerator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.
   Denominator: US Census Bureau, 2014 International Database.

2. Field Name: 2013
   Field Note:
   Numerator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.

3. Field Name: 2012
   Field Note:
   Updated data for 2010 and 2011.
   Numerator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.
   Denominator: Population Estimates provide by the US Census.
   Average Annual Percent Change (AAPC) between 2000 and 2011 was calculated to estimate 2012 data, Vital Statistics (VS) data was not available for this year, see Appendix 5.
   The annual performance objectives for 2013-2017 were revised.

4. Field Name: 2011
   Field Note:
   Updated data for 2009 and 2010.
   Numerator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.
   Denominator: Population Estimates provide by the US Census.
   Average Annual Percent Change (AAPC) between 2000 and 2010 was calculated to estimate 2011 data, Vital Statistics (VS) data was not available for this year, see Appendix 5.
   The annual performance objectives for 2012-2016 were revised.

Data Alerts:
None
NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

<table>
<thead>
<tr>
<th></th>
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<th>2014</th>
<th>2015</th>
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Field Level Notes for Form 10d NPMs:

1. **Field Name:** 2014
   - **Field Note:**
     Classification according to Perinatal Care Guidelines Review Committee, 2011.
   - Numerator and Denominator: Data provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health (Missing data not included).

2. **Field Name:** 2013
   - **Field Note:**
     Classification according to Perinatal Care Guidelines Review Committee, 2011.
   - Numerator and Denominator: Data provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health (Missing data not included).

3. **Field Name:** 2012
   - **Field Note:**
     Updated data for 2010 and 2011. Classification according to Perinatal Care Guidelines Review Committee, 2011.
   - Numerator and Denominator: Data provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health (Missing data not included).
   - The annual performance objectives for 2013-2017 were revised.

4. **Field Name:** 2011
   - **Field Note:**
   - Numerator and Denominator: Data provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.
     - Average Annual Percent Change (AAPC) between 2000 and 2010 was calculated to estimate 2011 data, Vital Statistics (VS) data was not available for this year, see Appendix 5.
     - Unknown data of birthweight is excluded.

**Data Alerts:**
None
### NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

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<td><strong>Annual Indicator</strong></td>
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<td>80.8</td>
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<tr>
<td><strong>Numerator</strong></td>
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<td>31,361</td>
<td>29,868</td>
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<td><strong>Denominator</strong></td>
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**Field Level Notes for Form 10d NPMs:**

1. **Field Name :** 2014  
   **Field Note :**  
   Numerator and Denominator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health (Missing data not included).

2. **Field Name :** 2013  
   **Field Note :**  
   Numerator and Denominator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health (Missing data not included).

3. **Field Name :** 2012  
   **Field Note :**  
   Updated data for 2010 and 2011.  
   Numerator and Denominator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health (Missing data not included).  
   The annual performance objectives for 2013-2017 were revised.

4. **Field Name :** 2011  
   **Field Note :**  
   Updated data for 2009 and 2010.  
   Numerator and Denominator: Provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.  
   Average Annual Percent Change (AAPC) between 2000 and 2010 was calculated to estimate 2011 data, Vital Statistics (VS) data was not available for this year, see Appendix 5.  
   The annual performance objectives for 2012-2016 were revised.  
   Unknown/missing values for prenatal care were excluded from analysis.  
   Unknown data of prenatal care is excluded.

**Data Alerts:**

None
**Form 10d**  
State Performance Measures (Reporting Year 2014 & 2015)  
State: Puerto Rico

### SPM 1 - The proportion of women of childbearing age consuming folic acid

<table>
<thead>
<tr>
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</tbody>
</table>

### Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2014  
   **Field Note:**  
   For year 2014, data was provided by the 2012 ESMIPR (PRAMS like survey) from the MCH Program of the PR Department of Health.

2. **Field Name:** 2013  
   **Field Note:**  
   For year 2013, data was provided by the 2012 ESMIPR (PRAMS like survey) from the MCH Program of the PR Department of Health.

3. **Field Name:** 2012  
   **Field Note:**  
   For year 2012, data was provided by the 2012 ESMIPR (PRAMS like survey) from the MCH Program of the PR Department of Health. The annual performance objectives were revised taking in consideration data for 2012.

4. **Field Name:** 2011  
   **Field Note:**  
   For year 2011, data was provided by the 2010 ESMIPR (PRAMS like survey) from the MCH Program of the PR Department of Health. The annual performance objectives were revised taking in consideration data for 2011. The annual performance objectives for 2012-2016 were revised.

