MATERNAL AND CHILD HEALTH SERVICES TITLE V BLOCK GRANT PROGRAM

GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT

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U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
Division of State and Community Health
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MATERNAL AND CHILD HEALTH SERVICES
TITLE V BLOCK GRANT TO STATES PROGRAM

APPLICATION/ANNUAL REPORT/GUIDANCE
FIFTH EDITION

As one of the largest Federal block grant programs, Title V is the key source of support for promoting and improving the health of all the Nation's mothers and children. When Congress passed the Social Security Act in 1935, it contained the initial key landmark legislation which established Title V. This legislation is the origin of the Federal Government's pledge of support to States and their efforts to extend and improve health and welfare services for mothers and children throughout the Nation. To date, the Title V Federal-State partnership continues to provide a dynamic program to improve the health of all mothers and children, including children with special health care needs.

Each year, all States are required to submit an Application and Annual Report for Federal funds for their Maternal and Child Health (MCH) Services Title V Block Grant to States Program to the Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA). All the information and instructions for the preparation and submission are contained in this Maternal and Child Health Services Title V Block Grant to States Program Guidance and Forms for the Title V Application and Annual Report (Guidance) document. The Guidance has undergone changes and revisions with each published edition. Over time, the previous editions of the Guidance represent the legislative changes and requirements passed by Congress. Each edition of the Guidance was developed in consultation with State Maternal and Child Health (MCH) Directors and Children with Special Health Care Needs (CSHCN) Directors. Further, each edition of the Guidance has served to provide the experience upon which changes are made and improvements in each subsequent edition. Following this tradition, this fifth edition involved a committee of State MCH and CSHCN Directors, public health scholars, along with parent representation, working with the Division of State and Community Health (DSCH) staff to create the new Guidance. As with previous editions, this fifth edition reflects several significant changes designed to both improve and facilitate the preparation and the submission of the Application and Annual Report by the 50 States and 9 Jurisdictions.

The major changes in this edition are revisions to PART TWO, Section II—NEEDS ASSESSMENT. The purpose of these revisions are: (1) To provide more complete information on the Background and Conceptual Framework for the Needs Assessment Process (Part A); (2) To clarify what State grantees are to include in the Five Year Needs Assessment Document (Part B); (3) To better explain the information to include in the Annual Needs Assessment Summary/Update, both in the year when the five year Needs Assessment is conducted and in interim years (Part C); and (4) To update Figure 2, the Needs Assessment diagram, to reflect all aspects of the Needs Assessment process. In addition, other minor changes and clarifications are included throughout the document to provide more complete information and enhance instructions.

This is the third edition of the Guidance issued since the Title V Block Grant Application and Annual Report became a Web-based application. For the six consecutive years (2003-2008) preceding this edition, States have submitted the application via a secure Web-based server as authorized by HRSA. The use of this online method for completing and submitting the Application and Annual Reports continues to be required of all States. This latest edition of the Guidance will continue to enhance the quality of submissions and the resultant availability of data output.

Any questions and comments regarding this edition of the Guidance may be addressed to:

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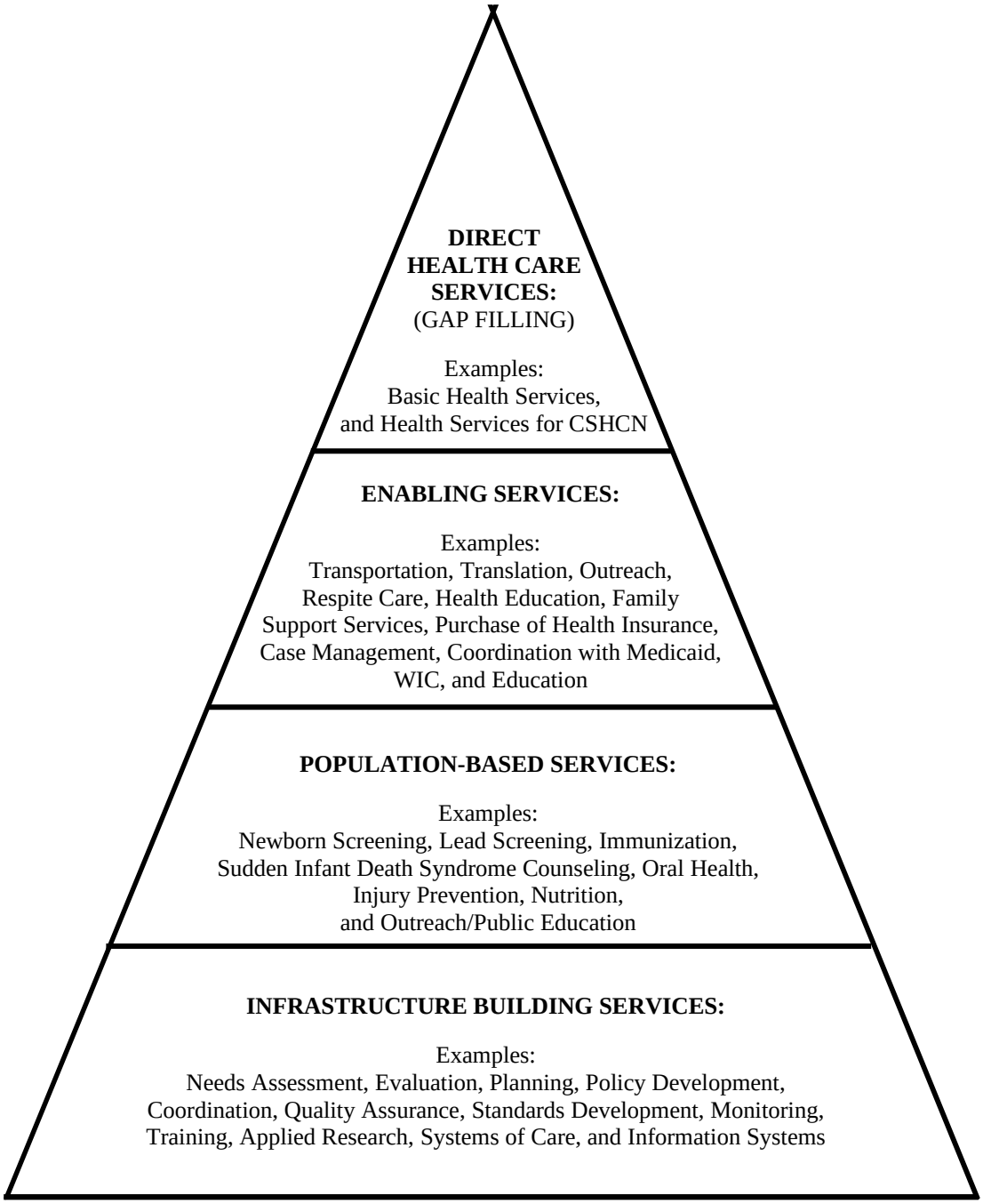
Figure 1

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/DSCH 10/20/97

THE MCH PYRAMID

The conceptual framework for the services of the Maternal and Child Health Title V Block Grant to States is envisioned as a pyramid, as depicted on the previous page, with four tiers of services and levels of funding that provide comprehensive services for mothers and children, including children with special health care needs in the Nation. This model displays the uniqueness of the MCH Title V Block Grant to States, which is the only Federal program that provides services at all levels. These services are direct health care services (gap filling), enabling services, population-based services, and infrastructure building. Since 1997, the MCH Pyramid has, over time, been the graphic representation of the MCH Title V Block Grant to States program.

TITLE V MATERNAL AND CHILD HEALTH
BLOCK GRANT TO STATES PROGRAM
APPLICATION AND ANNUAL REPORT GUIDANCE

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PART ONE

BACKGROUND AND ADMINISTRATIVE INFORMATION

I. HISTORY AND PURPOSE

A. The Maternal and Child Health Bureau

The Maternal and Child Health Bureau (MCHB) is the principal focus within Health Resources and Services Administration (HRSA) for all Maternal and Child Health (MCH) activities within the Department of Health and Human Services (DHHS). MCHB's mission is to provide national leadership through working in partnership with States, communities, public/private partners, and families, to strengthen the MCH infrastructure, and to build knowledge and human resources. Its mission also includes ensuring continued improvement in the health, safety, and well-being of the MCH population. To achieve its mission, MCHB directs resources towards a combination of direct health care services, enabling services, population-based services, and infrastructure or resource-building activities. Within MCHB the Division of State and Community Health (DSCH) has the administrative responsibility for the Title V Block Grant to States Program. DSCH is committed to being the Bureau's main line of communication with States and communities, in order to consult and work closely with both of these groups and others interested in providing a wide range of MCH programs and developing community-based service systems.

B. Maternal and Child Health Services Block Grant (Title V)

Since its original authorization in 1935, Title V of the Social Security Act has been amended several times to reflect the increasing national interest in maternal and child health and well-being. One of the first changes occurred when Title V converted to a block grant program as part of the Omnibus Budget Reconciliation Act (OBRA) of 1981. This change resulted in the consolidation of seven categorical programs into a single block grant. These programs included: Maternal and Child Health and services for Children with Special Health Care Needs (Title V of the Social Security Act); supplemental security income for children with disabilities (sec. 1651(c) of the Social Security Act); lead-based paint poisoning prevention programs (sec. 316 of the Public Health Service (PHS) Act); genetic disease programs (sec. 101 of the PHS Act); sudden infant death syndrome programs (sec. 1121 of the PHS Act); hemophilia treatment centers (sec. 1131 of the PHS Act); and adolescent pregnancy grants (Public Law PL 95-626).

Another significant change was contained in the Omnibus Budget Reconciliation Act (OBRA) of 1989 which specified new requirements for accountability. These amendments enacted under OBRA introduced stricter requirements for the use

of Federal funds and for State planning and reporting. Congress sought to balance the flexibility of the block grant with greater accountability, by requiring State Title V programs to report progress on key MCH indicators and other program information. Thus, the block grant legislation emphasizes accountability while providing States with appropriate flexibility to respond to MCH needs and to develop solutions. This theme of assisting States in the design and implementation of MCH programs to meet local needs, while at the same time asking them to account for the use of Federal/State funds, was embodied in the requirements contained in guidance documents for block grant applications and annual reports. In 1996, the MCHB began a process of programmatic assessments and planning activities aimed at improving those guidance documents.

In 1993 the Government Performance and Results Act (GPRA), Public Law 103-62, required Federal agencies to establish measurable goals that could be reported as part of the budgetary process. For the first time, funding decisions were linked directly with performance. Among its purposes, GPRA is intended to "...improve Federal program effectiveness and public accountability by promoting a new focus on results, service quality, and customer satisfaction." GPRA requires each Federal agency to develop comprehensive strategic plans, annual performance plans with measurable goals and objectives, and annual reports on actual performance compared to performance goals. The MCHB effort to respond to GPRA requirements coincided with other planned improvements to the block grant guidance. As a result, the block grant application annual report and forms contained in the 1997 edition of the *Maternal and Child Health Services Title V Block Grant Program - Guidance and Forms for the Title V Application/Annual Report* served two purposes: they ensured that the States and jurisdictions could clearly, concisely, and accurately tell their MCH "stories;" and, they became the basis by which MCHB met its GPRA Block Grant to States program reporting requirements.

Another significant milestone was the development in 1996 of an information system. The block grant application and annual report, submitted annually by all States, contains a wealth of information concerning various State MCH initiatives, State-supported programs, and other State-based responses designed to address their MCH needs. In order to better utilize the data contained in the application/annual report, MCHB developed an electronic information system, the Title V Information System (TVIS), designed to capture data contained in the application/annual report. The system designed initially to capture the qualitative programmatic information collected by the States, was modified according to MCHB's performance measurement model to collect quantitative data as well. This joint development of the Guidance and the database enabled the TVIS to become a powerful and useful tool for a number of audiences. The TVIS is available to the public on the World Wide Web at:

https://perfdata.hrsa.gov/mchb/mchreports/Search/search.asp.

As the chief financial foundation and the primary legislative authorization for the MCHB, Title V provides 80% of the funding sources for all Bureau programs. Under Title V, MCHB administers Formula Grants and competitive Discretionary Grants. The purpose of the Title V MCH Services Block Grant Program is to create Federal/State partnerships in all 50 States and 9 Jurisdictions to develop service systems to meet MCH challenges which include the following:

- Significantly reducing infant mortality;
- Providing comprehensive care for women before, during, and after pregnancy and childbirth;
- Providing preventive and primary care services for infants, children, and adolescents;
- Providing comprehensive care for children and adolescents with special health care needs;
- Immunizing all children;
- Reducing adolescent pregnancy;
- Preventing injury and violence;
- Putting into community practice national standards and guidelines for prenatal care, for healthy and safe child care, and for the health supervision of infants, children, and adolescents;
- Assuring access to care for all mothers and children; and
- Meeting the nutritional and developmental needs of mothers, children and families.

Under Title V, MCHB also administers two types of Federal Discretionary Grants, Community Integrated Service Systems (CISS) grants and Special Projects of Regional and National Significance (SPRANS). The CISS set-aside designates appropriations for programs to reduce infant mortality and improve the health of mothers, pregnant women, and children through the development and expansion of community integrated service systems. These systems are public-private partnerships of health-related and other relevant organizations and individuals collaborating to use community resources to address community-identified health problems.

The Community Integrated Service System (CISS) program seeks to improve the health of mothers and children through discretionary grant support for the development and expansion of community integrated service systems. These systems are public/private partnerships of health-related and other relevant organizations and individuals working collaboratively to use community resources to address the health of children in the context of their family in a comprehensive way. This program aims to support the health of children in all aspects of their physical, social, and emotional development.

A percentage of Title V funds are also set aside for a variety of SPRANS grants. SPRANS activities include:

- MCH research;
- MCH training;
- Genetic disease testing, counseling, and information dissemination;
- Hemophilia diagnostic and treatment centers; and
- MCH improvement projects that support a broad range of innovative strategies.

MCHB also administers the following categorical programs:

- Emergency Medical Services for Children;
- Traumatic Brain Injury;
- Healthy Start Initiative;
- Universal Newborn Hearing Screening; and
- Autism.

Throughout its illustrious 74 year history, the Maternal and Child Health Services Block Grant Program has sought to fulfill its intent of improving the health of all mothers and children consistent with the applicable health status goals and national health objectives. This brief history has provided a few highlights of that legacy under Title V.

II. LEGISLATIVE REQUIREMENTS

A. Who Can Apply for Funds [Section 505(a)]

The application and annual report shall be developed by, or in consultation with, the State maternal and child health agency and shall be made public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during its development and after its transmittal.

B. Use of Allotment Funds [Section 504]

The State may use funds paid to it for the provision of health services and related activities (including planning, administration, education, and evaluation) consistent with its application. It may also purchase technical assistance if the assistance is required in implementing programs funded by Title V. Related to technical assistance, the State should plan for and allot funds for two meetings each year for the MCH and Children with Special Health Care Needs (CSHCN) Directors. One of these meetings is the required Block Grant Application/Annual Report review that will be held at a site designated annually by DSCH. The second is the Partnership Meeting held each year in Washington, D.C., to update State MCH and CSHCN Directors on current legislation, implementation of recent legislation, and MCHB initiatives.

Funds may not be used for cash payments to intended recipients of health services or for purchase of land, buildings, or major medical equipment. Other restrictions apply.

C. Application for Block Grant Funds [Section 505]

Each State is required to conduct a statewide needs assessment every 5 years. The result of that needs assessment and any updates are submitted in the interim years in the annual application. The application will contain information (consistent with the health status goals and national health objectives) regarding the need for:

- preventive and primary care services for pregnant women, mothers, and infants up to age one;
- preventive and primary care services for children;
- services for CSHCN [as specified in section 501(a)(1)(D) "family-centered, community-based, coordinated care (including care coordination services) for children with special health care needs (CSHCN) and to facilitate the development of community-based systems of services for such children and their families"];

and includes for each fiscal year:

- a plan for meeting the needs identified by the statewide assessment; and
- a description of how the funds allotted to the State will be used for the provision and coordination of services to carry out the MCH program.

At least thirty percent (30%) of Federal Title V funds must be used for preventive and primary care services for children and at least thirty percent (30%) for services for CSHCN as specified in Section 501 (a)(1)(D). Such services include providing and promoting family-centered, community-based, coordinated care (including care coordination services) for CSHCN and facilitating the development of community-based systems of services for such children and their families. The thirty percent (30%) requirement may be waived as specified in Section 505(b)(1-2). A request for waiver must be included in the application transmittal letter. In addition, of the amount paid to a State under Section 503 from an allotment for a fiscal year under Section 502(c), not more than ten percent (10%) may be used for administering the funds paid under this section.

The State must maintain the level of funds being provided solely by such State for MCH programs at the level provided in fiscal year 1989. [Section 505(a)(4)].

Other requirements for allocating funds, charging for services, a toll-free hotline, and coordination of services with other programs are found in Section 505.

D. Annual Report [Section 506]

An Annual Report must be submitted to the MCHB each year in order to evaluate and compare the performance of different States assisted under this title and to assure the proper expenditure of funds. The Annual Report will include a description of program activities, a complete record of the purposes for which funds were spent, the extent to which the State has met the goals and objectives it set forth, as well as the national health objectives, and the extent to which funds were expended consistent with the State's application. The standardized format of the Annual Report allows for consistency in reporting and facilitates the preparation of the report to congress, as required in [Section 506(a)(3)].

As required in Section 509(a)(5), the MCHB has made a substantial effort not to duplicate other Federal data collection efforts. In partnership with the States, only MCH data necessary to fulfill the requirements of Title V which are not available at the national level or may be more timely from the State or required for tracking performance measures, are requested as part of the Annual Report. Data are not available from the National Center for Health Statistics (NCHS) or other Federal sources for the Marshall Islands, Federated States of Micronesia, Republic of Palau, Commonwealth of the Northern Mariana Islands, and American Samoa. These jurisdictions must report their own vital statistics and health data using general instructions from the NCHS.

All elements that comprise the Annual Report are located in **PART TWO (Sections I, III, IV, V, VI)** as described below**.** To assure that this document contains all of the statutorily required elements for an Annual Report, it is critical that the elements appear in the exact prescribed format as specified below:

SECTION I - <u>GENERAL REQUIREMENTS</u>

A Transmittal letter
B Face Sheet
C Assurances and Certifications
D Table of Contents
E Public Input

SECTION III - <u>STATE OVERVIEW</u>

A Overview of the State
B Agency Capacity
C Organizational Structure
D Other (MCH) Capacity
E State Agency Coordination
F Health Systems Capacity Indicators

Additional elements ***only*** for the Annual Report include:

SECTION IV – PRIORITIES, PERFORMANCE, AND PROGRAM ACTIVITIES
Narrative description of activities in **C 1a – 18a** for each of the National Performance Measures and **D 1a – 7a** to **10a** for each State Performance Measure.

SECTION V – BUDGET NARRATIVE
Narrative discussion of budget expenditures is located in **Section V A**.

SECTION VI – REPORTING FORMS

- Annual number of individuals served under this title (by class of individuals) as reported on Forms 6, 7, 8, 9, and the State Summary Profile as reported on Form 10;

- Progress made on the National and State Performance Measures from the previous reporting year as reported on the appropriate fiscal year annual performance indicators row on Form 11 – Tracking Performance Measures for each of the National and State Performance Measures; and

- Annual Expenditures as reported on Form 3 – State MCH Funding Profile; and the appropriate expended columns on Form 4 – Budget Details by Types of Individuals Served; and Form 5, State Title V Programs Budget and Expenditures by Types of Service, organized hierarchically from direct health care services through infrastructure building.

E. Administration of Federal and State Programs [Section 509]

MCHB in HRSA is the organizational unit responsible for the administration of Title V. Within the Bureau, DSCH has responsibility for the day-to-day operation of the MCH Title V Block Grant to States Program. Applicants may obtain additional information regarding administrative, technical and program issues concerning the Block Grant application by contacting:

Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 18-31
Rockville, Maryland 20857
Telephone: (301) 443-2204
Fax: (301) 443-9354

Within each State and Jurisdiction, the State Health Agency is responsible for the administration (or supervision of the administration) of programs carried out with Title V allotments.

III. BLOCK GRANT APPLICATION AND ANNUAL REPORT PREPARATION AND SUBMISSION

A. Deadline for Application and Annual Report

The application is due by close of business on July 15 of each year unless States are otherwise notified.