### Data Alerts:

None
### SPM 2 - The prevalence at birth of neural tube defects (NTD's)

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</table>

#### Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2014  
   **Field Note:**  
   The numerator is the number of neural tube defects at birth identified by the BDSPS and the denominator is the number of live births reported by the PR Vital Statistics Office.

2. **Field Name:** 2013  
   **Field Note:**  
   The source of the numerator is the BDSS, and the source of the denominator is the Vital Statistics Birth Certificates. The annual performance objectives were revised taking in consideration the updated 2013 NTD prevalence at birth.

3. **Field Name:** 2012  
   **Field Note:**  
   The source of the numerator is the BDSS, and the source of the denominator is the Vital Statistics Birth Certificates. The annual performance objectives were revised taking in consideration the updated 2011 NTD prevalence at birth.

4. **Field Name:** 2011  
   **Field Note:**  
   The source of the numerator is the BDSS, and the source of the denominator is the Vital Statistics Birth Certificates. The annual performance objectives were revised taking in consideration the updated 2010 NTD prevalence at birth.

   The annual performance objectives for 2012-2016 were revised.

#### Data Alerts:

None
SPM 3 - The degree to which the Puerto Rico Maternal, Child and Adolescent Program collect, analyze, and disseminates findings from data pertinent to ongoing target population health needs assessment.

<table>
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Field Level Notes for Form 10d SPMs:

1. **Field Name**: 2014
   
   **Field Note**:
   Checklist for State Performance Measure #3: Seven Indicators Documenting Data Collection, Analysis and Dissemination for Ongoing Needs Assessment, PR MCH Program (see Table IV-1 Checklist for SPM 3 FY 2014). The annual indicator considered seven (7) research activities, but during 2013 PRMCH determined to eliminate the Biennial Maternal and Child Health Research after consider expenses and budget impact. For that reason, the denominator in the formula to determine the annual indicator was amended in order to evaluate only six (6) research activities.

2. **Field Name**: 2013
   
   **Field Note**:
   Checklist for State Performance Measure #3: Seven Indicators Documenting Data Collection, Analysis and Dissemination for Ongoing Needs Assessment, PR MCH Program (see Table IV-1 Checklist for SPM 3 FY 2013). The annual indicator considered seven (7) research activities, but during 2013 PRMCH determined to eliminate the Biennial Maternal and Child Health Research after consider expenses and budget impact. For that reason, the denominator in the formula to determine the annual indicator was amended in order to evaluate only six (6) research activities.

   The annual performance objectives for 2014-2018 were revised.

3. **Field Name**: 2012
   
   **Field Note**:
   Checklist for State Performance Measure #3: Seven Indicators Documenting Data Collection, Analysis and Dissemination for Ongoing Needs Assessment, PR MCH Program (see Table IV-1 Checklist for SPM 3 FY 2013).

   The annual performance objectives for 2013-2017 were revised.

4. **Field Name**: 2011
   
   **Field Note**:
   Checklist for State Performance Measure #3: Seven Indicators Documenting Data Collection, Analysis and Dissemination for Ongoing Needs Assessment, PR MCH Program (see Table IV-1 Checklist for SPM 03 FY 2012).

Data Alerts:

None
### SPM 4 - The percent of late preterm births (34-36 weeks of gestation).

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### Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2014  
   **Field Note:**  
   Numerator and Denominator: Data provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health (Missing data not included).

2. **Field Name:** 2013  
   **Field Note:**  
   Numerator and Denominator: Data provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health (Missing data not included).

3. **Field Name:** 2012  
   **Field Note:**  
   Updated data for 2010 and 2011.  
   Numerator and Denominator: Data provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health (Missing data not included).  
   The annual performance objectives for 2013-2017 were revised.

4. **Field Name:** 2011  
   **Field Note:**  
   Updated data for 2009 and 2010.  
   Numerator and Denominator: data provided by the Office of Informatics and Technology Advances (OITA) of the PR Department of Health.  
   Average Annual Percent Change (AAPC) between 2000 and 2010 was calculated to estimate 2011 data, Vital Statistics (VS) data was not available for this year, see Appendix 5.  
   The annual performance objectives for 2012-2016 were revised.  
   Unknown/missing values for gestational age were excluded from analysis.