B. Electronic Submission

The Title V Application/Annual Report is completed electronically, using a computer that is connected to the Internet. The annual application that is available to the States via the Web includes a copy of this Guidance, a copy of the Title V law, narrative outlines with required tables, forms, and diagrams. It also includes tools to assist the States in assessing the completeness of their applications as they are being prepared and alerts to help reduce data entry errors and to help ensure data validity.

States identify those individuals that will have access to the electronic applications. These users access the system through use of a user name and password. This identification system allows access to the Web-based application and serves as an authentication of the Block Grant Applicant. States and Jurisdictions will receive detailed information from MCHB about these registration, log-on and submission procedures prior to the opening of the system for access. When technical assistance is needed with the preparation and submission of the Application/Annual Report, the HRSA Call Center is available. The Call Center can be contacted at 1-877-Go4-HRSA (877-464-4772) or at CallCenter@hrsa.gov.

C. General Information on Preparation and Submission

- The Application/Annual Report format for the Block Grant described in this document enables data on each State's needs, priorities, program activities, and performance and outcomes measures to be compiled and compared with information from other States. The Title V Information System (TVIS) has been developed to capture information from States' Block Grant Applications/Annual Reports. This relational database system is open to the public and allows easier and more accurate access to information such as State performance measures, budget figures, etc. It is important, therefore, that States be as accurate as possible with their data and follow carefully the organization and formatting instructions in the online system.

- States complete electronic versions of the forms in this guidance in the Web-based Title V Application.

- A Glossary of Terms is presented in Part Two, Section VIII. Definitions for most of the significant words, terms, and phrases used on the various forms in the Application/Annual Report may be found there. Differences in the State's definitions for programs, services, or other elements as compared to those presented in the glossary should be clarified in the narrative of the Application/Annual Report.

- The Application/Annual Report must be concise, accurate, and complete in addressing the minimum requirements of both Title V and this Guidance. All necessary formatting in the electronic Title V Application has been determined by MCHB and will be included in the annual Application/Annual Report Guidance that is provided.

- The sections of the narrative portion of the Application/Annual Report have character length limitations enforced by the electronic system. These length limits are identified at the top of each section in the online system. States should keep these length limitations in mind as they compose the narrative in the word processing package of their choice. The State user should then cut and paste each section from the document into the appropriate section in the online system. These length limitations do not apply to a State's needs assessment, which is a stand-alone document.

- The narrative is to be composed of text only, using standard characters. Embedding charts, tables or graphs in the narrative is not possible. Use of special characters, such as bullets, is not permitted.

- ***For every year*** after the first in a five year cycle, leave all of the previous year's narrative in place. Where changes of any kind (additions, corrections, updates, and revisions) are needed, begin at the left margin of each paragraph or section where the change applies and begin the corrected narrative with the following symbol: **/Application Year/** and conclude with **//Application Year//.** For example, the first reporting year of this guidance will use **/2010/** and conclude with **//2010//**. This will allow this text between these symbols to be displayed as bolded italics (NOTE: The bold and italics will be added automatically by the system in the readable version of the report). In this manner, entire sections will not have to be rewritten and all changes will be easy for all readers of the application to find.

  For example, to quickly locate each section updated for 2009, use the FIND function (found under the Edit menu of the browser or word processing package) to search for the associated tags

(/2009/). The following is a short illustration of how this will appear (on the View version of the online application):

> [From the 2008 Application]: The Program Director of the State Maternal and Child Health Program is Dr. Jane Doe. Dr. Doe reports to the Director of the State Department of Health.
> **/2009/** ***Dr. Doe moved to a new program in December. The new Director of the State Maternal and Child Health Program is Dr. John Smith. New organizational lines of authority have Dr. Smith reporting directly to the Governor.//2009//***

If further changes are required in subsequent years, use the same procedure. Leave the previous years' narrative changes in place, remove the italics and begin the new changes with the appropriate year within backslashes. (Once the entries are saved, the system will automatically place text between the brackets in bold and italics.) To continue the illustration, it would look as follows:

> [From the 2008 Application]: The Program Director of the State Maternal and Child Health Program is Dr. Jane Doe. Dr. Doe reports to the Director of the State Department of Health.
> /2009/ Dr. Doe moved to a new program in December. The new Director of the State Maternal and Child Health Program is Dr. John Smith. New organizational lines of authority have Dr. Smith reporting directly to the Governor.//2009//
> **/2010/** ***Dr. Smith remains the Director of the MCH program but that position once again reports to the Director of the State Department of Health.//2010//***

This procedure allows for rapid determination of differences from year to year without the need to find previous years' applications and compare narratives in order to discover exactly what changes have been made.

- Since the text of the performance measures changes each year and does not retain the previous year's narrative, the use of the "/Application Year/" update is not necessary in narrative sections addressing performance measures.

- States may attach one document per section to further explain the discussion in that section. This allows a State to provide charts, graphs, and tables that cannot be included in the narrative. This attachment is not to be a continuation of the narrative for that section.

- All letters of support and other documents may be formulated into a single list which is included in the application with a statement that the actual items are available upon request in the State MCH office.

- As required in Section 509(a)(5), the MCHB has made a substantial effort not to duplicate other Federal data collection efforts. In partnership with the States, only maternal and child health data necessary to fulfill the requirements of Title V which are not available at the national level or may be more timely from the State or required for tracking performance measures, will be gathered for the annual report. Data are not available from National Center for Health Statistics or other Federal sources for the Marshall Islands, Federated States of Micronesia, Republic of Palau, Commonwealth of the Northern Mariana Islands, and American Samoa. These jurisdictions must report their own vital statistics and health data using general instructions from the National Center for Health Statistics.

- Since the MCHB production of Annual Reports will be an extraction process it is critical for their development that States carefully follow the general instructions for completing the forms and the specific instructions included with each form.

IV. APPLICATION REVIEW PROCESS

Each State is required to submit its Annual Application/Annual Report. Once submitted, each application is examined by computer software for completeness of data. Any application that is incomplete may be returned to the State to procure the missing data. All complete applications are submitted to a standardized review process by MCHB staff and other experts in MCH, families, and consumers of the MCH population. Present at the review are the State MCH leadership and representation from the Central Office MCHB staff for an in-depth discussion of the Application/Annual Report and the State's plan for the coming year. These reviews are conducted in a face to face format. In some cases, the reviews may be conducted via audio/video conference call format. In all cases, the focus of the review is on the progress being made by each State in meeting its performance goals in the State specific as well as the National Performance Measures, and what type(s) of technical assistance may be needed in order for the State to move towards achieving these goals. In addition, the face to face review includes a detailed discussion on the major financial, policy, and legislative actions that will affect the State's program in the coming year.

PART TWO

INSTRUCTIONS FOR COMPLETING THE APPLICATION/ANNUAL REPORT

There are several major changes in this new edition of the Guidance. The major changes are as follows:

- PART TWO, Section II, Part A. Needs Assessment Process--Background and Conceptual Framework: Revisions provide more complete information on the Background and Conceptual Framework for the Needs Assessment Process.

- PART TWO, Section II, Part B. Five Year Needs Assessment Document: Revisions to this section clarify what State grantees are to include in the Five Year Needs Assessment Document.

- PART TWO, Section II, Part C. Annual Needs Assessment Summary or Update: Revisions to this section better explain the information to include in the Annual Needs Assessment Summary/Update, both in the year when the five year Needs Assessment is conducted and in the interim years.

- PART TWO, Section II, Figure 2: Updates to Figure 2 serve to more comprehensively reflect all aspects of the Needs Assessment process.

- PART TWO, Section III, Part B. Agency Capacity: The second paragraph clarifies that States should discuss the system of services for both the MCH and CSHCN programs.

- Standard Form (SF) 424: The requirement to print, sign, and mail in the Application Face Sheet (SF 424) has been deleted. SF 424 is now submitted electronically along with the rest of the application and annual report.

- Tables 4a and 4b: The headings and instructions have been clarified to indicate that States are to report information from the Annual Report year in these tables.

- PART TWO, Section IV, Part E. Health Status Indicators (HSIs): Revisions clarify the type of information that States are to report annually for the HSIs.

- PART TWO Section IV, Part F. Other Program Activities: Revisions clarify the types of information that States may want to include in this section.

- Form 11, Performance Measure Tracking: Instructions clarify that States are to provide a footnote that identifies the data source for each measure.

The application kit that is provided annually to the States via the Web includes a copy of the Guidance, a copy of the Title V law, and all required tables, forms, and diagrams.

I – GENERAL REQUIREMENTS

A. Letter of Transmittal

An electronic letter of transmittal from the responsible State health agency official must be the first page of the Application/Annual Report. The letter must also contain the documentation for waiver of a 30 percent allotment if the State is so requesting. The letter of transmittal is attached in the Title V Application to Section IA.

B. Face Sheet

Each section of the Application Face Sheet (Standard Form 424) must be completed and submitted electronically along with the rest of the application and annual report. Procedures for authentication of the Block Grant applicant will be sent to each State and Jurisdiction.

C. Assurances and Certifications

The appropriate Assurances and Certifications--non-construction program, debarment and suspension, drug free work place, lobbying, program fraud, and tobacco smoke--that accompany this guidance are to be maintained on file in the State's MCH program's central office. They may be attached to this section but this is not required. Instead, provide either the URL to access these assurances or provide information as to where and how the assurances and certifications can be made available.

D. Table of Contents

The Table of Contents is automatically generated by the system, and conforms to the headings in Parts One and Two on pages seven to nine of the Guidance.

E. Public Input [Section 505(a)]

Describe the process by which the State will make this application public to facilitate comment from any person during its development and after its transmittal. This includes not only illustrating how it facilitated or provided opportunities for the public to provide ideas, comments, or concerns about needs or programs, as well as how it facilitated or provided the opportunity for the public to comment on the application.

Some activities are linked specifically to the application process. Such activities may include:

- Public Hearings
- Advisory Council Review
- Web Posting

- Public Notices
- Other Use of Media
- Outreach to Specific Stakeholders

States also have regular mechanisms in place to obtain input and feedback on their programs. Such methods include advisory groups and task forces addressing specific programs or issues. Many, if not most states, have mechanisms in place to obtain regular and ongoing input from parents, especially parents of CSHCN. Some states engage youth directly in planning programs and developing materials in areas such as suicide prevention. If applicable, these mechanisms should also be described.

Further information regarding public input can be found under the Resource Page link on the MCHB/DSCH technical assistance (TA) website, http://www.mchtaproject.com.

II – NEEDS ASSESSMENT

A. Needs Assessment Process—Background and Conceptual Framework

Title V legislation requires that the State prepare a statewide needs assessment every five (5) years that shall identify (consistent with health status goals and national health objectives) the need for:

- preventive and primary care services for pregnant women, mothers and infants up to age one;
- preventive and primary care services for children; and
- services for CSHCN. [Section 505 (a)(1)].

The next five year Needs Assessment will be submitted in calendar year 2010 as an attachment in the electronic application system. It is intended to function for the State as a stand-alone document.

An overview of the MCH needs assessment process and its relationship with planning and monitoring functions is presented in Figure 2 on page 38. The following is a conceptual framework for this process.

Improved Outcomes and Strengthened Partnerships: Figure 2 reflects the expectation that following the ten identified steps of the Needs Assessment process, as described below, will result in two ultimate goals: (1) Improved Outcomes for MCH populations and (2) Strengthened Partnerships. The strengthened partnerships should include, but are not limited to, collaboration efforts with the Federal MCHB, State Department of Health, other agencies and organizations within each State and jurisdiction that have an interest in the wellbeing of the MCH population, families, practitioners, and the community.

The following is a brief description of the steps involved in the Needs Assessment process.

1. Engage Stakeholders

As depicted in Figure 2, the starting point is to **engage stakeholders**. Engaging stakeholders and strengthening partnerships is a continuous and on-going activity. The State needs strong partnerships with its stakeholders throughout the Needs Assessment process. Effective coalitions can help the State realistically assess needs and identify desired outcomes and mandates, assess strengths and examine capacity, select priorities, seek resources, set performance objectives, develop an action plan, allocate resources, and monitor progress for impact on outcomes.

2. Assess Needs and Identify Desired Outcomes and Mandates

The second stage in the process is to **assess needs** of the MCH population groups using Title V indicators, performance measures and other quantitative and qualitative data available in the State. The MCH population groups identified in Section 505(a)(1) of the statute are: pregnant women, mothers, and infants; children; and children with special health care needs. The anticipated outcome is to identify the community/system needs and **desired outcomes** by specific MCH population group. In addition, the State will need to **identify** legislative, political, community-driven, financial, or other internal and external **mandates** that they will be required to implement, regardless of what the Needs Assessment reveals.

3. Examine Strengths and Capacity

The third stage in the process is **examining strengths and capacity**. This stage involves examining the State's capacity to engage in various activities, including conducting the 5-year Needs Assessment and collecting annual performance data, and to provide services by each pyramid level. The pyramid appears on page 5. This stage involves describing and assessing the State's current resources, activities, and services as well as the State's ability to continue to provide quality services by each of the pyramid levels. These levels include direct health care services, enabling services, population-based services, and infrastructure-building services. The anticipated outcome is a better understanding of the relationship of existing program/system capacity to identified strengths and needs for each State and Jurisdiction. This examination may reveal strengths and weaknesses in capacity not previously identified.

4. Select Priorities

In the **select priorities** stage, each State examines the needs identified and matches those needs to desired outcomes, required mandates, and level of existing capacity. Based on the results of this process, the State then selects its most important, or highest priority, MCH strengths and needs to receive targeted efforts for improvement and/or continuation of progress. The inputs include: the needs assessment, the opinions of stakeholders, the examination of capacity, and the political priorities within the State. The anticipated outcome is development of a set of priority needs unique to each individual State based on Needs Assessment findings. Mandated activities are understood as continuing. Priority needs should include those areas in which the State believes it has a reasonable opportunity to maintain, modify, or enhance existing interventions, initiatives, or systems that have been successful, or begin new

interventions, initiatives, or systems that are expected to result in needed improvements.

5. Seek Resources

Depending upon the priorities selected and existing resources identified, the State may need to **seek** additional **resources**, funds, or authority from the State legislature or funding agencies in order to address priority areas.

6. Set Performance Objectives

Setting performance objectives consists of two phases. First, each State will select seven to ten State-negotiated Performance Measures to assess progress on State priorities not already monitored through National Performance and Outcome Measures. Next, each State will set Outcome Measure targets and State and National Performance Measure targets. The anticipated outcome is the identification of State-negotiated Performance Measures and Performance Measure targets.

7. Develop an Action Plan

The next stage is to **develop an action plan**, which includes identifying activities to address priority strengths and needs. This stage involves describing the activities that have been identified by the four pyramid levels: direct health care services, enabling services, population-based services, and infrastructure building services.

8. Allocate Resources

Following the identification of activities is the **allocation of resources** stage. In this stage, the focus is on the funding of planned activities to address State priorities. The inputs include the action plan, current budgets, political priorities, and partnerships. The anticipated outcome is the development of a budget that directs available resources towards activities that have been identified in Stage Seven as most important for addressing the State's priorities.

9. Monitor Progress for Impact on Outcomes

In **monitoring progress for impact on outcomes**, the States examine the results of their efforts to see if there has been improvement. The inputs include the State Performance Measures, National Performance Measures, Outcome Measures, Health Status Indicators, Health System Capacity Indicators, performance objectives, and other quantitative and qualitative information. Potential outcomes may include altered activities and shifting of resource allocations to address current levels of

performance and the availability of resources. Feedback loops between various stages of the process allow for continuous input and re-evaluation of the outputs.

10. Report Back to Stakeholders

This final step assures accountability to the stakeholders and partners who have worked with the MCH staff throughout the Needs Assessment process. It also assures the continued involvement of all stakeholders and partners in the ongoing Needs Assessment process.

B. Five Year Needs Assessment Document

States should structure the five year needs assessment document to include six sections, with each section addressing the items described below**.**

1. Process for Conducting Needs Assessment

Describe the **process** used by the State to conduct the Title V comprehensive needs assessment for each of the three defined population groups. At a minimum, the State should address the following:

- **Goals and Vision:** Describe the goals and the framework that guided the Needs Assessment process and how the State arrived at them. Include the State's vision and purpose for the Needs Assessment. Indicate what this document means to the State and how it will be used to guide the State's MCH activities, such as allocation of resources.

- **Leadership:** Define the roles and responsibilities of the Needs Assessment leadership team.

- **Methodology:** Describe the State's overall needs assessment methodology, what actions are taken to insure the ongoing nature of the process, and how needs assessment results and activities interface with other portions of the Title V grant application and annual report (e.g., how performance measures, health status, and capacity indicators are used in the needs assessment; how resources are allocated based on the State's priorities, etc.) Describe how the State cycles from the analysis phase to examining capacity to identifying priority needs, establishing State-negotiated performance measures, setting annual targets for National and State Performance Measures, identifying activities to address priorities, allocating resources, and monitoring progress. Describe stakeholder involvement in the Needs Assessment.

- **Methods for Assessing Three MCH Populations:** Describe the quantitative and qualitative methods used to assess the strengths and needs of each of the MCH populations: (1) pregnant women, mothers, and infants, (2) children, and (3) children with special health care needs.

- **Methods for Assessing State Capacity:** Describe the methods used to assess the State's capacity to provide direct health care, enabling, population-based, and infrastructure building services.

- **Data Sources:** Describe all data sources used. Note any specific limitations of the data not commonly understood from the literature (e.g., limitations of vital records do not need to be presented).

- **Linkages between Assessment, Capacity, and Priorities:** Describe linkages between the assessment of strengths and needs, the examination of capacity, and the selection of priorities.

- **Dissemination:** Describe and explain the rationale for the State's strategies, audiences, and formats for disseminating the Needs Assessment document to stakeholders and the public.

- **Strengths and Weaknesses of Process:** Describe the strengths and the weaknesses of current methods and procedures for the comprehensive needs assessment.

2. Partnership Building and Collaboration Efforts

Reference formal and informal collaboration processes and partnerships with the public and private sector and State and local levels of government. Describe the methods used to build and enhance partnerships with:

- State and local MCH programs (e.g., CSHCN, teen pregnancy prevention, Healthy Start, Maternal and Infant Program, family planning, etc.);
- Other HRSA programs (e.g., Primary Health Care, HIV/AIDS);
- Other programs within the State Department of Health (e.g., chronic disease prevention and health promotion, immunization, vital records and health statistics, injury prevention and control, disabilities, etc.);
- Other governmental agencies (e.g., Medicaid, Education, Social Services, etc.). States are encouraged to attach a copy of the Inter-Agency Agreement (IAA) between Medicaid and the State Title V agency; and
- Other State and local public and private organizations.

Describe stakeholder involvement, including what stakeholders are involved, their purpose, when they contribute to the process, how they participate, and why they are important. This should include a discussion of public and family members' involvement in the needs assessment. Describe collaboration efforts related to analyzing the strengths and needs of the MCH population, assessing capacity, selecting priority needs, and identifying and implementing activities to help meet priority needs. Describe the results, strengths, and weaknesses of these efforts.

3. Strengths and Needs of the Maternal and Child Health Population Groups and Desired Outcomes

Using both quantitative and qualitative methods, describe the health status of each State MCH population group:

- Pregnant women, mothers, and infants
- Children
- Children with special health care needs

Discuss cross-cutting strengths and needs across all population groups.

Describe major morbidity, mortality, risk reduction or maintenance of health/wellness successes, problems, gaps, and disparities of the State MCH population groups. At a minimum, include major health issue areas (e.g., rates of pregnancies, fetal losses, births, age-specific deaths, prevalence of preventable disease and chronic diseases) within the MCH population as a whole and for significant sub-populations (e.g., racial, ethnic, age, income, geographic, frontier/rural/urban, or other relevant characteristics).

Use Performance Measures, Outcome Measures, Health Status Indicators, Health System Capacity Indicators, and progress towards meeting the Healthy People 2010 objectives, as appropriate, to describe the health status of the State MCH population groups. Analyze selected MCH measures and indicators by finer stratifications (e.g., county/region, race/ethnicity, age group, etc.) than reported in interim years, as appropriate for the State's Needs Assessment and as small number limitations allow. Include other indicators selected by the State to present a complete picture of each MCH population group's strengths and needs.

Report the results of qualitative strengths and needs analysis methods for each population group and describe how these results confirm, conflict with, or enhance the results of the State's quantitative analysis of strengths and needs.

Describe what is working well and should be continued, as well as areas that need to be enhanced or strengthened.

4. MCH Program Capacity by Pyramid Levels.

Describe and assess the State's capacity to meet the needs of the State's MCH population by level of the pyramid.

a. Direct Health Care Services

Describe the State's capacity to provide or to assure the availability of direct health care services for the MCH population, including both strengths and unmet needs. Specify the **priority State concerns** regarding availability of health care and health-related services, including prevention and primary care services and specialty care services when needed.

Assess and describe the **availability** of care. Enumerate, as appropriate, any shortages of specific types of health care providers such as primary care physicians, nutritionists, registered dietitians (including specialty registered dietitians), public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, dentists, sub-specialty physicians who serve CSHCN, audiologists, occupational therapists, physical therapists, and speech and language therapists. Illustrate underserved geographical areas (by map).

b. Enabling Services

Describe the State's capacity to provide or to assure enabling services for the MCH population, including both strengths and unmet needs. Specify the **priority State concerns** regarding enabling services, including financial access and cultural acceptability. Assess and describe **barriers** and the extent to which they impact accessibility of primary/preventive care, specialty/sub-specialty care, and habilitation and rehabilitation services for each population group.

Describe the impact of "**emerging issues**" (e.g., accessibility of oral health care for low-income populations, any relevant changes in the State's Child Health Insurance Program, etc.) on the State's ability to provide or to assure enabling services to MCH population groups.

Describe the **linkages** that exist to promote provision of services and referrals between primary level care, specialized secondary

level care and highly specialized tertiary level care. Assess and describe existing resources for providing community-based care, specialty care through pediatric centers, community-based specialty clinics, and multi-disciplinary centers, etc.

c. Population-Based Services

Assess and describe the State's capacity related to this level of the pyramid. Assess and describe the State's involvement in the direct management of these services and programs; the State's coordination with other agencies and organizations (universities, managed care organizations, physician groups) in the provision of these services; geographic availability/distribution of these services; and funding mechanisms for these services. Describe other population-based programs provided by the State for each of the Title V population groups.

d. Infrastructure-Building Services

Assess and describe the State's **capacity** to promote comprehensive systems of services. Assess from the State perspective how local delivery systems (include regional areas as appropriate) meet the population's health needs. Assess existing systems and collaborative mechanisms for the population groups: preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children, and services for CSHCN.

Assess and describe the State's planning, evaluation, research, and workforce development efforts.

Discuss **coordination** efforts, which address the following programs, organizations and groups:

- Medicaid, Supplemental Security Income Program (SSI), Ryan White and Title IV AIDS programs, social services programs, special education programs, early intervention programs including Part C of the Individuals with Disabilities Act (IDEA), vocational rehabilitation programs, mental health programs including the Child and Adolescent Services System Program (CASSP), State interagency transition programs, developmental disabilities programs, SSDI, school health programs and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

- Other groups of major providers of health and health-related services, as appropriate for the State. Examples include children's hospitals and tertiary medical centers, State chapter of the American Academy of Pediatrics, the American Academy of Family Practice, the American College of Obstetrics and Gynecology, and family and parent advocacy organizations.

Assess and describe the State's specific efforts related to the development and implementation of standards of care, guidelines, monitoring of program effectiveness, and approaches to evaluation of care. Discuss efforts to monitor continuous quality improvement for each MCH population group. Discuss the State's effort to monitor the development of community-based service systems.

For CSHCN, discuss the following four constructs of a service system: (1) State program collaboration with other State agencies and private organizations, (2) State support for communities, (3) coordination of health components of community-based systems, and (4) coordination of health services with other services at the community level (see glossary). Specify the groups and individuals involved in the assessment process. In order to determine a measure of the degree to which characteristics documenting family participation in CSHCN programs are demonstrated within the States, complete Form 13.

5. Selection of State Priority Needs

The narrative addressing the determination of State MCH priorities and the summary list of priority needs (and instructions to complete Form 14) should include the following:

- **List of Potential Priorities:** Provide a list of all items considered for inclusion as State priority needs, including pertinent discussion of each need, why it was considered for inclusion, and why it was or was not included. For example, an item may be considered but not chosen as a priority because (1) it is already being measured by a National Performance Measure; (2) it falls outside the area of responsibility of the MCH or CSHCN Director; (3) a system has already been put in place to address the need; or (4) the issue is too broadly focused.
- **Methodologies for Ranking/Selecting Priorities**: Describe the methodologies used for ranking the priorities identified and for selecting the final State priorities to include on Form 14 from all the priorities identified. Provide an explanation of why and how the State chose its priorities.

- **Priorities Compared with Prior Needs Assessment**: Discuss any factors that brought changes in the priorities in the four interim years between State MCH needs assessments, with identification of: (1) Priorities continued from the previous Needs Assessment; (2) Priorities replaced; and (3) Priorities added. For each priority, discuss why it was continued, replaced, or added.
- **Priority Needs and Capacity**: Discuss the State priorities as they relate to the four service levels of the pyramid. Discuss the relationship between the priority needs and MCH program capacity, including a description of the MCH program capacity that is available to address the priority needs and any areas where there may be inadequate capacity to impact the priority needs in a meaningful way. For example, if there is a high need but no capacity to address that need, the State may consider this area to be an emerging need for possible inclusion as a priority in the future, when the State has improved capacity for addressing it.
- **MCH Population Groups**: Provide assurances that there are priorities that cover the three major MCH population groups (preventive and primary care services for pregnant women, mothers and infants; preventive and primary care for services for children; and, services for CSHCN).
- **Priority Needs and State Performance Measures:** Describe how the State will measure success in meeting each priority need, including how it has linked the Priority Needs with the State Performance Measures. Examples of how a State may measure its success in meeting a priority need include using (1) multiple National or State Performance Measures; (2) one National or State Performance measure that serves as a proxy for meeting the priority need; or (3) one National or State Performance Measure that is worded in a manner that is identical to the priority need. Discuss each of the State Performance Measures in terms of why each measure was chosen and the relationship of each measure to the State priority needs. Include the rationale for any State Performance Measure that is not linked to priority needs. The State may want to include a chart or table that lists each priority need and the National and/or State Performance Measure(s) that support that need.

When formulating the priority needs statements, use clearly and plainly stated phrases such as “the infant mortality rate for minorities should be reduced” or “reduce the barriers to the delivery of care for pregnant women.” Each priority should have measurable indicators that the State can use to track progress related to health status and program or system capacity. Copy the 7 to 10 Priority Needs statements to Form 14, List of MCH Priority Needs. The Title V information system will record up to 10 priority needs, but the State may list and describe more if desired.

6. Outcome Measures - Federal and State

The MCH Outcome Measures enumerate the final desired result of program activities and interventions undertaken to achieve MCH objectives. Outcome measures should ultimately answer the question: "Why does the State undertake its chosen MCH program activities?" It is recognized that there are numerous and varied factors that influence outcome measures. Therefore, in this section, rather than attempting an enumeration of the myriad of factors that may impact outcomes, include a brief discussion on the relationship between State program activities, the National and State Performance Measures, and the Outcome Measures. Include in the discussion changes in existing program activities as well as new activities for the coming year that are being planned in an effort to positively influence specific outcomes. The State has the option of creating one or more State Outcome Measures. If the State has developed one or more State Outcome Measures, complete the Tracking Health Outcomes Measure form at the end of Form 12. Insert a completed detail sheet for each State Outcome Measure at the end of the National Outcome Measures Detail Sheets.

In general, briefly describe the relationship between State MCH program activities and the National and State Performance Measures and their collective contributory positive impact on the outcome measures for the Title V population. If the performance measure was not met, discuss those factors both within and outside the control of the Title V program that may have affected the achievement of this performance measure.

C. Annual Needs Assessment Summary or Update

1. Year that Needs Assessment is Due—Needs Assessment Summary

During any year when a 5-year Needs Assessment is due, the State must summarize the results of the State's Needs Assessment in this section of the application, with a focus on the 7-10 priority needs. The Needs Assessment summary should be approximately 2 pages in length and should include a discussion of the following:

a. Any changes in the population strengths and needs in the State priorities since the last 5-year Needs Assessment.

b. Any changes in the State MCH program or system capacity in those State priorities since the last 5-year Needs Assessment.

2. Interim Years—Needs Assessment Update

During any interim year when a 5-year Needs Assessment is not due, the State must provide a Needs Assessment update in this section of the application. The Needs Assessment update should be approximately 2 pages in length and should include a discussion of the following:

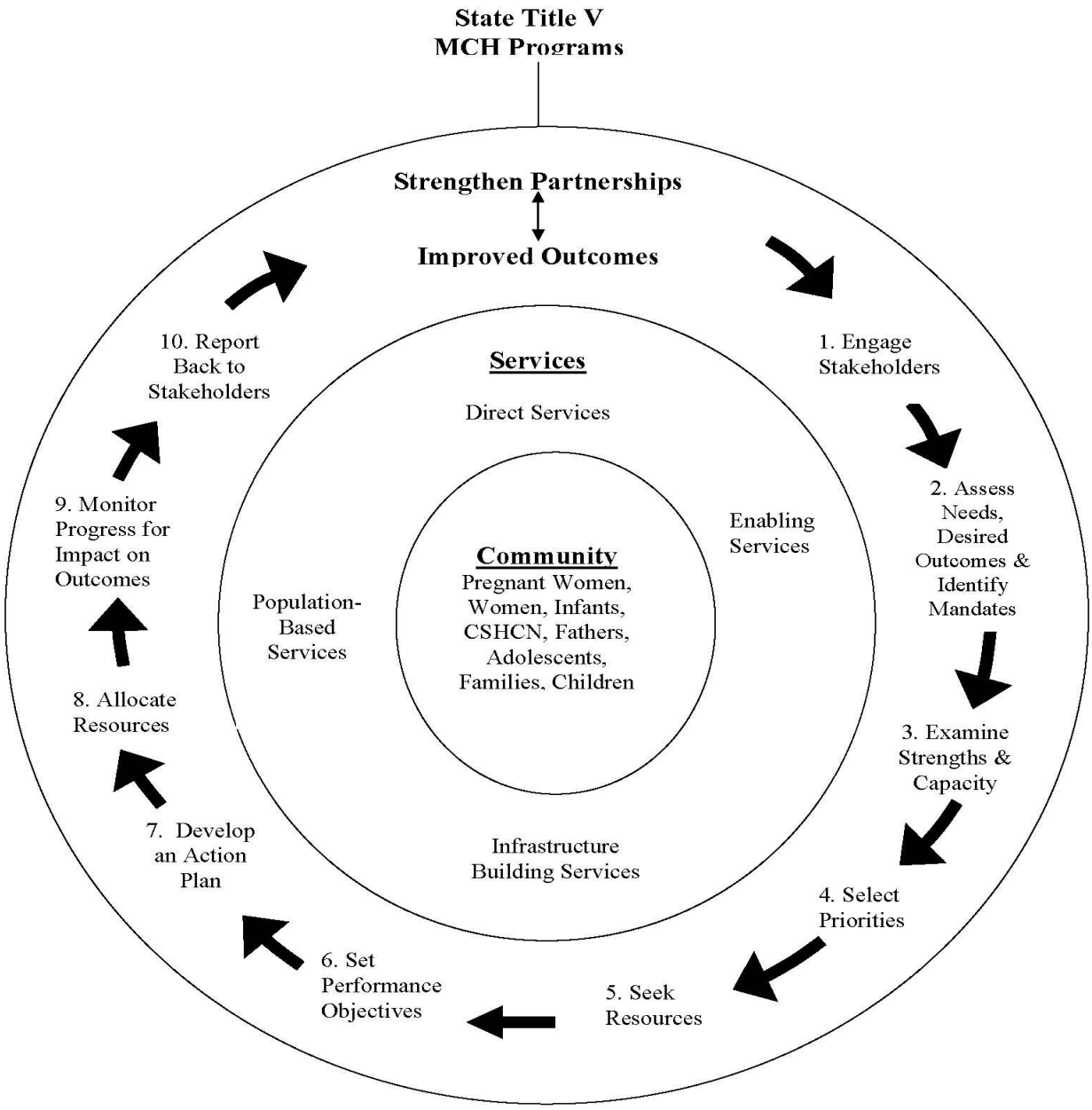
a. Any changes in the population strengths and needs in the State priorities since the last Block Grant application.

b. Any changes in the State MCH program or system capacity in those State priorities since the last Block Grant application.

c. A brief description of ongoing needs assessment activities, such as data collection and analysis, evaluations, focus groups, surveys, that enable the State to continue to monitor and assess, on an ongoing basis, its priority needs and its capacity to meet those needs.

d. A brief description of any activities undertaken to operationalize the 5-year Needs Assessment, such as establishing an advisory group to monitor State progress in addressing the findings and recommendations resulting from the Needs Assessment.

Figure 2. State Title V MCH Program
Needs Assessment, Planning, Implementation
& Monitoring Process



III - STATE OVERVIEW

A. Overview of the State

This section should put into context the Title V program within the State's health care delivery environment. Discuss the principal characteristics important to understanding the health needs of the entire State's population. Describe the State health agency's current priorities or initiatives and the resulting Title V program's roles and responsibilities.

This overview should include a description of the process used by the Title V administrator to determine the importance, magnitude, value, and priority of competing factors impacting health services delivery in the State including the current and emerging issues and how these are taken into consideration as well.

Include in this description the extent to which poverty, racial and ethnic disparities in health status, geography, urbanization, and the private sector create unique challenges for the delivery of Title V services.

B. Agency Capacity

Describe in this section the State Title V agency's capacity to promote and protect the health of all mothers and children, including CSHCN.

The State MCH and CSHCN Programs have the opportunity to indicate some of the steps taken to ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care which are essential for effectively fostering and facilitating activities. Describe the extent to which the following occur:

- State program collaboration with other State agencies and private organizations;
- State support for communities;
- Coordination with health components of community-based systems; and
- Coordination of health services with other services at the community level.

Describe State statutes relevant to Title V program authority and how they impact upon the Title V program.

Provide a description of the State's Title V capacity to provide:

1. preventive and primary care services for pregnant women, mothers and infants;
2. preventive and primary care services for children;

3. services for CSHCN [Section 505(a)(1)], including the capacity:
    a. to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI (the Supplemental Security Income Program), to the extent medical assistance for such services is not provided under Title XIX (Medicaid);
    b. to provide and promote family-centered, community-based, coordinated care including care coordination services, for CSHCN and facilitate the development of community based systems of services for such children and their families; and,
4. culturally competent care that is appropriate to the State's MCH populations.

Provide examples of the mechanisms that have been developed to have culturally competent approaches to service delivery. Examples of such activities can include:

- Collect and analyze data according to different cultural groups (e.g. race, ethnicity, language) and use the data to inform program development and service delivery.

- Ensure the provision of training, both in orientation and ongoing professional development, for staff, family leaders, volunteers, contractors and subcontractors in the area of cultural and linguistic competence.

- Collaborate with informal community leaders/groups (e.g. natural networks, informal leaders, spiritual leaders, ethnic media, family advocacy groups) and families of culturally diverse groups in needs/assets assessments, program planning, service delivery and evaluation/monitoring/quality improvement activities.

- Have in place allocation of resources that adequately meet the unique access, informational and service needs of culturally diverse groups.

- Performance standards for staff and contractors which incorporate cultural competence practices/policies.

- Provide policies and guidelines that support the above items.

C. Organizational Structure

Describe the organizational structure and placement of the Governor, State health agency, the MCH and CSHCN programs in the State government. Official and dated organizational charts that include all program elements of the Title V

program, clearly depicted, should be on file in the State office and available upon request at the time of the Block Grant review. Describe concisely how the State health agency is "responsible for the administration (or supervision of the administration) of programs carried out with allotments under Title V" [Section 509(b)]. All programs funded by the Federal-State Block Grant Partnership budget total (Form 2, Line 8) should be included.

D. Other (MCH) Capacity

Describe the number and location (central and out-stationed) of staff that work on Title V programs. Include staff that provides planning, evaluation, and data analysis capabilities. Include the qualifications, in the form of a brief biography, of senior level management employees in lead positions. Also include the number and role of parents of special needs children on staff. In addition, States are encouraged to provide other MCH workforce information that may be available, such as full time equivalents (FTEs) at the State and local levels, tenure of the State MCH workforce, and projected changes to the MCH workforce in the coming year.

E. State Agency Coordination

Describe the relevant organizational relationships among the State Human Services agencies (e.g., public health, mental health, social services/child welfare, education, corrections, Medicaid, SCHIP, Social Security Administration, Vocational Rehabilitation, disability determination unit, alcohol and substance abuse, rehabilitation services); the relationship of State and local public health agencies (including city MCH programs) and federally qualified health centers; primary care associations; tertiary care facilities; and available technical resources such as public health and health professional educational programs and universities, all of which may enhance the capacity of the Title V program.

In this section also describe the plan for coordination of the Title V program with (1) the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), (2) other federal grant programs (including WIC, related education programs, and other health, developmental disability, and family planning programs), and (3) providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for services [Section 505(a)(5)(F)]. Also discuss coordination with the Social Security Administration, State Disabilities Determination Services unit, Vocational Rehabilitation, and family leadership and support programs.

F. Health Systems Capacity Indicators

The nine Health Systems Capacity Indicators (HSCI) are reported annually on Forms 17, 18, and 19. These indicators are meant to be used as a self-assessment tool.

Besides describing data sources and current findings, the State should utilize this section to illustrate such things as:

- What has influenced the program's ability to maintain and/or improve the HSCIs;
- What efforts are being made by the program in developing new strategies for meeting the HSCIs;
- Any interpretation of what the data indicates; and
- If a State Systems Development Initiative is in place, what is notable regarding it and HSCI 9A (The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information).

SUMMARY OF HEALTH SYSTEMS CAPACITY INDICATORS
Reported Annually

#01 HEALTH SYSTEMS CAPACITY INDICATOR
The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 – 493.9) per 10,000 children less than five years of age.

#02 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

#03 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

#04 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

#05 HEALTH SYSTEMS CAPACITY INDICATOR
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State

#06 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.

#07A HEALTH SYSTEMS CAPACITY INDICATOR
The percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.
(Formerly National Performance Measure #14)

#07B HEALTH SYSTEMS CAPACITY INDICATOR
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

#08 HEALTH SYSTEMS CAPACITY INDICATOR
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program."

#09(A) HEALTH SYSTEMS CAPACITY INDICATOR

The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

#09(B) HEALTH SYSTEMS CAPACITY INDICATOR

The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

IV - PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES ANNUAL REPORT/ANNUAL PLAN

A. Background and Overview

The Government Performance and Results Act (GPRA – Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations.

Since 1999 MCHB has included performance plans and performance information in its budget submission. MCHB must submit annual reports to Congress on the actual performance achieved compared to that proposed in the performance plan. This section of the guidance describes how the Federal – State partnership will implement these performance reporting requirements. Figure 3, page 45, "Title V Block Grant Performance Measurement System" presents a schematic of a system approach that begins with the needs assessment and identification of priorities and culminates in improved outcomes for the Title V population. After each State establishes a set of priority needs from the five year Statewide needs assessment, programs are designed, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH "pyramid" — direct health care, enabling, population-based, and infrastructure building services. Because of the flexibility inherent in the Block Grant, the program activities or the role that Title V plays in the implementation of each performance measure may vary among States (i.e., monitor, advocate, provide, supplement, assure). Program activities, as measured by 18 National performance measures and from 7 to 10 State performance measures should have a collective contributory effect to positively impact a set of 6 National outcome measures for the Title V population.

Accountability is determined in 3 ways: (1) by measuring the progress towards successful achievement of each individual performance measure; (2) by having budgeted and expended dollars spread over all four of the recognized MCH services; direct health care, enabling services, population-based services, and infrastructure building services, and (3) by having a positive impact on the outcome measures

While improvement in outcome measures is the long term goal, more immediate success may be realized by positive impact on the performance measures which are shorter term, intermediate, and precursors for the outcome measures. This is particularly important since there may be other significant factors outside of Title V control affecting the outcomes.