### Data Alerts:

None
### SPM 5 - The rate per 100,000 of emergency room visits due to all unintentional injuries among children aged 1 to 14 years.

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<td>658,293</td>
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</tbody>
</table>

### Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2014  
   **Field Note:**  
The MCH Program requests the number of unduplicated cases of unintentional injuries (ICD-9: E800-E999) in emergency rooms to the Health Insurance Commissioner (HICO).

   Numerator: Number of children who visited ER due to unintentional injuries as reported by HICO.  
   Denominator: US Census Bureau, 2014 International Database.

2. **Field Name:** 2013  
   **Field Note:**  
The MCH Program requests the number of unduplicated cases of unintentional injuries (ICD-9: E800-E999) in emergency rooms to the Health Insurance Commissioner (HICO).

   Numerator: Number of children who visited ER due to unintentional injuries as reported by HICO.  
   Denominator: US Census Bureau, 2013 International Database.

   The annual performance objectives for 2013-2017 were revised.

3. **Field Name:** 2012  
   **Field Note:**  
The MCH Program requests the number of unduplicated cases of unintentional injuries (ICD-9: E800-E999) in emergency rooms to the Health Insurance Commissioner (HICO).

   Numerator: Number of children who visited ER due to unintentional injuries as reported by HICO.  

   The annual performance objectives for 2013-2017 were revised.

4. **Field Name:** 2011  
   **Field Note:**  
The MCH Program requests the number of unduplicated cases of unintentional injuries (ICD-9: E800-E999) in emergency rooms to the Health Insurance Commissioner (HICO).

   Numerator: Number of children who visited ER due to unintentional injuries as reported by HICO.  
Data Alerts:
None
### SPM 6 - The number of preschool children who present behavioral problems.

<table>
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### Field Level Notes for Form 10d SPMs:

1. **Field Name:** 2014  
   **Field Note:**  
   Numerator: Children enrolled in Head Start (School Year: 2014-2015) reported to have conduct problems or ADHD.  
   Denominator: Children enrolled in Head Start (School Year: 2014-2015) reported with any condition.

2. **Field Name:** 2013  
   **Field Note:**  
   Numerator: Children enrolled in Head Start (School Year: 2013-2014) reported to have conduct problems or ADHD.  
   Denominator: Children enrolled in Head Start (School Year: 2013-2014) reported with any condition.  
   The annual performance objectives for 2014-2018 were revised.

3. **Field Name:** 2012  
   **Field Note:**  
   Numerator: Children enrolled in Head Start (School Year: 2012-2013) reported to have conduct problems or ADHD.  
   Denominator: Children enrolled in Head Start (School Year: 2012-2013) reported with any condition.  
   The annual performance objectives for 2013-2017 were revised.

4. **Field Name:** 2011  
   **Field Note:**  
   Numerator: Children enrolled in Head Start (First Semester School Year: 2011-2012) reported to have conduct problems or ADHD.  
   Denominator: Children enrolled in Head Start (School Year: 2011-2012) reported with any condition.

### Data Alerts:

None
SPM 7 - The degree to which selected organizations incorporate the Positive Youth Development Model (PYDM) in the services provided to adolescents.

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Field Level Notes for Form 10d SPMs:

1. **Field Name**: 2014  
   **Field Note**: Checklist for State Performance Measure #7: Eight Characteristics Documenting Youth Development Model Implementation in Naranjito Adolescent Program (NAP), PR MCH Program (See Table IV-2 Checklist for SPM 07).

2. **Field Name**: 2013  
   **Field Note**: Checklist for State Performance Measure #7: Eight Characteristics Documenting Youth Development Model Implementation in Naranjito Adolescent Program (NAP), PR MCH Program (See Table IV-2 Checklist for SPM 07).

3. **Field Name**: 2012  
   **Field Note**: Checklist for State Performance Measure #7: Eight Characteristics Documenting Youth Development Model Implementation in Naranjito Adolescent Program (NAP), PR MCH Program (See Table IV-2 Checklist for SPM 07).

4. **Field Name**: 2011  
   **Field Note**: Checklist for State Performance Measure #7: Eight Characteristics documenting the Positive Youth Development Model (PYDM) implementation in Naranjito Adolescent Program (NAP), PR MCH Program (see Table IV-2 Checklist for SPM 07).

Data Alerts:

None
While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.
State Action Plan Table

State: Puerto Rico

Please click the link below to download a PDF of the State Action Plan Table.

[State Action Plan Table](#)