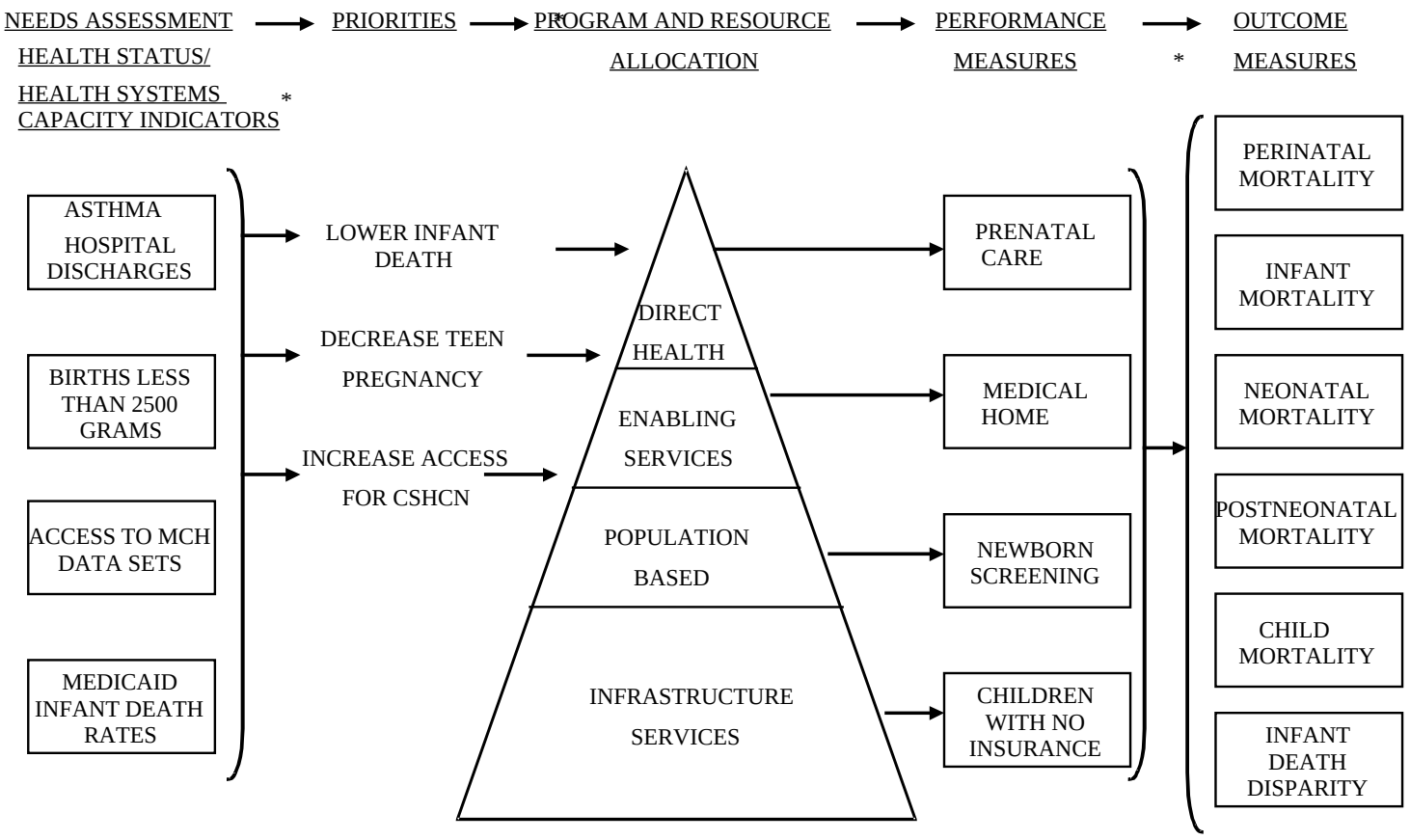
B. State Priorities

Describe the relationship of the priority needs, the National and/or State performance measures, and the capacity

Figure 3

TITLE V BLOCK GRANT

PERFORMANCE MEASUREMENT SYSTEM



and resource capability of the State Title V program. In this discussion, mention where appropriate, the specific number of the National and State performance that relate to those activities. Details of the development of performance measures and the relationships between priorities and performance measures are discussed in parts C and D of this section, below.

C. National Performance Measures

Table 4a, page 47, lists the 18 National Performance Measures. Each measure is described in the Detail Sheets beginning on page 100 and includes the following 5 major components — goal, definition, Healthy People 2010 objective, data sources/issues, and significance. A review of the Detail Sheets assists in assuring a consistent understanding and reporting of the measures among States and in the aggregation of National performance results.

In this section of the narrative discuss, in numerical order, each of the 18 National Performance Measures. The discussion should focus on MCH populations served and activities by level of the pyramid. The discussion should be organized by: (a) a report of last year's (annual report) accomplishments, (b) current activities, and (c) plan for the coming (application) year.

There may be multiple activities for each performance measure. Throughout this section of the narrative label each National Performance Measure with a "NPM#" to differentiate it from the State Performance Measures. Discuss activities as they relate to the population groups, etc., and discuss how each activity relates to the level of the pyramid. Major activities conducted during the annual report year should be listed on Table 4a. ***Specific activities may reflect different levels of the pyramid than the corresponding performance measure.*** An *example* of some activities has been provided for the first Performance Measure in Table 4a. Each State should provide their listing of major activities for each corresponding performance measure. Up to ten major activities per each performance measure may be listed.

TABLE 4a
NATIONAL PERFORMANCE MEASURES SUMMARY FROM THE ANNUAL REPORT YEAR

NATIONAL PERFORMANCE MEASURES	Pyramid Level of Service				
	DHC	ES	PBS	IB	
1) The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs. ***List all major ongoing activities, such as:** ***1. Purchase of PKU formula and food products for individuals*** ***2. Contracts providing statewide coverage for consultation related with related metabolic conditions.*** ***3. Development of a data system linking newborn screening records with birth certificates.*** ***4. Arranging transportation, as needed, to access follow up services*.**	X	X		X	X
2) The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. (CSHCN Survey) ***List all ongoing major activities.** **1.** **2.** **3.** **4.**	X				X
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey) ***List all ongoing major activities.** **1.** **2.** **3.** **4.**		X	X		
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey) ***List all ongoing major activities.** **1.** **2.** **3.** **4.**			X		X

5) The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily. (CSHCN Survey) ***List all ongoing major activities.** **1.** **2.** **3.** **4.**		X	X	
6) The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey) ***List all major ongoing activities.** **1.** **2.** **3.** **4.**		X	X	
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B. ***List all major ongoing activities.** **1.** **2.** **3.** **4.**			X	X
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years. ***List all major ongoing activities.** **1.** **2.** **3.** **4.**			X	X
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth. ***List all major ongoing activities.** **1.** **2.** **3.** **4.**			X	X
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. ***List all major ongoing activities.** **1.** **2.** **3.** **4.**			X	X

11) The percent of mothers who breastfeed their infants at 6 months of age. ***List all major ongoing activities.** **1.** **2.** **3.** **4.**				X	X X
12) Percentage of newborns who have been screened for hearing before hospital discharge. ***List all major ongoing activities.** **1.** **2.** **3.** **4.**				X	X
13) Percent of children without health insurance. ***List all major ongoing activities.** **1.** **2.** **3.** **4.**					X X
14) Percentage of children, ages 2 to 5 years, receiving WIC services that have a Body Mass Index (BMI) at or above the 85th percentile. ***List all major ongoing activities.** **1.** **2.** **3.** **3.**					X X
15) Percentage of women who smoke in the last three months of pregnancy ***List all major ongoing activities.** **1.** **2.** **3.** **4.**					X X
16) The rate (per 100,000) of suicide deaths among youths 15-19. ***List all major ongoing activities.** **1.** **2.** **3.** **4.**					X X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. ***List all major ongoing activities.** **1.** **2.** **3.** **4.**					X X

18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. ***List all major ongoing activities.** **1.** **2.** **3.** **4.**				X X

NOTE: **DHC** = Direct Health Care **ES** = Enabling Services **PBS** = Population Based Services **IB** = Infrastructure Building. *****List all major ongoing activities in space provided. If there are more than four major activities on-going, please include these.

TABLE 4b
STATE PERFORMANCE MEASURES SUMMARY FROM THE ANNUAL REPORT YEAR

STATE PERFORMANCE MEASURES	Pyramid Level of Service			
	DHC	ES	PBS	IB
1).				
2.)				
3.)				
4.)				
5.)				
6.)				
7.)				
8.)				
9.)				
10).				

NOTE: **DHC**=Direct Health Care **ES**=Enabling Services **PBS**=Population Based Services **IB**=Infrastructure Building. List all major ongoing activities in space provided for each State Performance Measure.

D. State Performance Measures

In order to promote State flexibility, while assuring accountability in responding to the specific priority needs determined through the needs assessment, each State shall develop at least 7, but not more than 10, additional performance measures based on their identified priorities that best describes their own unique needs and may not otherwise be captured by the National Performance Measures. For each State Performance Measure, complete a Performance Outcome Measure Detail Sheet (Form 16). Throughout the narrative of the Application/Annual Report label each State Performance Measure with a "SPM#" to differentiate it from the National Performance Measures.

In this section of the narrative, if there have been changes to any of the SPMs since the last application, discuss each new SPM in terms of why it was chosen, and its relationship to one or more of the priority needs.

For all SPMs, the discussion should include populations served and activities by level of the pyramid. The discussion should be organized by: (a) a report of last year's (annual report) accomplishments, (b) current activities, and (c) plan for the upcoming (application) year. It is understood that there may be more than one activity for each performance level. These activities may relate to different levels of the pyramid and more than one population group.

Lastly, in order to provide a performance measurement summary, list all major activities that occurred during the annual report year under each performance measure in Table 4b, page 49. While there are four lines provided to list the major activities, up to ten major activities can be included.

SPMs are reviewed relative to the priorities established in the Needs Assessment; their representation of important State Title V program activities; and to ensure that they are generally measurable and practical. The review process also provides an opportunity to increase consistency among similar measures submitted by other States by encouraging uniform definitions of numerators and denominators that may lead to National data aggregation of corresponding measures.

Since it is likely that priority needs and program activities change and evolve over time, the SPMs may need to be discontinued when new ones are added. In any given year, when a State measure is discontinued, reporting on that measure is no longer required and a State may 'deactivate' the measure in the system. In this case, the State should provide an explanation of the reason for deactivating the measure. In the first interim reporting year after a

Needs Assessment year any State measures that were dropped at any time in the previous 5 year reporting cycle are to be removed from Table 4b and Forms 11, 12, and 16 (Detail Sheets).

E. Health Status Indicators

The Health Status Indicators (HSI) are to be reported annually. The HSIs contribute to the State Title V agency's ability to:

- Provide information on the State's residents;
- Assist in directing public health efforts;
- Serve as a surveillance or monitoring tool; and
- Function as an evaluative measure.

Besides describing data sources and current findings, the State should utilize this section to illustrate such things as:

- What has influenced the program's ability to maintain and/or improve the HSIs;
- What efforts are being made by the program in developing new strategies for meeting the HSIs; and
- Any interpretation of what the data indicates.

SUMMARY OF HEALTH "STATUS" INDICATORS
Reported Annually

#01A. ***The percent of live births weighing less than 2,500 grams***

#01B. ***The percent of live singleton births weighing less than 2,500 grams***

#02A. ***The percent of live births weighing less than 1,500 grams***

#02B. ***The percent of live singleton births weighing less than 1,500 grams.***

#03A. ***The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.***

#03B. ***The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger.***

#03C. ***The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years***.

#04A. ***The rate per100,000 of all non-fatal injuries among children aged 14 years and younger.***

#04B. ***The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.***

#04C. ***The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.***

#05A. ***The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.***

#05B. ***The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.***

#06A & B. ***Infants and children aged 0 through 24 years enumerated by sub-populations of age group, race, and ethnicity.***

#07A & B. ***Live births to women (of all ages) enumerated by maternal age, race and ethnicity.***

#08A & B. ***Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity.***

#09A & B. ***Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity***

#10. ***Geographic living area for all resident children aged 0 through 19 years***

#11. ***Percent of the State population at various levels of the federal poverty level***

#12. ***Percent of the State population aged 0 through 19 years at various levels of the federal poverty level***

F. Other Program Activities

State MCH program activities have considerable breadth. In order to adequately describe those activities which fall outside the parameters of priority needs and National and State performance measures outlined above, separate descriptions may be necessary. Any activity not discussed within the priority needs and the performance measurement sections should be described here. These program activities often make significant contributions to the health and well-being of mothers and infants, children, and CSHCN within each State. Without these on-going program activities, the MCH population groups would not benefit from the full array of services available to them in some States. Each State has the opportunity to present these other activities in this section of the Application/Annual Report. Examples of other important issues for discussion here may include the following: (1) characteristics documenting family/consumer participation in MCH and CSHCN programs; (2) special efforts made

to address health disparities; (3) evaluations that have been recently completed, are ongoing, or are planned relative to State MCH and CSHCN activities; (4) cultural competency; or (5) any other specific changes or challenges in the upcoming year not covered elsewhere in the application.

Include a discussion of the toll-free hotline [Section 505(a)(5)(E)].

G. Technical Assistance Needs

The purpose of Form 15 is to obtain a preliminary idea of the major issues that the State has identified to receive special attention and effort during the coming next year. The technical assistance (TA) items listed on this form will be regarded as a starting point for the State and MCHB for planning an efficient and effective strategy for obtaining the most appropriate technical assistance to meet the State's unique needs. Priority will be given to providing technical assistance in those areas where the State desires to increase its progress in realizing one or more performance objectives for its State or national performance measures. In some cases, the State may want to obtain technical assistance from another State who has achieved a high level of performance. States may also be interested in obtaining TA from other experts at universities, public health agencies, consulting firms, etc. As the State's TA needs clarify or change over the course of the year, it is expected that it will submit new and/or more detailed TA requests.

V - BUDGET NARRATIVE

A. Expenditures

The State should maintain budget documentation for Block Grant funding/expenditures for reporting, consistent with Section 505(a), and consistent with Section 506(a)(1) for audit. Describe any significant year to year expenditure variations that appear on Forms 3, 4, or 5.

B. Budget

The budget narrative is to reflect how Federal support complements the State's total effort and what amounts will be utilized in compliance with the 30% - 30% requirements. It should further describe how other spending categories (administration and maintenance of effort) of Title V funds as shown on Form 2 are maintained. Describe how satisfaction of the required match is achieved. Adequate discussion is included for significant year to year variations in budget or expenditures.

In this section describe briefly the maintenance of effort from 1989 [Sec. 505(a)(4)]; any continuation funding for special projects [Sec. 505(a)(5)(C)(i)]; or special consolidated projects noted in Sec. 501(b)(1) [Sec. 505(a)(5)(B)].

The budget justification should further describe sources of other Federal MCH dollars, State matching funds, including non-federal dollars that meet at least the legislatively-required minimum match for Title V, and other State funds used by the agency to provide the Title V program. Describe any significant year to year budget variations that appear on Forms 3, 4, or 5.

Remember that any amount payable to a State under this title from allotments for a fiscal year which remains unobligated at the end of such year shall remain available to such State for obligation during the next fiscal year. No payment may be made to a State under this title from allotments for a fiscal year for expenditures made after the following fiscal year [Section 503(b)].

VI - REPORTING FORMS - GENERAL INFORMATION

Form 1 - Application for Federal Assistance - This is the "official" application form requiring electronic signature by the appropriate State official.

Form 1 is formally titled The Application Face Sheet (SF424) and it is a standard Office of Management and Budget (OMB) form. The form should be filled out in accordance with the standard instructions that accompany it. However, in order to have it serve MCHB purposes some definitions in its sub-sections have been assigned new meanings. These are spelled out in the detailed instructions that follow the form.

Form 2 - MCH Budget Details for FY __ - Is the premier annual planning form. It presents, at a glance all the funding by the Federal - State Block Grant Partnership and other MCH related funding sources. It also stipulates what amounts will be utilized in compliance with the various spending requirements such as the 30%-30% requirements, administration and maintenance of effort.

Form 2 is also the "drive" form for the budget figures that appear on the other financial forms....Forms 3, 4, and 5. The figures entered for the application year will automatically be entered in the appropriate "budgeted" columns in those forms. Care should be taken to complete this form accurately.

Form 3 - State MCH Funding Profile - This form is used for both reporting and planning purposes. For Annual Report purposes complete the "Expended" column for the appropriate Fiscal Year. For Annual Plan purposes complete the "Budgeted" column for the appropriate Fiscal Year.

Form 4 - Budget Details by Types of Individuals Served (I) and Sources of Other Federal Funds (II) - This form is used for both reporting and planning purposes. For Annual Report purposes complete the "Expended" column for the appropriate Fiscal Year. For Annual Plan purposes complete the "Budgeted" column for the appropriate Fiscal Year.

Form 5 - State Title V Program Budget and Expenditures by Types of Service - Form 5, "State Title V Programs Budget and Expenditures by Types of Service" parallels the pyramid shown in Figure 1, page 5, which organizes Maternal and Child Health Services hierarchically from direct health care services through infrastructure building. Because the narrative description and the implementation of performance measures are integrally related to this pyramid, special care should be used in completing the appropriate fiscal year Expended fund column on this form.

Form 6 - Number and Percentage of Newborn and Others Screened, Cases Confirmed, and Treated - Annual Report form.

Form 7 - Number of Individuals Served (Unduplicated) Under Title V - Annual Report form.
Form 8 - Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX - Annual Report form.

Form 9 - State MCH Toll-Free Telephone Line Data - Part of the Annual Report.

Form 10 - Title V Maternal & Child Health Services Block Grant State Profile for FY __. - The information in this profile will be used as a stand alone document to quickly summarize a State's accomplishments during the last fiscal year. Follow the instructions carefully.

Form 11 - Tracking Performance Measures - lists the 18 National Performance Measures and, up to 10 State Outcome Measures and the objectives (targets) and the indicators (actual progress) for each, by fiscal year.

For National Measures: For Annual Report purposes complete the appropriate fiscal year annual performance **indicators** by entering data into the "Numerator" and "Denominator" rows for each of the National and State Performance Measures. Using this data, the indicator will be automatically calculated and entered in the appropriate row for the measure. For Annual Plan purposes complete the annual performance **objective** row for the State's five year targets for each measure.

For the State Measures: Complete Form 11 by adding each State Performance Measure after the National measures.

For both National and State Measures: Since it is likely that priority needs and program activities will evolve over time it is also likely the performance objective values may need to be changed. These values may be changed in either the National or State measures if necessary. When changed, add a note in the *Add Notes For This Measure* section of Form 11 explaining the reasons for the change.

Form 12 - Tracking Health Outcome Measures - lists the 6 National Outcome Measures and, if developed, optional State Outcome Measures and the objectives (targets) and the indicators (actual progress) for each, by year.

For the State Measures: Complete Form 12 by adding the State's (optional) Outcome Measure after the National measures.

For Annual Report purposes: Complete the appropriate fiscal year annual outcome indicators by entering data into the "Numerator" and "Denominator" rows for each of the National and State Outcome Measures. Using this data, the indicator will be automatically calculated and entered in the appropriate row for the measure.

For Annual Plan purposes: Complete the annual outcome objective row for the State's five year targets for each measure.

Form 13 – Characteristics Documenting Family Participation in Children With Special Health Care Needs - This form will provide an idea of the characteristics documenting family participation in the care of children with potential or actual chronic and disabling conditions and their families.

Form 14 - List of MCH Priority Needs - Basically, this form will provide a summary of the 5 year Statewide needs assessment. Use information about the health status of the MCH population gathered as a result of the 5 year needs assessment. Condense this data into a summary of the State's top 7 to 10 needs and place them on this form. Use a simple phrase, such as: "The infant mortality rate for minorities should be reduced," or, "To reduce the barriers to the delivery of care for pregnant women." Each of the three population groups should be covered by the State's selected priorities. The Title V information system will record up to 10 priority needs, but the State may list and describe more if desired in a form note.

Form 15 - Technical Assistance (TA) Request Form - A preliminary listing of the State's technical assistance needs for the next fiscal year. This form's purpose is mainly to develop discussion areas that reviewers and State staff may use to determine ongoing TA needs.

Form 16 - State Performance/Outcome Measure Detail Sheet - Contains the details of all the data elements that make up the State Performance and Outcome Measures. These data elements are: title, service level category (direct health services, enabling services, population-based services, or capacity/infrastructure), goal, measure, definition, Healthy People 2010 objective, data source and data issues, and a description of the measure's significance.

For State Performance Measures: These Detail Sheet forms are identical in format to the National Performance Measures Detail Sheets. They should be completed in that format and with terminology similar to that found in the National Measures Detail Sheets. For these State Performance Measure Detail Sheets it is important to include as much detail as can be determined for all of the data elements. When a Form 16 Detail Sheet is completed for each of the State Performance Measures, the title of that measure will be automatically added to Table 4b, and Form 11. It is recognized

that the assignment of service level (of the MCH pyramid) is a matter of judgment and should be chosen by the primary category of program activities planned to meet the measure during the next 5 years.

For the State Outcome Measure: Each State may also develop one additional State Outcome Measure. Use Form 16 to enumerate the details of the measure in the same manner as described for the State Performance Measures above.

For both National and State measures: Footnotes containing additional explanatory material may be added to the Detail Sheets to enhance understanding or highlight special conditions or concerns within the State. This is important since all of the National Performance and Outcome Measures have been and will continue to be, a "work in progress" and, taken together, the conditions and concerns represent various developmental stages from the recommendations on data collection methods, to the collection of baseline information that may lead to the development of more sophisticated performance measurements.

Form 17 – Health System Capacity Indicators – Reporting/Tracking Forms for HSCIs 01, 02, 03, 04, 07 & 08 –

Form 18 – Health Systems Capacity Indicators –Reporting/Tracking Forms for HSCIs 05 and 06 –

Form 19 – Health Systems Capacity Indicators – Reporting/Tracking Forms for HSCIs 09A and B -

Form 20 – Health Status Indicators #01 - #05

Form 21—Health Status Indicators #06 - #12

FORMS

APPLICATION FOR FEDERAL ASSISTANCE
0043

OMB Approval No. 0348-

		2. DATE SUBMITTED	**Applicant Identifier**
1. TYPE OF SUBMISSION:		3. **DATE RECEIVED BY STATE**	**State Application Identifier**
Application	***Pre-application***		
☐ Construction	☐ Construction	4. **DATE RECEIVED BY FEDERAL AGENCY**	**FEDERAL IDENTIFIER**
☐ Non-Construction	☐ Non-Construction		

5. **APPLICANT INFORMATION**

Legal Name:	**Organizational Unit:**
Address ***(give city, county, state, and zip code)***	**Name and telephone number of the person to be contacted on matters involving this application** ***(give area code)***

6. EMPLOYER IDENTIFICATION NUMBER (EIN):

7. TYPE OF APPLICANT: ***(Enter appropriate letter in box)***

A. State
B. County
C. Municipal
D. Township
E. Interstate
F. Intermunicipal
G. Special District
H. Independent School District
I. State Controlled Institution of Higher Learning
J. Private University
K. Indian Tribe
L. Individual
M. Profit Organization
N. Other (Specify) _____

8. TYPE OF APPLICATION:

☐ **New** ☐ **Continuation** ☐ **Revision**

If Revision, enter appropriate letter(s) in box (es) ☐ ☐

A. Increase Award B. Decrease Award C. Increase Duration
Decrease Duration Other *(specify):*

_____

9. NAME OF FEDERAL AGENCY:

10. **CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:**

TITLE:

11. **DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:**

12. **AREAS AFFECTED BY PROJECT** ***(cities, counties, states, etc.)***

13. PROPOSED PROJECT:		**14. CONGRESSIONAL DISTRICTS OF:**	
Start Date	**Ending Date**	**a. Applicant**	**b. Project**

15. ESTIMATED FUNDING:		
a. Federal	$	.00
b. Applicant	$	.00
c. State	$	.00
d. Local	$	.00
e. Other	$	.00
f. Program Income	$	.00
g. TOTAL	$	.00

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. YES, THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12373 PROCESS FOR REVIEW ON

DATE _____

b. NO ☐ **PROGRAM IS NOT COVERED BY E.O. 12372**

☐ **OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW**

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT

☐ **Yes If "Yes", attach an explanation** ☐ **No**

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a. Typed Name of Authorized Representative	**b. Title**	**c. Telephone number**
d. Signature of Authorized Representative		**e. Date Signed**

Previous Editions Not Usable

Standard Form 424 (REV. 4-88)
Prescribed by OMB A-102

INSTRUCTIONS FOR THE SF 424

This is a standard form used by applicants as a required facesheet for the pre-applications and applications submitted for Federal Assistance. It will be used by Federal agencies to obtain applicant certification that States which have established a review and government procedure in response to Executive Order 12372 and have selected the program to be included in their process, have been given an opportunity to review the applicant's submission.

Item:	Entry:
1.	Self-explanatory
2.	Date application
3.	State use only (if applicable).
4.	If this application is to continue or revise an existing award, enter present Federal identifier number. If for a new project, leave blank.
5.	Legal of applicant, name of primary organizational unit which will undertake the assistance activity, complete address of the applicant, and name and telephone number of the person to contract on matters related to this application.
6.	Enter Employer Identification Number (EIN) as assigned by the Internal Revenue Service.
7.	Enter the appropriate letter in the space provided.
8.	Check the appropriate box and enter appropriate letter(s) in the space(s) provided: - "New" means a new assistance award - "Continuation" means an extension for an additional funding/budget period for a project with a projected completion date. - "Revision" means any change in the Federal Government's financial obligation or contingent liability from an existing obligation.
9.	Name of Federal agency from which assistance is being requested with this application.
10.	Use the Catalog of Federal Domestic Assistance number and title of the program under which assistance is requested.
11.	Enter a brief descriptive title of the project, if more than one program is involved, you should append an explanation on a separate sheet. If appropriate (e.g., construction or real property projects), attach a map showing project location. For pre-applications, use a separate sheet to provide a summary description of this project.
12.	List only the largest political entities affected (e.g., State, counties
13.	Self-explanatory
14.	List the applicant's Congressional District and Districts affected by the program or project.
15.	Amount requested or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines as applicable. If the action will result in a dollar change to an existing award, indicate *only* the amount of the change. For decreases, enclose the amounts in parenthesis. If both basic and supplemental amounts are included, show breakdown on an attached sheet. For multiple program funding, use totals and show breakdown using same categories as in Item 15.
16.	Applicants should contact the State Single Point of Contact (SPOC) for Federal Executive Order 12372 to determine whether the application is subject to the State intergovernmental review process.
17.	This question applies to the applicant organization, not the person who signs as the authorized representative. Categories of debt include delinquent audit disallowances, loans and taxes.
18.	To be signed by the authorized representative of the applicant. A copy of the governing body's authorization for you to sign this application as official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)

INSTRUCTIONS FOR THE COMPLETION OF FORM 1

APPLICATION FACE SHEET (STANDARD FORM 424)

The Application Face Sheet (SF424) is not subject to revision; it is an OMB standard form that can be revised by OMB only. The Form should be filled out in accordance with the standard instructions that accompany it. However, in order for the SF424 to serve MCHB purposes, the sub-groupings of funding categories under Section 15 will be defined as follows:

15. Estimated Funding:

a. Federal -	The Title V MCH Block grant allocation only.
b. Applicant -	The unobligated balance from previous year's MCH Block Grant allocation.
c. State -	Total State funds. The State's total matching funds plus overmatch for the Title V Allocation.
d. Local -	Total of MCH dedicated funds from local jurisdictions within the State.
e. Other -	Foundation and other public and private and non-profit monies, used for Title V programs.
f. Program Income -	Funds collected by State MCH agencies from insurance payments, Medicaid, HMOs, etc.
g. TOTAL -	ALL the MCH funds administered by the State MCH program.

FORM 2

MCH BUDGET DETAILS FOR FY ____

[Secs.504(d) and 505(a)(3)(4)]

1. FEDERAL ALLOCATION $_____

(Item 15a of the Application Face Sheet [SF 424]
Of the Federal Allocation (1 above), the amount earmarked for:

A. Preventive and primary care for children:
$_____ (_____%)

B. Children with special health care needs:
$_____ (_____%)
(If either A or B is less than 30%, a waiver request must accompany the application) [Sec. 505(a)(3)]

C. Title V administrative costs:
$_____(_____%)
(The above figure cannot be more than 10% [Sec. 504(d)]

2. UNOBLIGATED BALANCE (Item 15b of SF 424) $_____

3. STATE MCH FUNDS
(Item 15c of SF 424) $_____

4. LOCAL MCH FUNDS (Item 15d of SF424) $_____

5. OTHER FUNDS (Item 15e of the SF 424) $_____

6. PROGRAM INCOME (Item 15f of SF 424) $_____

7. TOTAL STATE MATCH (Lines 3 through 6)
(Enter below your State=s FY1989 Maintenance of Effort Amount) $_____
$_____

8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP (SUBTOTAL) $_____
(Total lines 1 through 6. Same as line 15g of SF 424)

9. OTHER FEDERAL FUNDS
(Funds under the control of the person responsible for the administration of the Title V program)

a. SPRANS: $_____
b. SSDI: $_____
c. CISS: $_____
d. Abstinence Education $_____
e. Healthy Start: $_____
f. EMSC: $_____
g. WIC: $_____
h. AIDS: $_____
i. CDC: $_____
j. Education: $_____
k. Other: _____$_____
_____$_____
_____$_____
_____$_____

10. OTHER FEDERAL FUNDS (SUBTOTAL of all funds under item 9) $_____

11. STATE MCH BUDGET GRAND TOTAL $_____
(Partnership subtotal + Other Federal MCH Funds subtotal)

INSTRUCTIONS FOR COMPLETION OF FORM 2
MCH BUDGET DETAILS FOR FY ____

Title V Citation: Section 504(d) states: "Of the amounts paid to a State...not more than 10 percent may be used for administering the fund paid...@ In order to be entitled to payments for allotments under Title V, Section 505(a)(3) provides that the State will use: "(A) at least 30 percent of such payment amounts for preventive and primary care services for children, and (B) at least 30 percent of such payment amounts for services to children with special health care needs.@ Section 505(a)(4) provides that "a State receiving funds for maternal and child health services...shall maintain the level of funds being provided solely by such State for maternal and child health programs at a level at least equal to the level that such State provided for such programs in fiscal year 1989...@

Instructions: A glossary of terms is presented in Part Two, Section VIII of this document.

This form provides details of the State=s MCH budget and the fulfillment of certain spending requirements under Title V for a given year.

Line 1. Enter the amount of the Federal Title V allocation. This is to be the same figure that appears in line 15a of the AFS (SF 424) and in the "Budgeted" column of line 1 of Form 3 (for the appropriate year).

Line 1A. Enter the amount of the Federal allotment your State is budgeting for preventive and primary care for children and enter the percentage of the total (Line 1) this amount represents.

Line 1B. Enter the amount of the Federal allotment your State is budgeting for children with special health care needs and enter the percentage of the total (Line 1) this amount represents.

Line 1C. Enter the amount of the Federal allotment your State is budgeting for the administration of the allotment and enter the percentage of the total (Line 1) this amount represents.

Line 2. Enter the amount of carryover from the previous year=s MCH Block Grant Allocation (the unobligated balance). This is to be the same figure that appears in line 15b of the AFS (SF 424) and in the "Budgeted" column of line 2 of Form 3 (for the appropriate year).

Line 3. Enter the amount of your State total funds for the Title V allocation (match). This is to be the same figure that appears in line 15c of the AFS (SF 424) and in the "Budgeted" column of line 3 of Form 3 (for the appropriate year).

Line 4. Enter the amount of total MCH dedicated funds garnered from local jurisdictions within your State. This is to be the same figure that appears in line 15d of the AFS (SF 424) and in the "Budgeted" column of line 4 of Form 3 (for the appropriate year).

Line 5. Enter the total of MCH funds available from other sources such as foundations. This is to be the same figure that appears in line 15e of the AFS (SF 424) and in the "Budgeted" column of line 5 of Form 3 (for the appropriate year).

Line 6. Enter the amount of MCH program income funds collected by your State=s MCH agencies from insurance payments, MEDICAID, HMO=s, etc. This is to be the same figure that appears in line 15f of the AFS (SF 424) and in the "Budgeted" column of line 6 of Form 3 (for the appropriate year).

Line 7. Enter the sum total of Lines 3, 4, 5, and 6 for the total of your State match and overmatch.

Line 7A. Enter your State=s FY 1989 Maintenance of Effort amount.

Line 8. Enter the amount of the total of lines 1, 2, and 7. This is the "Federal-State Title V Block Grant "Partnership" and is to be the same figure that appears in line 15g of SF 424 and in the "Budgeted" column of line 7 of Form 3.

Line 9. On the appropriate lines (a through k) enter Federal funds **other** than the Title V Block Grant that are under the control of the person responsible for the administration of the Title V program. If line 8k is utilized, specify the source(s) of the funds in the order of the amount provided starting with the source of the most funds. If more than two lines are required, add a footnote at the bottom of the page showing additional sources and amounts.

Line 10. Enter the sum of all Lines in item 9. This is to be the same figure that appears in the "Budgeted" column of line 8 of Form 3 (for the appropriate year).

Line 11. Enter the sum of lines 7 and 10. This is the total of all MCH funds administered by your State=s MCH program and is to be the same figure that appears in the "Budgeted" column of line 9 of Form 3 (for the appropriate year)

FORM 3
STATE MCH FUNDING PROFILE
[Secs. 505(a) and 506((a)(I-3)]

	FY 2004		FY 2005		FY 2006		FY 2007		FY 2008	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation										
(Line 1, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
2. Unobligated Balance										
(Line 2, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
3. State Funds										
(Line 3, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
4. Local MCH Funds										
(Line 4, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
5. Other Funds										
(Line 5, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
6. Program Income										
(Line 6, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
7. **SUBTOTAL**										
(Line 8, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____

(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)

8. Other Federal Funds										
(Line 10, Form 2	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
9. **TOTAL**										
(*Line 11, Form 2)*	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____

(STATE MCH BUDGET TOTAL)

FORM 3
STATE MCH FUNDING PROFILE
[Secs. 505(a) and 506((a)(I-3)]

	FY 2009		FY 2010		FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation										
(Line 1, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
2. Unobligated Balance										
(Line 2, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
3. State Funds										
(Line 3, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
4. Local MCH Funds										
(Line 4, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
5. Other Funds										
(Line 5, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
6. Program Income										
(Line 6, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
7. **SUBTOTAL**										
(Line 8, Form 2)	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____

(THE FEDERAL-STATE TITLE BLOCK GRANT PARTNERSHIP)

8. Other Federal Funds										
(Line 10, Form 2	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
9. **TOTAL**										
(*Line 11, Form 2)*	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____

(STATE MCH BUDGET TOTAL)

INSTRUCTIONS FOR THE COMPLETION OF FORM 3
STATE MCH FUNDING PROFILE

Title V Citation: Section 505(a) states, in part: "In order to be entitled to payments for allotments...a State must prepare and transmit to the Secretary an application (in a standard form specified by the Secretary)...". The columns labeled "Budgeted" on this form are intended to partially fulfill the Secretary's application requirements.

Section 506(a)(1-3) describe the annual reporting requirements that A...each State shall prepare and submit to the Secretary annual reports on its activities under this title."

Instructions: A glossary of terms applicable to this form is presented in Part Two, Section VIII of this document.

Complete all required data cells. If an actual number is not available, make an estimate. Please explain all estimates in a footnote.

The form is intended to provide "at a glance" funding data on the estimated budgeted amounts and actual expended amounts of a State's MCH program. For each fiscal year, the lines under the columns labeled "Budgeted" are to contain the same figures (for that year) that appear in section 15 of Application Face Sheet (SF 424) for that year. Lines 1 through 7 are also to contain the same figures (for the applicable year) as lines 1 through 6 and 8 of Form 2, and Line 8 is to contain the same figure as Line 10 of Form 2, and Line 9 is to contain the same figure as Line 11 of Form 2. The lines under the columns labeled "Expended" are to contain the actual amounts expended for the applicable year.

FORM 4
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (1) AND SOURCES OF OTHER FEDERAL FUNDS (II)
[Secs 506(2)(2)(iv)

	FY 2006		FY 2007	
I. Federal-State MCH Block Grant Partnership	Budgeted	Expended	Budgeted	Expended
a. Pregnant Women	$_____	$_____	$_____	$_____
b. Infants < 1 year old	$_____	$_____	$_____	$_____
c. Children 1 to 22 years old	$_____	$_____	$_____	$_____
d. CSHCN	$_____	$_____	$_____	$_____
e. All Others	$_____	$_____	$_____	$_____
f. Administration	$_____	$_____	$_____	$_____
g. **SUBTOTAL**	$_____ (Line 8 and Line 7, Form 3)	$_____ (Line 7, Form 3)	$_____ (Line 8 and Line 7, Form 3)	$_____ (Line 7, Form 3)

II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).

a. SPRANS	$_____	$_____
b. SSDI	$_____	$_____
c. CISS	$_____	$_____
d. Abstinence Education	$_____	$_____
e. Healthy Start	$_____	$_____
f. EMSC	$_____	$_____
g. WIC	$_____	$_____
h. AIDS	$_____	$_____
i. CDC	$_____	$_____
j. Education	$_____	$_____
k. Other:	$_____	
_____ (Specify)		$_____
_____ (Specify)	$_____	$_____
_____ (Specify)	$_____	$_____
_____ (Specify)	$_____	$_____
III. SUBTOTAL	$_____ (Line 10, Form 2 and Line 8, Form 3)	$_____ (Line 10, Form 2 and Line 8, Form 3

FORM 4 (Continuation Page)
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (1) AND
SOURCES OF OTHER FEDERAL FUNDS (II)
[Secs 506(2)(2)(iv)

FY 2008		FY 2009		FY 2010	
Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
$_________	$_________	$_________	$_________	$_________	$_________
$_________	$_________	$_________	$_________	$_________	$_________
$_________	$_________	$_________	$_________	$_________	$_________
$_________	$_________	$_________	$_________	$_________	$_________
$_________	$_________	$_________	$_________	$_________	$_________
$_________ (Line 7 & Line 8, Form 3)	$_________ (Line 7, Form 3)	$_________ (Line 7 & Line 8, Form 3)	$_________ (Line 7, Form 3)	$_________ (Line 7 & Line 8, Form 3)	$_________ (Line 7, Form 3)

$____________	$____________	$____________
$____________	$____________	$____________
$____________	$____________	$____________
$____________	$____________	$____________
$____________	$____________	$____________
$____________	$____________	$____________
$____________	$____________	$____________
$____________	$____________	$____________
$____________	$____________	$____________
$____________	$____________	$____________
$____________	$____________	$____________
$_________	$_________	$________
$_________	$_________	$_________
$_________	$_________	$_________
$___________ (Line 10, Form 2 and Line8, Form 3)	$__________ (Line 9, Form 2 and Line 8, Form 3)	$___________ (Line 10, Form 2 and Line 8, Form 3)

FORM 4 (Continuation Page)
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (1) AND SOURCES OF OTHER FEDERAL FUNDS (II)
[Secs 506(2)(2)(iv)

FY 2011		FY 2012		FY 2013	
Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
(Line 8 and Line 7, Form 3)	(Line 7, Form 3)	(Line 8 and Line 7, Form 3)	(Line 7, Form 3)	(Line 8 and Line 7, Form 3)	(Line 7, Form 3)

$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
$_____	$_____	$_____
(Line 10, Form 2 and Line8, Form 3)	(Line 9, Form 2 and Line 8, Form 3)	(Line 10, Form 2 and Line 8, Form 3)

INSTRUCTIONS FOR COMPLETION OF FORM 4
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED (I) AND
SOURCES OF OTHER FEDERAL FUNDS (II)

Title V Citation: Section 506(a)(2)(iv) requires that each State submit an annual report of its activities under its Title V program. Among the items required to be reported are, "...the amount spent under this title...by class of individuals served."

Instructions: A glossary of terms applicable to the terms used in this form is provided in Part Two, Section VIII of this document.

Complete all required data cells. If an actual number is not available make an estimate. Please explain all estimates in a footnote.

Lines I(a) through I(f) - enter the budgeted and expended amounts for the appropriate fiscal year.

Line I(g) - enter the sum of the figures of lines I(a) through (f). Note that for the "Budgeted" columns this figure is to be the same figure that appears in the "Budgeted" column of Line 8, Form 2, and in Line 7, Form 3, and for the "Expended" column this is the same figure that appears in the "Expended" columns of Line 7, Form 3.

Lines II(a) through II(k) - enter the budgeted amounts for the appropriate fiscal year. Note that these figures are to be the same figures that appear in the "Budgeted" columns of lines 9(a) through (k) of Form 2.

Line III - enter the sum of the figures of lines II(a) through (k). Note that this figure is to be the same figure that appears in Line 10, Form 2, and in the "Budgeted" column of Line 8, Form 3.

FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES
BY TYPES OF SERVICES
[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

		FY 2006		FY 2007	
	TYPES OF SERVICES	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I.	**Direct Health Care Services** (Basic Health Services and Health Services for CSHCN.)	$_____	$_____	$_____	$_____
II.	**Enabling Services** (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC, and Education.)	$_____	$_____	$_____	$_____
III.	**Population-Based Services** (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	$_____	$_____	$_____	$_____
IV.	**Infrastructure Building Services** (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	$_____	$_____	$_____	$_____
V.	**FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP TOTAL** (Federal-State Partnership only. Item 15g of SF 424. For the "Budget" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7 Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.)	$_____	$_____	$_____	$_____

FORM 5 (Continuation Page)
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES
BY TYPES OF SERVICES
[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

FY 2008		FY 2009		FY 2010	
Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____

FORM 5 (Continuation Page)
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES
BY TYPES OF SERVICES
[Secs. 505(a)(2)(A-B) and 506(a)(1)(A-D)]

FY 2011		FY 2012		FY 2013	
Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____
$_____	$_____	$_____	$_____	$_____	$_____

INSTRUCTIONS FOR THE COMPLETION OF FORM 5
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

Title V Citation: Section 505(a)(2)(A)(B) and (B)(iii) states, in part, "In order to be entitled to payments for allotments...a State must prepare and transmit to the Secretary an application...that - includes for each fiscal year (A) a plan for meeting the needs identified by the state-wide needs assessment...and (B) a description of how funds allotted to the State...will be used for the provision and coordination of services to carry out such a plan that shall include - [(B)(iii)] an identification of the types of services to be provided..." Section 506(a)(1)(A-D) states, "Each State shall prepare and submit to the Secretary annual reports on its activities under this title. Each such report shall be prepared by, or in consultation with, the State maternal and child health agency. In order to properly evaluate and to compare the performance of different States assisted under this title and to assure the proper expenditure of funds under this title, such reports shall be in such standardized form and contain such information...as the Secretary determines...to be necessary (A) to secure an accurate description of those activities, (B) to secure a complete record of the purposes for which funds were spent, of the recipients of such funds, (C) to describe the extent to which the State has met the goals and objectives it set forth...and the national health objectives...and (D) to determine the extent to which funds were expended consistent with the State's application..."

Instructions: A Glossary of terms applicable to the terms used in this form contained in Part Two, Section VIII of this document.

For reference see Figure 1, "Core Public Health Services Delivered by MCH Agencies."

Complete all required data cells. If an actual number is not available, make an estimate. Please explain all estimates in a footnote. Administrative dollars should be allocated to the appropriate level(s) of the pyramid on the lines below. If an estimate is necessary, one method would be to allocate those dollars at the same percentage as program dollars.

Line I. Direct Health Care Services - enter the budgeted and expended amounts for the appropriate fiscal year.

Line II. Enabling Services - enter the budgeted and expended amounts for the appropriate fiscal year.

Line III. Population-Based Services - enter the budgeted and expended amounts for the appropriate fiscal year.

Line IV. Infrastructure Building Services - enter the budgeted and expended amounts for the appropriate fiscal year.

Line V. Total Federal-State Partnership Budget and Expenditures - enter the totals of the budgeted and expended figures shown in lines I through IV for the appropriate fiscal year. Federal-State Partnership only; item 15g of the SF 424. For the "Budgeted" columns this is the same figure that appears in Line 8, Form 2, and in the "Budgeted" columns of Line 7, Form 3. For the "Expended" columns this is the same figure that appears in the "Expended" columns of Line 7, Form 3.

FORM 6
NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED
Sect. 506(a)(2)(B)(iii)

Total Births by Occurrence:_____ **Reporting Year:_____**

Type of Screening Tests	**(A) Receiving at least one Screen(1)** No.	%	**(B) No. Presumptive Positive Screens**	**(C) No. Confirmed Cases(2)**	**(D) Needing Treatment that Received Treatment(3)** No.	%
Phenylketonuria (Classical)						
Congenital Hypothyroidism (Primary)						
Galactosemia (Classical)						
Sickle Cell Disease						
Other Screening (Specify) 1)						
2)						
3)						
4)						
5)						
6)						
Screening Programs for Older Children & Women (Specify Tests by name)						

(1) Use occurrent births as denominator.
(2) Report only those from resident births.
(3) Use number of confirmed cases as denominator.

INSTRUCTIONS FOR THE COMPLETION OF FORM 6
NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED

Title V citation: Section 506(a)(2)(B)(iii) requires each State to submit an annual report on its activities under Title V. Included in this requirement is the following (iii) "... information on such other indicators of maternal, infant, and child health care status as the Secretary may specify."

Instructions: A glossary of terms applicable to this form is presented in Part Two, Section VIII of this document.

Complete all required data cells. If an actual number is not available, make an estimate. Please explain all estimates in a footnote.

1. At the top of the form, on the lines "Total Births by Occurrence" and "Reporting Year" enter the total number of occurrent births for your State and the year for which the data applies. Total births by occurrence is to be defined as all births that occur in the State regardless of residency. Use the umber submitted by vital records to the National Center for Health Statistics. The reporting year is to be defined as calendar year, Jan. 1 – Dec. 31. Please note that the "Total Births..." figure is related to the "Total infants < 1 year of age" row in Form 7, and the "TOTAL INFANTS IN STATE" row in section I of Form 8. While these figures are not expected to match, they should show a fairly close relationship to each other.

2. In column A, for all screening tests listed, enter the number and percentage of occurrent births that received one of the tests indicated. Percentage is to be based on occurrent births receiving one test out of the total listed at the top of the form.

3. In column B, enter the number of presumptive positive screens.

4. In column C, enter the number of confirmed cases discovered. Use only those from resident births.

5. In column D, enter the number and percent of those confirmed cases needing and receiving treatment. Use confirmed cases as the denominator.

6. Under "Other Screening" enter the specific names of any other screens not listed and then complete columns A through D. Other tests may include, but are not limited to: homocystinuria, biotinidase deficiency, and maple syrup urine disease.

7. Under "Screening Programs for Older Children and Women," enter the specific names of any screening tests specific to those populations and then complete columns A through D. Note that the % (percentage) portion of column A is <u>not</u> to be completed since the denominator of Total Births by Occurrence does not apply.

All States now require screening for at least 2 disorders, and the four most common tests are specifically noted on the form, with room to write in other tests. All tests which are done during the reporting year should be listed along with the numbers screened and followed.

Follow-up is based on State activity; therefore, use resident live births for confirmed cases. For those needing treatment use confirmed cases as the denominator. If the program continues to monitor older children or adults for any of these conditions, these should be reported in the row labeled <u>Screening Programs for Older Children and Women</u>.

FORM 7
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V
(By class of Individuals and Percent of Health Coverage)
[Sec. 506(a)(2)(A)(i-ii)]

Reporting Year_____

	(A)	(B)	(C)	(D)	(E)	(F)
	TITLE V	PRIMARY SOURCE OF COVERAGE				
		Title XIX	Title XXI	Private/Other	None	Unknown
Type of Individuals Served	Total Served	%	%	%	%	%
Pregnant Women						
Infants < 1 year of age						
Children 1 to 22 years of age						
Children with Special Health Care Needs						
Others						
Total						

INSTRUCTIONS FOR THE COMPLETION OF FORM 7
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) UNDER TITLE V
[Sec. 506(a)(2)(A)(i-ii)]

Title V citation: [Sec. 506(a)(2)(A)(i-ii)] requires each State to submit an annual report on its activities under Title V. Included in this requirement is the following: "(2) Each annual report...shall include the following information: (A)(i) The number of individuals served by the State under the title (by class of individuals). (ii) The proportion of each class of such individuals which has health coverage."

Instructions: A glossary of terms applicable to this form is presented in Part Two, Section VIII of this document.

Complete all required data cells. If an actual number is not available, make an estimate. Please explain all estimates in a footnote.

1. At the top of the Form, on the Line "Reporting Year", enter the year for which the data applies.

2. In column (A) enter the unduplicated count of individuals who received a direct service (in person, by phone) from the Title V program regardless of the primary source of coverage. These services would generally be included in the top three levels of the MCH pyramid (the fourth, or base level, would generally not contain direct services) and would include individuals served by total dollars reported on line 8 of Form 2, and may include individuals served by dollars reported on Line 9 of Form 2.

   Please note that the figure in the "Title V Total Served" column of the "Infants < 1 year of age" row is related to the "Total Births by Occurrence" line in Form 6, and the "TOTAL INFANTS IN STATE" row in section I of Form 8. While these figures are not expected to match, they should show a fairly close relationship to each other.

3. In the following columns report by the class of individuals served by the Title V program the percentage of those who have as their primary source of coverage either:

   Column B: Title XIX (includes Medicaid expansion under Title XXI)

   Column C: Title XXI
   Column D: Other (public or private) coverage
   Column E: None
   Column F: Unknown

   These may be estimates. If individuals are covered by more than one source, they should be listed under the column of their primary source.

FORM 8
DELIVERIES AND INFANTS SERVED BY TITLE V
AND ENTITLED TO BENEFITS UNDER TITLE XIX
(By Race and Ethnicity)
[Sec. 506(a)(2)(C-D])

Reporting Year:_____

I. UNDUPLICATED COUNT BY RACE

	(A) TOTAL ALL RACES	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More Than One Race Reported	(H) Other & Unknown
TOTAL DELIVERIES IN STATE								
TITLE V SERVED								
ELIGIBLE FOR TITLE XIX								
TOTAL INFANTS IN STATE								
TITLE V SERVED								
ELIGIBLE FOR TITLE XIX								

II. UNDUPLICATED COUNT BY ETHNICITY

	(A) TOTAL NOT Hispanic or Latino	(B) TOTAL Hispanic or Latino	(C) Ethnicity Not Reported	HISPANIC OR LATINO (Sub-categories by country or area of origin)				
				(B.1) Mexican	(B.2) Cuban	(B.3) Puerto Rican	(B.4) Central and South American	(B.5) Other and Unknown
TOTAL DELIVERIES IN STATE								
TITLE V SERVED								
ELIGIBLE FOR TITLE XIX								
TOTAL INFANTS IN STATE								
TITLE V SERVED								
ELIGIBLE FOR TITLE XIX								

INSTRUCTIONS FOR THE COMPLETION OF FORM 8
DELIVERIES AND INFANTS SERVED BY TITLE V
AND ENTITLED TO BENEFITS UNDER TITLE XIX

Title V Citation: Section 506 (a)(2)(C-D) requires each State to submit an annual report on its activities under Title V. Included in this requirement is the following:

(C) "Information (by racial and ethnic group) on--
- (i) the number of deliveries in the State in the year, and
- (ii) the number of such deliveries to pregnant women who were provided prenatal, delivery, or postpartum care under this title or were entitled to benefits with respect to such deliveries under the State plan under title XIX in the year.

(D) Information (by racial and ethnic group) on--
- (i) the number of infants under one year of age who were in the State in the year, and
- (ii) the number of such infants who were provided services under this title or were entitled to benefits under the State plan under title XIX at any time during the year."

Instructions: A glossary of terms applicable to this form is presented in Part Two, Section VIII of this document.

At the top of the form, on the line "Reporting Year," enter the year for which the data applies. The same "Reporting Year" is to be used for both parts I and II of this form.

Complete all required data cells. If an actual number is not available, make an estimate. Please explain all estimates in a footnote.

Section I:

"Total Deliveries in State" - In column A enter the number for the population-based total of all deliveries in the State for the reporting year eligible for Title XIX who were provided delivery of services in the reporting year. For columns B-H enter the number of individuals who were eligible by race. In column A, for "Total infants in State," enter the number of infants who were eligible for Title XIX during the reporting year. (Please note that this figure is related to the "Total Births by Occurrence" line in Form 6, and the "Total infants < 1 year of age" row in Form 7. While these figures are not expected to match, they should show a fairly close relationship to each other). For columns B-H enter the number of infants who were eligible by race.

Section II

States without a significant Hispanic or Latino population should report only Hispanic or Latino, Not Hispanic or Latino, or Ethnicity Not Reported categories in columns A through C. States with a significant Hispanic or Latino population are encouraged to report subcategories by country or area of origin in columns B.1 through B.5. If these columns are used, the total of the populations reported in those columns must equal the population figure in column B.

There will be overlap between the figures listed for "Title V Served" and "Eligible for Title XIX," because this form asks for all individuals served by Title V and an estimate of all those in the State eligible for Title XIX. The form does not ask for a report on those served by Title V who are also eligible for Title XIX.

FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM
[Secs. 505(a)(5)(E) and 509(a)(8)]

STATE: _____

	FY____	FY ____	FY ____	FY ____	FY ____
1. State MCH Toll-Free "Hotline" Telephone Number	_____	_____	_____	_____	_____
2. State MCH Toll-Free "Hotline" Name	_____	_____	_____	_____	_____
3. Name of Contact Person for State MCH "Hotline"	_____	_____	_____	_____	_____
4. Contact Person's Telephone Number	_____	_____	_____	_____	_____
5. Number of calls received On the State MCH "Hotline" This reporting period	_____	_____	_____	_____	_____

INSTRUCTIONS FOR THE COMPLETION OF FORM 9
STATE MCH TOLL-FREE TELEPHONE LINE DATA FORM

Title V citations: Section 505(a)(5)(E) and 509(a)(8) state, in part, "the State agency (or agencies) administering the State's program under this title will provide for a toll-free number (and other appropriate methods) for the use of parents to access information about health care providers and practitioners who provide health care services under this title and Title XIX and about other relevant health and health-related providers and practitioners..."

The Maternal and Child Health Bureau is the designee of the Secretary of the Department of Health and Human Services to carry out the mandate of Section 509(a)(8) of Title V, which requires that a national directory of toll-free numbers be made available to State agencies that administer the State's Title V programs.

Instructions: Complete all required data cells. If an actual number is not available for line 5, make an estimate. Please explain the estimate in a footnote.

1. On the line labeled "State" enter the name of your State.
2. At the top of the first column labeled "FY___" enter the appropriate reporting year and then, in each succeeding column to the right, enter the next year in chronological order.

For each year:

3. On line 1, enter your State's toll-free MCH information line telephone number.
4. On line 2, enter the name of your State's toll-free information line.
5. On line 3, enter the name of the person who should be contacted with any concerns about the toll-free line.
6. On line 4, enter the telephone number of the contact person listed on line 3.
7. On line 5, <u>for the reporting year only</u>, enter the number of calls your State's toll-free MCH information number received for the reporting period.

If your State has an additional toll-free telephone number administered by Title V that you wish to report, use an additional copy of this form. The first Form 9 should be for the primary MCH toll-free number for your State.

FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE FOR FY____
[Sec. 506(a)(1)]

STATE: _____

1. State MCH Administration:

Block Grant Funds

2. Federal Allocation (Line 1, Form 2) $_____
3. Unobligated balance (Line 2, Form 2) $_____
4. State Funds (Line 3, Form 2) $_____
5. Local MCH Funds (Line 4, Form 2) $_____
6. Other Funds (Line 5, Form 2) $_____
7. Program Income (Line 6, Form 2) $_____
8. **Total Federal-State Partnership (Line 8, Form 2)** **$_____**

9. Most significant providers receiving MCH funds: _____
_____
_____
_____
_____

10. Individuals served by the Title V Program (Col. A, Form 7)

a. Pregnant Women _____

b. Infants < 1 year old _____

c. Children 1 to 22 years old _____

d. CSHCN _____

e. Others _____

FORM 10 (Continued)
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE

11. Statewide Initiatives and Partnerships:
    a. Direct Medical Care and Enabling Services:

    b. Population-Based Services:

    c. Infrastructure Building Services:

12. The primary Title V Program contact person:

13. The children with special health care needs (CSHCN) contact person:

INSTRUCTIONS FOR THE COMPLETION OF FORM 10
TITLE V MATERNAL & CHILD HEALTH SERVICES BLOCK GRANT
STATE PROFILE

Title V Citation: Section 506(a)(1) states, in part, "Each State shall prepare and submit to the Secretary annual reports on its activities under this title. Each such report...shall be in such standardized form and contain such information...as the Secretary determines..."

(This summary information is extremely useful as a stand-alone document for those who don't have the time or desire to read the entire Block Grant Application/Annual Report).

Instructions: A glossary with definitions of terms used in this form is presented in Part Two, Section VIII of this document.

(While this is a "reporting" form certain future year(s) data, as specified in the instructions, will be required for its completion)

Fill in the appropriate fiscal year in the title of the form. Enter the name of your State on the line indicated.

Item 1. State which agency administers the Title V program and provide a brief summary of services included within Title V's administrative control.

Items 2-8. Complete the items for Block Grant Funds. These figures should correspond with figures that are shown on lines 1 through 6 and line 8 on Form 2.

Item 9. List a few of the most significant providers to the community and State receiving MCH funds for the provision of key MCH services.

Item 10. (Items a through e) - Enter the figures for the populations served by the Title V program. These figures should be the same as shown in Column A of Form 7.

Item 11. Complete 2 to 4 short (3 or 4 sentences) examples of statewide initiatives, public health activities, or community-based efforts for each level of the pyramid (6 to 12 examples total). These descriptions should include particularly successful programs or activities that were either provided directly, or coordinated by Title V. Begin each example with a brief title of the program activity followed by the description.

Item 12. Enter the name of the primary Title V program contact. Include title, address, telephone number, FAX number, e-mail address, and Title V program Web site address, if available.

Item 13. Enter the name of the primary CSHCN program contact. Include title, address, telephone number, FAX number, e-mail address, and CSHCN program Web site address, if available.

FORM 11
TRACKING PERFORMANCE MEASURES
[Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]

	Annual Objective and Performance Data				
PERFORMANCE MEASURE #1	FY__	**FY__**	**FY__**	**FY__**	**FY__**
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.					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #2					
The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive (CSHCN Survey)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #3	_____	_____	_____	_____	_____
The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES
[Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]

	Annual Objective and Performance Data				
PERFORMANCE MEASURE #4 *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*	FY__	**FY__**	**FY__**	**FY__**	**FY__**
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #5 *The 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)*					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #6 (Please refer to the instructions for this Performance Measure) *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey)*					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES
[Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]

	Annual Objective and Performance Data				
PERFORMANCE MEASURE #7	FY__	**FY__**	**FY__**	**FY__**	**FY__**
Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilis Influenza, Hepatitis B.					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #8					
The birth rate (per 1,000) for teenagers aged 15 through 17 years.					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #9					
Percent of third grade children who have received protective sealants on at least one permanent molar tooth.					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES
[Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]

	Annual Objective and Performance Data				
PERFORMANCE MEASURE #10	FY__	**FY__**	**FY__**	**FY__**	**FY__**
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 11					
The percent of mothers who breastfeed their infants at 6 months of age.					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #12					
Percentage of newborns who have been screened for hearing before hospital discharge.					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES
[Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]

	Annual Objective and Performance Data				
PERFORMANCE MEASURE #13	FY__	**FY__**	**FY__**	**FY__**	**FY__**
Percent of children without health insurance.					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
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.					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #15					
Percentage of women who smoke in the last three months of pregnancy.					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES
[Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]

	Annual Objective and Performance Data				
PERFORMANCE MEASURE #16 *The rate (per 100,000) of suicide deaths among youths aged 15-19.*	FY__	**FY__**	**FY__**	**FY__**	**FY__**
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #17 *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE #18 *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 11 (Continuation Page)
TRACKING PERFORMANCE MEASURES
[Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]

PERFORMANCE MEASURE #	**Annual Objective and Performance Data** FY__	**FY__**	**FY__**	**FY__**	**FY__**
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

INSTRUCTIONS FOR THE COMPLETION OF FORM 11
PERFORMANCE MEASURE TRACKING

Title V Citation: Section 505(a)(2)(B)(i & iii) requires the States to submit an application that includes, A...a statement of the goals and objectives consistent with the health status goals and national health objectives...for meeting the needs specified in the State plan...[and]...an identification of the types of services to be provided... "Section 506(a)(2)(A)(iii) requires the States to report annually on the A...type (as defined by the Secretary) of services provided under this title..."

General Instructions: A glossary of terms applicable to this form is presented in Part Two, Section VIII of this document.

Complete all required data cells. If an actual number is not available, make an estimate. Please explain all estimates in a footnote. If neither actual data nor an estimate can be provided, the State must provide a footnote that describes a time framed plan for providing the required data. In such cases the "Annual Performance Objective" and "Annual Performance Indicator," lines are to be left blank.

This form serves two purposes: to show performance measures with 5-year planned performance objective targets for the application, and performance "Annual Performance Indicator," values actually achieved each year for the annual report for each national and State "negotiated" performance measure.

Under the applicable "FY" heading, each State will complete the Annual Performance Objectives, the Annual Performance Indicators, and numerator and denominator data for each measure as described below under Specific Instructions. For State "negotiated" measures, enter these data on the form beginning with the first blank Performance Measure area under the national measure(s).

Specific Instructions:

Note: Because the CSHCN SLAITS Survey did not yield reliable State Estimates for NPM number 6, (except for Maine) the numbers shown on Form 11 for this NPM reflect only the National estimate. As a result, States are not required to set Performance Objectives for this Performance Measure. However, a State may set an objective if the State is using another data source. States are encouraged to discuss any activities related to this Performance Measure in the narrative for IV, D.

In the first available space under "Performance Measure" on the appropriate form, enter the brief title of the State performance measure that has been selected. The titles are to be numbered consecutively with notations of "SP 1, SP 2," etc. Titles are to be written exactly as they appear on Form 16, "State Performance/Outcome Measure Detail Sheet."

For both national and State measures, in the lines labeled "Annual Performance Objective" enter a numerical value for the target the State plans to meet for the next 5 years. These values may be expressed as a number, a rate, a percentage, or "yes - no."

For both national and State measures, in the lines labeled "Annual Performance Indicator," enter the numerical value that expresses the progress the State has made toward the accomplishment of the performance objective for the appropriate reporting year. Note that the indicator data are to go in the years column from which they were actually derived even if the data are a year behind the "reporting" year. This value is to be expressed in the same units as the performance objective: a number, a rate, a percentage, or a "yes - no."

If there are numerator and denominator data for the performance measures, enter those data on the appropriate lines for the appropriate fiscal year. If there are no numerator and denominator data leave these lines empty.

For each national and State measure, provide a footnote that identifies the data source for the measure.

Repeat this process for each performance measure. A continuation page is included. If the continuation page is used, be sure to enter the number for each listed performance measure.

VIIA - National Performance Measures Detail Sheets

01

PERFORMANCE MEASURE

The percent of screen positive newborns who received timely[1] follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

GOAL

To assure all screen positive newborns receive timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

DEFINITION

Numerator: The number of newborns screened and confirmed with condition(s) mandated by the State sponsored newborn screening program that received timely follow-up to definitive diagnosis and clinical management.

Denominator: The number of newborns screened and confirmed with condition(s) mandated by the State sponsored newborn screening program.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objectives 16.20: (Developmental) Ensure appropriate newborn bloodspot screening, follow-up testing, and referral to services.

Related to Objectives 16.21: (Developmental) Reduce hospitalization for life-threatening sepsis among children aged 4 years and under with sickling hemoglobinopathies.

DATA SOURCES and DATA ISSUES

Data supplied annually by each State to the National Newborn Screening and Genetic Resource Center.

SIGNIFICANCE

Screening programs for newborns and children have been shown to be cost-effective and successful and have been shown to prevent mortality and morbidity. Their success reflects the systems approach from early screening to appropriate early intervention and treatment.

---

1 Timely is defined by each State based on established National guidelines for the individual conditions.

02

PERFORMANCE MEASURE

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)

GOAL

To increase the number of families with CSHCN who partner in decision making and are satisfied with the services they receive.

DEFINITION

Numerator: The number of children with special health care needs in the State age 0 to 18 whose families report participating in decision making and being satisfied with the services they received during the reporting period.

Denominator: The number of children with special health care needs in the State age 0 to 18 during the reporting period.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.

DATA SOURCES and DATA ISSUES

The National CSHCN Survey provides State level data on the extent to which families perceive that their doctors make the family feel like a partner and the family is very satisfied with the overall care experience. If State uses another data source, please cite source.

SIGNIFICANCE

Family/professional partnerships have been: incorporated into the MCHB Block Grant Application, the MCHB strategic plan. The Omnibus Budget Reconciliation Act of 1989 (OBRA ’89) mandated that the States provide and promote family centered, community-based, coordinated care. Family satisfaction is also a crucial measure of system effectiveness.

03

PERFORMANCE MEASURE

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)

GOAL

To increase the number of children with special health care needs who have a medical home.

DEFINITION

Numerator: The percent of children with special health care needs in the State age 0 to 18 who have a medical home during the reporting period.

Denominator: The number of children with special health care needs in the State age 0 to 18 during the reporting period.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16.22: (Developmental): Increase the proportion of children with special health care needs who have access to a medical home.

DATA SOURCES and DATA ISSUES

The National CSHCN Survey will provide State and national level data on the extent to which families perceive that their child with a special health care need has access to a medical home. Indicators include having a regular doctor for routine and sick care: access to care that is coordinated with specialty care and community services; ease in obtaining referrals: and receipt of respectful and culturally competent care.

The National CSHCN Survey, conducted every four years, provides national and State estimates. If State uses another data source, please cite source.

SIGNIFICANCE

Providing primary care to children in a "medical home" is the standard of practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The MCHB uses the AAP definition of "medical home." (AAP Medical Home Policy Statement, presented in *Pediatrics*, Vol. 110 No. 1, July, 2002)

04

PERFORMANCE MEASURE

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)

GOAL

To increase the percent of children with special health care needs, age 0 to 18, with adequate insurance coverage for all the services they need.

DEFINITION

Numerator: Number of children with special health care needs in the State age 0 to 18 whose families perceive that they have adequate insurance coverage.

Denominator: Number of children with special health care needs in the State age 0 to 18 during the reporting period.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.

Related to Objective 1.1: Increase the proportion of persons with health insurance to 100 percent.

DATA SOURCES and DATA ISSUES

The National CSHCN Survey provides State level data on the percent of parents of children with special health care needs reporting private or public health insurance coverage, no gaps in coverage, coverage that meets their child's needs, reasonable out-of-pocket costs, access to needed providers, and lack of unmet needs due to health plan coverage.

The National CSHCN Survey, conducted every four years, provides national and State estimates.

SIGNIFICANCE

Children with special health care needs often require an amount and type of care beyond that required by typically developing children and are more likely to incur catastrophic expenses. This population of children and families often have disproportionately low incomes and, therefore, are at higher risk of being uninsured. Since children are more likely to obtain health care if they are insured, insurance coverage and the content of that coverage is an important indicator of access to care. Because children with special health care needs often require more and different services than typically developing children, under-insurance is a major factor in determining adequacy of coverage. Adequacy of insurance ensures comprehensive care, which in turn reduces emergency room visits, hospitalizations, and time lost from school/work.

05

PERFORMANCE MEASURE

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)

GOAL

To increase the number of families with CSHCN who have access to easy-to-use community-based service systems.

DEFINITION

Numerator:
The number of children with special health care needs in the State age 0 to 18 whose families report that community-based service systems are organized so they can use them easily.

Denominator:
The number of children with special health care needs in the Sate age 0 to 18 whose families report that community-based service systems are organized so they can use them easily.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.

DATA SOURCES and DATA ISSUES

The National CSHCN Survey provides State and national level data on the extent to which families perceive that services are organized for easy use.

The National CSHCN Survey, conducted every four years, provides national and State estimates.

SIGNIFICANCE

Families, service agencies and the Federal Interagency Coordinating Council (FICC) have identified major challenges confronting families in accessing coordinated health and related services that families need for their children with special health care needs. Differing eligibility criteria, duplication and gaps in services, inflexible funding streams and poor coordination among service agencies are concerns across most States. Addressing these issues will lead to more efficient use of public funds and reduced family stress.

06

PERFORMANCE MEASURE

The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey)

GOAL

To increase the percent of youth with special health care needs who have received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

DEFINITION

Numerator: Number of youth with special health care needs in the Sate 18 years of age and younger whose families perceive that they have received the services necessary to transition to adult health care, work, and independence.

Denominator: Number of youth with special health care needs in the State 18 years of age and younger during the reporting period.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.

DATA SOURCES and DATA ISSUES

The National CSHCN Survey provides State and level data on the percent of parents of children with special health care needs reporting that their child receives support in the transition to adult health care and vocational and career training. This survey, conducted every four years, provides National and State estimates.

SIGNIFICANCE

The transition of youth to adulthood has become a priority issue nationwide as evidenced by the President's "New Freedom Initiative: Delivering on the Promise" (March 2002). Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.

07

PERFORMANCE MEASURE

Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilis Influenza, and Hepatitis B.

GOAL

To avert all cases of vaccine-preventable morbidity and mortality in children.

DEFINITION

Numerator: Number of resident children who have received the complete immunization schedule for DTP/DTAP, OPV, measles, mumps, rubella (MMR), H. influenza, and hepatitis B before their second birthday. Complete immunization status is generally considered to be:

- 3 Hepatitis B
- 4 DtaP
- 3 Polio
- 1 MMR
- 3 Hib

Denominator: Number of resident children aged 2 years.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 14-24: Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for at least 5 years. Increase the proportion of children aged 19 through 35 months who received all recommended vaccines to 80 percent. (Baseline: 73 percent in 1998).

DATA SOURCES and DATA ISSUES

State Immunization Registry, CDC National Immunization Survey, State Vital Records, and Bureau of Census population estimates.

SIGNIFICANCE

Infectious diseases remain important causes of preventable illness in the United States despite significant reductions in incidence in the past 100 years. Vaccines are among the safest and most effective preventive measures.

08
PERFORMANCE MEASURE

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

GOAL

To lower the birth rate among teenagers, especially those age 15 through 17 years.

DEFINITION

Numerator: Number of live births to teenagers aged 15-17 years in the calendar year.

Denominator: Number of females aged 15 through 17 years in the calendar year.

Units: 1,000 **Text:** Rate per 1,000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 9-7. Reduce pregnancies among females aged 15-17 to no more than 46 per 1,000 females aged 15-17 years. (Baseline: 72 pregnancies per 1,000 females aged 15-17 years in 1995).

DATA SOURCES and DATA ISSUES

Vital records are the source of data on mother's age and births. Population records are available from the Census.

SIGNIFICANCE

DHHS is making lowering the rate of teen pregnancies (a major threat to healthy and productive lives) a priority goal in its strategic plan. Teen parenting is associated with the lack of high school completion and initiating a cycle of poverty for mothers.

09

PERFORMANCE MEASURE

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

GOAL

To prevent pit and fissure tooth decay (dental caries).

DEFINITION

Numerator: Number of third grade children who have a protective sealant on at least one permanent molar tooth.

Denominator: Number of third grade children in the State during the year.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 21.8: Increase the proportion of children who have received dental sealants on their molar teeth to 50 percent. (Baseline: 23 percent of children aged 8 years received sealants on their molars in the years 1988-94.)

DATA SOURCES and DATA ISSUES

This requires primary data collection, such as examination or screening of a representative sample of school children.

SIGNIFICANCE

Dental caries affects two-thirds of children by the time they are 15 years of age. Developmental irregularities, called pits and fissures, are the sites of 80-90% of childhood caries. Sealants selectively protect these vulnerable sites, which are found mostly in permanent molar teeth. Targeting sealants to those at greatest risk for caries has been shown to increase their cost-effectiveness. Although sealants have the potential to combine with fluorides to prevent almost all childhood tooth decay, they have been underutilized.

In addition to being an excellent service in preventing tooth decay, sealants may also be a surrogate indicator of dental access, oral health promotion and preventive activities, and a suitable means to assess the linkages that exist between the public and private services delivery system. Public managed sealant programs are usually school-based or school-linked and target under served children, thus providing entry to other services. It has been stated on several occasions that dental sealants are the oral health equivalent of immunization.

10
PERFORMANCE MEASURE

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

GOAL

To reduce the number of deaths to children aged 14 years old and younger caused by motor vehicle crashes.

DEFINITION

Numerator: Number of deaths to children aged 14 years and younger caused by motor vehicle crashes. This includes all occupant, pedestrian, motorcycle, bicycle, etc. deaths caused by motor vehicles.

Denominator: All children in the State aged 14 years and younger.

Units: 100,000 **Text:** Rate per 100,000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 15-15: Reduce deaths caused by motor vehicle crashes to 9.0 deaths per 100,000 population. (Baseline: 15 deaths per 100,000 population by motor vehicle crashes in 1998. Baseline for children aged 14 years and under, 4.2 deaths per 100,000 in 1998).

DATA SOURCES and DATA ISSUES

Fatal Accident Reporting System (FARS), U.S. Department of Transportation, and Vital Statistics Systems are sources of the data.

SIGNIFICANCE

About 50% of all deaths to children aged 14 years and younger are due to injuries, and around 80% of these are from motor vehicle crashes. Injuries are the leading cause of mortality in this age group and they are the most significant health problems affecting the Nation's children.

11

PERFORMANCE MEASURE	**The percent of mothers who breastfeed their infants at 6 months of age.**
GOAL	To increase the percent of mothers who breastfeed their infants at 6 months of age.
DEFINITION	**Numerator:** Number of mothers who indicate that breastmilk is at least one of the types of food their infant is fed at 6 months of age. **Denominator:** Number of mothers with infants at 6 months of age. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-19b: Increase the proportion of mothers who breastfeed their infants at 6 months of age to 50 percent. (Baseline: 29 percent in 1998).
DATA SOURCES and DATA ISSUES	CDC's National Immunization Survey (NIS), Ross Laboratories Mothers Survey, State WIC data, CDC's Pediatric Nutrition Surveillance System (PedNSS), and HRSA's National Survey of Children's Health (NSCH).
SIGNIFICANCE	Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits.

- Breastfeeding is defined as including any amount of breast milk in the infant's diet, regardless of additional food substances consumed by an infant.
- Exclusive breastfeeding is defined as being fed breast milk or water only. Introduction of other substances to an infant such as formula, cow's milk, juice and solid foods in addition to breast milk does not qualify as "exclusive" breastfeeding.

12

PERFORMANCE MEASURE	**Percentage of newborns that have been screened for hearing before hospital discharge.**
GOAL	To reduce the morbidity associated with hearing impairment through early detection.
DEFINITION	**Numerator:** The number of infants in the State whose hearing has been screened before hospital discharge by tests of either otoacoustic emissions or auditory brainstem responses. **Denominator:** Number of births in the State in the calendar year. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 28-11: Increase the proportion of newborns that are screened for hearing loss by age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services by age 6 months.
DATA SOURCES and DATA ISSUES	State birth certificates, newborn hearing registries, tests of otoacoustic emissions and auditory brainstem responses. Potential data source – State based Early Hearing Detection and Intervention (EDHI) Program Network, CDC.
SIGNIFICANCE	The advantages of early detection of hearing impairments are indisputable and include necessary follow-up of free and appropriate enrollment in habilitation and education programs.

13

PERFORMANCE MEASURE

Percent of children without health insurance.

GOAL

To ensure access to needed and continuous health care services for children.

DEFINITION

Numerator: Number of children under 18 in the State who are not covered by any private or public health insurance (Including Medicaid or risk pools) at some time during the reporting year.

Denominator: Number of children in the State under 18 (estimated by Census in March).

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objectives 1-1: Increase the proportion of persons with health insurance to 100 percent. (Baseline: 86 percent of the population was covered by health insurance in 1997).

DATA SOURCES and DATA ISSUES

There is no current uniform source of data at the State level, but data may be available by State estimate beginning in 1997 from the March CPS, U.S. Bureau of the Census. States need to choose among existing estimating techniques and use one consistently.

SIGNIFICANCE

There is a well-documented association between insurance status and utilization of health care services among adults. Less is known about the utilization of services in children. A 1996 study by the Harvard School of Public Health, The Henry J. Kaiser Foundation and the National Opinion Research Center found the uninsured are four more times likely to have an episode of needing and not getting medical care. As noted in the 1997 "Families USA Report," children without health insurance have an average of 1 less visit per year and receive less treatment than insured children with similar problems.

14

PERFORMANCE MEASURE	**Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index[2] (BMI) at or above the 85th percentile.**
GOAL	To reduce the proportion of children, ages 2 to 5 years, who are at risk of overweight or obese.[3]
DEFINITION	**Numerator:** The number of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile. **Denominator:** Number of children, ages 2 to 5 years that receive WIC services during the reporting period. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objective 19.3: Reduce the proportion of children and adolescents who are overweight or obese. (1988-1994 Baseline for children aged 6 to 11 years of age: 11 %)
DATA SOURCES and DATA ISSUES	State WIC Data, CDC's Pediatric Nutrition Surveillance System (PedNSS), and HRSA's National Survey of Children's Health (NSCH).
SIGNIFICANCE	Childhood overweight is a serious health problem in the United States, and the prevalence of overweight among preschool children has doubled since the 1970s. There have been significant increases in the prevalence of overweight in children younger than 5 years of age across all ethnic groups. Onset of overweight in childhood accounts for 25 percent of adult obesity; but overweight that begins before age 8 and persists into adulthood is associated with an even greater degree of adult obesity. Childhood overweight is associated with a variety of adverse consequences, including an increased risk of cardiovascular disease, type 2 diabetes mellitus, asthma, social stigmatization, and low self-esteem.

2 Body Mass Index is defined as the ratio of weight in kilograms to the square of the height in meters.

3 Childhood overweight is defined as a BMI at or above the 95th percentile for children of the same age and sex, based on the reference values included in the National Center for Health Statistics 2000 growth charts. The term "at risk for overweight" is applied to children whose BMI is between the 85th and 95th percentiles.

15

PERFORMANCE MEASURE	**Percentage of women who smoke in the last three months of pregnancy.**
GOAL	Decrease smoking during pregnancy.
DEFINITION	**Numerator:** The number of women reporting smoking in the last three months of pregnancy during the calendar year. **Denominator:** The number of women delivering babies during the calendar year. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 27-6. Increase smoking cessation during pregnancy.
DATA SOURCES and DATA ISSUES	Birth certificate. States are encouraged to use US Standard Certificate of Live Birth (revised 11/2003); Pregnancy Risk Assessment Monitoring System (PRAMS).
SIGNIFICANCE	Birth weight is the single most important determinant of a newborn's survival during the first year. Maternal smoking during pregnancy has been directly related to low birth weight.

16

PERFORMANCE MEASURE	**The rate (per 100,000) of suicide deaths among youths aged 15 through 19.**
GOAL	To eliminate self-induced, preventable morbidity and mortality.
DEFINITION	**Numerator:** Number of deaths attributed to suicide among youths aged 15 through 19. **Denominator:** Number of youths aged 15 through 19. **Units:** 100,000 **Text:** Rate per 100,000
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objectives 18-1: Reduce the suicide rate to 6.0 deaths per 100,000 population. (Baseline: 10.8 suicide deaths per 100,000 in 1997). Related to Objective 18-2: Reduce the rate of suicide attempts by adolescents in grades 9 through 12 to a 12 month average of 1 percent. (Baseline: 12 month average of 2.6 percent among adolescents in grades 9 through 12 in 1997).
DATA SOURCES and DATA ISSUES	State vital records are the source.
SIGNIFICANCE	Suicide is the third leading cause of death in the United States among youths aged 15 through 19, and in many States it ranks as the second leading cause of death in this population.

17

PERFORMANCE MEASURE

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

GOAL

To ensure that higher risk mothers and newborns deliver at appropriate level hospitals.

DEFINITION

Numerator: Number of infants with a birth weight less than 1,500 grams born at sub-specialty facilities (Level III facility).

Denominator: Total number of infants born with a birth weight of less than 1,500 grams.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-9: Increase the proportion of very low birth weight (VLBW) infants born at Level III hospitals or sub-specialty perinatal centers to 90 percent. (Baseline: 73 percent of VLBW born at level III hospitals or sub-specialty perinatal centers in the years 1996-97).

DATA SOURCES and DATA ISSUES

There is no national data source for this at present. Vital records and hospital discharge records would be sources.

SIGNIFICANCE

Very low birth weight infants are more likely to survive and thrive if they are born/cared for in an appropriately staffed and equipped facility with a high volume of high-risk admissions.

18

PERFORMANCE MEASURE	**Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.**
GOAL	To ensure early entrance into prenatal care to enhance pregnancy outcomes.
DEFINITION	**Numerator:** Number of live births with reported first prenatal visit during the first trimester (before 13 weeks' gestation) in the calendar year. **Denominator:** Number of live births in the State in the calendar year. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-16a: Increase the proportion of pregnant women who receive early and adequate perinatal care beginning in the first trimester of pregnancy to 90 percent. (Baseline: 83 percent in 1998.)
DATA SOURCES and DATA ISSUES	Birth certificate data in the State vital records are available for over 99% of births.
SIGNIFICANCE	Early identification of maternal disease and risks for complications of pregnancy or birth are the primary reason for first trimester entry into prenatal care. This can help ensure that women with complex problems and women with chronic illness or other risks are seen by specialists. Early high-quality prenatal care is critical to improving pregnancy outcomes.

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[*Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]*

	Annual Objective and Performance Data				
OUTCOME MEASURE 1	**CY__**	**CY__**	**CY__**	**CY__**	**CY__**
The infant mortality rate per 1,000 live births. **Annual Outcome Objective**	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
OUTCOME MEASURE 2					
The ratio of the black infant mortality rate to the white infant mortality rate. **Annual Outcome Objective**	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
OUTCOME MEASURE 3					
The neonatal mortality rate per 1,000 live births. **Annual Outcome Objective**	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 12 (Continuation Page)
TRACKING HEALTH OUTCOME MEASURES
[*Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]*

	Annual Objective and Performance Data				
OUTCOME MEASURE 4	**CY__**	**CY__**	**CY__**	**CY__**	**CY__**
The post-neonatal mortality rate per 1,000 live births.					
Annual Outcome Objective	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
OUTCOME MEASURE 5					
The perinatal mortality rate per 1,000 live births plus fetal deaths.					
Annual Outcome Objective	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
OUTCOME MEASURE 6					
The child death rate per 100,000 children aged 1 through14.					
Annual Outcome Objective	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 12
TRACKING HEALTH OUTCOME MEASURES
[*Secs. 505(a)(2)(B)(iii) and 506(a)(2)(A)(iii)]*

	Annual Objective and Performance Data				
STATE OUTCOME MEASURE #__	**CY__**	**CY__**	**CY__**	**CY__**	**CY__**
Annual Outcome Objective	_____	_____	_____	_____	_____
Annual Outcome Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

INSTRUCTIONS FOR THE COMPLETION OF FORM 12
TRACKING HEALTH OUTCOME MEASURES

Title V Citation: Section 505(a)(2)(B)(i & iii) requires the States to submit an application that "…a statement of the goals and objectives consistent with the health status goals and national health objectives…for meeting the needs of specified in the State plan…[and]…an identification of the types of services to be provided…" Section 506(a)(2)(A)(iii) requires the States to report annually on the "…type (as defined by the Secretary) of services provided under this title…"

Instructions: A glossary of terms applicable to this form is presented in Part Two, Section VIII of this document.

Complete all required data cells. If an actual number is not available, make an estimate. Please explain all estimates in a footnote.

This form serves two purposes: (1) to show health outcome measures with planned outcome objective targets for the application, and, (2) outcome indicator values actually achieved each year for the annual report.

The "Outcome Measure" titles will already be completed for National Outcome Measures.

On each "Annual Outcome Objective" line, enter a value for the targets the State plans to meet. This value may be expressed as a number, a rate, a percentage, or a "yes – no."

On each "Annual Outcome Indicator" line, enter the value that expresses the progress the State has made toward the accomplishment of the outcome objective for the appropriate reporting year. This value is to be expressed in the same units as the outcome objective: a number, a rate, a percentage, or a "yes – no."

Repeat this process for each health outcome measure.

States have the option of adding one State Outcome Measure of their choice. For this purpose a blank continuation page has been added. To add a State Outcome Measure, enter "ASO 1" in the blank provided on the line **STATE OUTCOME MEASURE**. Under that line enter the title of the State Outcome Measure exactly as it appears on Form 12. Complete the remaining columns in the same manner as described above for National Outcome Measures.

VIIB - National Outcome Measures Detail Sheets

01
OUTCOME MEASURE

The infant mortality rate per 1,000 live births.

GOAL

To reduce the number of infant deaths.

DEFINITION

Numerator: Number of deaths to infants from birth through 364 days of age.

Denominator: Number of live births.

Units: 1,000 **Text:** Rate per 1,000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-1c: Reduction of infant deaths (within 1 year) to 4.5 per 1,000 live births. (Baseline: 7.2 in 1998)

DATA SOURCES and DATA ISSUES

Vital records collected by the State.

SIGNIFICANCE

All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate, but the rate of decline has slowed in the last 10 years. There is still significant racial disparity, as noted in the Healthy People 2000 Mid-course Review. Rates are much higher in the lower social class and in the lowest income groups across all populations.

02
OUTCOME MEASURE

The ratio of the black infant mortality rate to the white infant mortality rate.

GOAL

To reduce the disparity (ratio) between the black and white infant mortality rates.

DEFINITION

Numerator: The black infant mortality rate per 1,000 live births.

Denominator: The white infant mortality rate per 1,000 live births.

Units: 1 **Text:** Ratio

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-1c: Reduce all infant deaths (within 1 year) to 4.5 per 1,000 live births. Objective 16-1d: Reduce all neonatal deaths (within the first 28 days of life) to 2.9 per 1,000 live births. Objective 16-1e: Reduce all post-neonatal deaths (between 28 days and 1 year) to 1.5 per 1,000 live births. (Baselines [all 1997] – Infant deaths: White = 6.0 and Black = 13.7; Neonatal deaths: White = 4.0 and Black = 9.2; Post-neonatal deaths: White = 2.1 and Black = 4.5)

DATA SOURCES and DATA ISSUES

Vital records collected by the State.

SIGNIFICANCE

All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate, but the rate of decline has slowed in the last 10 years. There is still significant racial disparity, as noted in the Healthy People 2000 Mid-course Review. Rates are much higher in the lower social class and in the lowest income groups across all populations. The disparity (ratio) for black infant mortality is over twice the white rate. Black women are twice as likely as white women to experience prematurity, low birth weight, and fetal death.

03 **OUTCOME MEASURE**	**The neonatal mortality rate per 1,000 live births.**

GOAL	To reduce the number of neonatal deaths
DEFINITION	**Numerator:** Number of deaths to infants under 28 days. **Denominator:** Number of live. **Units:** 1,000 **Text:** Rate per 1,000
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-1d: Reduce all neonatal deaths (within the first 28 days of life) to 2.9 per 1,000 live births. (Baseline: 4.8 in 1998)
DATA SOURCES and DATA ISSUES	Vital records collected by the State.
SIGNIFICANCE	Neonatal mortality is a reflection of the health of the newborn and reflects health status and treatment of the pregnant mother and of the baby after birth.

04
OUTCOME MEASURE

The post-neonatal mortality rate per 1,000 live births.

GOAL

To reduce the number of post-neonatal deaths.

DEFINITION

Numerator: Number of deaths to infants 28 through 364 days of age.

Denominator: Number of live births.

Units: 1,000 **Text:** Rate per 1,000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-1e: Reduce all post-neonatal deaths (between 28 days and 1 year) to 1.5 per 1,000 live births. (Baseline: 2.4 in 1998)

DATA SOURCES and DATA ISSUES

Vital records collected by the State.

SIGNIFICANCE

This period of mortality reflects the environment and the care infants receive. SIDS deaths occur during this period and have been recently reduced due to new infant positioning in the U.S. Poverty and a lack of access to timely care are also related to late infant deaths.

05 **OUTCOME MEASURE**	**The perinatal mortality rate per 1,000 live births plus fetal deaths.**

GOAL	To reduce the number of perinatal deaths.
DEFINITION	**Numerator:** Number of fetal deaths 28 weeks or more gestation plus early neonatal deaths occurring under 7 days. **Denominator:** Live births + fetal deaths. **Units:** 1,000 **Text:** Rate per 1,000
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-1b: Reduce the death rate during the perinatal period (28 weeks of gestation or more to 7 days or less after birth) to 4.5 per 1,000 live births plus fetal deaths. (Baseline: 7.5 in 1997)
DATA SOURCES and DATA ISSUES	Vital records collected by the State.
SIGNIFICANCE	Perinatal mortality is a reflection of the health of the pregnant woman and newborn and reflects the pregnancy environment and early newborn care.

06
OUTCOME MEASURE

The child death rate per 100,000 children aged 1 through 14.

GOAL

To reduce the death rate of children aged 1 through 14.

DEFINITION

Numerator: Number of deaths among children aged 1 through 14 years.

Denominator: Number of children aged 1 through 14.

Units: 100,000 **Text:** Rate per 100,000

HEALTHY PEOPLE 2010 OBJECTIVE

Combination of Objectives 16-2a: Reduce deaths in children aged 1 to 4 years to 25.0 per 100,000 in that age group. (Baseline: 34.2 in 1998) Objectives 16-2b: Reduce deaths in children aged 5 to 9 years to 14.3 per 100,000 in that age group. (Baseline: 17.6 in 1998) Objectives 16-3a: Reduce deaths in adolescents aged 10 to 14 years to 16.8 per 100,000 in that age group. (Baseline: 21.8 in 1998)

DATA SOURCES and DATA ISSUES

Child death certificates are collected by State vital records. Data on total number of children comes from the Census.

SIGNIFICANCE

While children's likelihood of survival increases dramatically after the first year of life, the child death rate remains certain. The child death rate has decreased in the last decade, falling from 33.8 in 1985 to 28.8 in 1992. The DHH's strategic plan identifies improvements in the rates of preventable death as part of priority goals for children and youth.

VIIC - State Outcome Measures Detail Sheets

[If the State has developed Outcome Measures, insert the completed Detail Sheet in this Section.]

FORM 13
CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CSHCN PROGRAMS

0 1 2 3*

1. GGGG

Family members participate on advisory committee or task forces and are offering training, mentoring, and reimbursement, when appropriate.

0 1 2 3

2. GGGG

Financial support (financial grants, technical assistance, travel, and child care) is offered for parent activities or parent groups.

0 1 2 3

3. GGGG

Family members are involved in the Children with Special Health Care Needs elements of the MCH Block Grant Application process.

0 1 2 3

4. GGGG

Family members are involved in service training of CSHCN staff and providers.

0 1 2 3

5. GGGG

Family members are hired as paid staff or consultants to the State CSHCN program (a family member is hired for his or her expertise as a family member.

0 1 2 3

6. GGGG

Family members of diverse cultures are involved in all of the above activities.

---

*0 = Not Met 1 = Partially Met 2 = Mostly Met 3 = Completely Met

INSTRUCTIONS FOR THE COMPLETION OF FORM 13
FAMILY PARTICIPATION IN CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAMS

Title V Citation: Section 501(a)(1)(D) states in part: That a portion of Title V funds shall be appropriated for the purpose of enabling each State "…to provide and to promote family-centered, community-based, coordinated care (including care coordination services…for children with special health care needs and to facilitate the development of community-based systems of services for such children and their families.)"

The goal of this form is to determine the degree to which family participation exists for the care of children with special health care needs. These are defined ***as (For planning and systems development)*** – Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. The establishment of systems of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care is essential for effectively fostering and facilitating activities to:

- Strengthen the ability of families to care for children with actual or potential chronic and disabling conditions; and
- Enable children with special health care needs to remain in the home and community-based living arrangements, rather than in institutional settings.

The completion of the form will assist the Maternal and Child Health Bureau in determining the degree to which families participate in children with special health care needs programs as required by Public Law 101-239. Check the degree to which each describes the State CSHCN program.

Instructions: For each item, on lines 1 through 6, please check the box that best relates the degree which indicates the characteristic that describes the State CSHCN program. The numbers of the boxes represent the degree to which participation have been met. States should seek family input when filling out this form.

FORM 14
LIST OF MCH PRIORITY NEEDS
[*Sec. 505(a)(1)*]

STATE_____ FY_____

Your State's 5-year Needs Assessment should identify the need for preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for Children with Special Health Care Needs. With each year's Block Grant application provide a list, (whether or not the priority needs change) of the top maternal and child health needs in your State. Using a simple sentence or phrase, list below your State's needs. Examples of such statements are: "To reduce the barriers to the delivery of care for pregnant women," and "The infant mortality rate for minorities should be reduced."

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes; you must list at least 7 and no more than 10. Note that the numbers list below is for computer tracking only and is not meant to indicate a priority order.

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FORM 15
TECHNICAL ASSISTANCE (TA) REQUEST

This form should contain a PRELIMINARY statement of the TA that you anticipate requesting for the application year. All TA requested on your Block Grant Application may be changed or revised AT ANY TIME during the year. When updating the information on this form during the year, you may photocopy or download the form from the Block Grant *Guidance*. The form should then be submitted to your MCHB Project Officer, with a copy to the MCHB TA coordinator. Revised forms can be transmitted via mail, fax or as an email attachment. Please attach a detailed explanation of any item not fully described in the Table. A glossary of terms applicable to this form is included in Part Two, Section VIII of this document.

STATE _____ DATE _____

Category of Technical Assistance Requested	**Reason(s) Why Assistance Is Needed**	**What State, Organization or Individual Would You Suggest Provide the TA (if known)**
I. GENERAL SYSTEMS CAPACITY ISSUES *A.*		
B.		
C.		

FORM 15 (Continuation Page)
TECHNICAL ASSISTANCE (TA) REQUEST

II. <u>STATE PERFORMANCE MEASURE ISSUES</u> **Measure # __.**		
Measure # __.		
Measure # __.		
III. <u>NATIONAL PERFORMANCE MEASURE ISSUES</u> **Measure # __.**		
Measure # __.		
Measure # __.		

FORM 15 (Continuation Page)
TECHNICAL ASSISTANCE (TA) REQUEST

IV. <u>DATA-RELATED ISSUES</u> **A. Data System Development**		
B. Needs Assessment		
C. Performance Indicators		

INSTRUCTIONS FOR COMPLETION OF FORM 15
TECHNICAL ASSISTANCE (TA)

Instructions:

Identify your State and date of initial request on page 1. Subsequent requests (made later in the year) can be entered on a Technical Assistance Support Form available from the Division of State and Community Health (MCHB).

Enter all assistance requested in the appropriate category:

1. General Systems Capacity – Assistance needed to improve State's ability to support services to MCH populations, i.e., workforce training, distance learning, hotlines, etc.
2. State Performance Measures – Assistance needed to increase State's ability to meet its objectives for one or more State Performance Measures where performance has not been as strong as desired/expected.
3. National Performance Measures – Assistance needed to increase State's ability to meet its objectives for one or more National Performance Measures where performance has not been as strong as desired/expected.
4. Data Related Issues – Assistance needed to improve State's ability to increase its capacity to collect, tabulate, and report data accurately and reliably.

Complete all data cells for each item requested, providing a detailed explanation of why each of item of assistance is needed, and what person or persons State would like to have provide TA, if known. (Include the performance measure number if appropriate.)

FORM 16
STATE PERFORMANCE/OUTCOME MEASURE DETAIL SHEET

SP# _____ (Or SO#) **PERFORMANCE MEASURE:**	
GOAL	
DEFINITION	**Numerator:** **Denominator:** **Units: _____ _____** **(Number) (Text)**
HEALTHY PEOPLE 2010 **OBJECTIVE**	
DATA SOURCES and **DATA ISSUES**	
SIGNIFICANCE	

INSTRUCTIONS FOR THE COMPLETION OF FORM 16
STATE PERFORMANCE/OUTCOME MEASURE DETAIL SHEET

Title V Citation: Section 505(a)(2)(B)(i & iii) requires the States to submit an application that includes: "...a statement of the goals and objectives consistent with the health status goals and national health objectives...for meeting the needs specified in the State plan...[and]...an identification of the types of services to be provided..." Section 506(a)(2)(A)(iii) requires the States to report annually on the "...type (as defined by the Secretary) of services provided under this title..."

Instructions: A glossary of terms applicable to this form is presented in Part Two, Section VIII of this document. This form is to be used for both State Performance Measures and the additional State Outcome Measure if the State chooses to add one. Complete each section as appropriate for the measure being described.

SP# (or SO): Enter the number of the State Performance or Outcome Measure

Performance Measure: Enter the narrative description of the performance or outcome measure**.**

Goal: Enter a short statement indicating what the State hopes to accomplish by tracking this measure.

Definition: Describe how the value of the measure is determined from the data. If the value of the measure is "yes/no" or some other narrative indicator such as "stage 1/stage 2/stage 3," a clear description of what those values mean and how they are determined should be provided.

Numerator: If the measure is a percentage, rate, or ratio, provide a clear description of the numerator.

Denominator: If the measure is a percentage, rate, or ratio, provide a clear description of the denominator.

Units: If the measure is a percentage, rate, ratio, or scale, indicate the units in which the measure is to be expressed (e.g., 1,000, 100) on the **"Number"** line and type of measure (e.g., percentage, rate, ratio or scale) on **"Text"** line. If the measure is a narrative, indicate "yes/no" or "stage 1, stage 2", etc. on the **"Text"** line and make no entry on the **"Number"** line.

Healthy People 2010 Objective: If the measure is related to a *Healthy People 2010* objective describe the objective and corresponding number.

Data Source &Data Issues: Enter the source(s) of the data used in determining the value of the measure and any issues concerning the methods of data collection or limitations of the data used.

Significance: Briefly describe why this measure is significant, especially as it relates to the Goal.

Note that the Performance or Outcome measure title and numerator and denominator data are to appear on Form 11 exactly as they appear on this Form.

FORM 17
HEALTH SYSTEMS CAPACITY INDICATORS
FORMS FOR HSCI 01 THROUGH 04, 07A, 07B & 08 – MULTI-YEAR DATA

	Annual Indicator Data				
	FY __	**FY __**	**FY __**	**FY __**	**FY __**
HEALTH SYSTEMS CAPACITY INDICATOR #01 *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 – 493.9) per 10,000 children less than five years of age.*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
HEALTH SYSTEMS CAPACITY INDICATOR #02 *The percent of Medicaid enrollees whose age is less than one year who received at least one initial or periodic screen.*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
HEALTH SYSTEMS CAPACITY INDICATOR #03 *The percent of SCHIP enrollees whose age is less than one year who received at least one periodic screen.*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 17 (Continuation Page)
HEALTH SYSTEMS CAPACITY INDICATORS
FORMS FOR HSCI 01 THROUGH 04, 07A, 07B, & 08 – MULTI-YEAR DATA

	Annual Indicator Data				
	FY __	**FY __**	**FY __**	**FY __**	**FY __**
HEALTH SYSTEMS CAPACITY INDICATOR #04 *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
HEALTH SYSTEMS CAPACITY INDICATOR #07A *The percent of potentially Medicaid-eligible children, aged 1 to 21 years, who have received a service paid by the Medicaid Program.*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
HEALTH SYSTEMS CAPACITY INDICATOR #07B *The percent of EPSDT eligible children Medicaid aged 6 through 9 years who have received any dental services during the year.*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 17 (Continuation Page)
HEALTH SYSTEMS CAPACITY INDICATORS
FORMS FOR HSCI 01 THROUGH 04, 07A, 07B, & 08 – MULTI-YEAR DATA

	Annual Indicator Data				
	FY __	**FY __**	**FY __**	**FY __**	**FY __**
HEALTH SYSTEMS CAPACITY INDICATOR #08 *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN Program.*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

INSTRUCTIONS FOR TRACKING HEALTH SYSTEMS CAPACITY INDICATORS 01 THROUGH 04, 07A, 07B, AND 08

General Instructions:

A glossary of terms applicable to this form is presented in Part Two, Section VIII of this document.

Complete all required data cells. If an actual number is not available make an estimate. Please explain all estimates in a footnote.

The purpose of this form is to show, annually, selected measurements (indicators) of MCH Health Systems Capacity status in the State and to track those indicators over a five year period.

For each of the Health Systems Capacity Indicators, on the lines labeled "Annual Indicator," enter the numerical value that shows the status for the indicator for the appropriate reporting year. Note that the indicator data is to go in the years column from which it was actually derived even if the data is a year behind the "reporting" year. This value is to be expressed in the units that are described on the health status indicator detail sheets which, for these indicators, are either a rate or a percentage.

If there are numerator and denominator data for the indicator value, enter those data on the appropriate lines for the appropriate fiscal year. If actual data is not available for the reporting year, use provisional or estimated numbers for numerator and denominator to generate the indicator value.

Specific Instructions:

Systems Capacity Indicator #01 (Ambulatory Sensitive Condition) There is one part to this indicator. The value is to be expressed as the hospitalization rate per 10,000 children less than 5 years of age.

Systems Capacity Indicator #02 and #03 (Adequacy of Primary Care) The values are to be expressed as percents of Medicaid or SCHIP enrollees who received at least one initial or periodic screen in the age ranges indicated.

Systems Capacity Indicator #04 (Prenatal Care Participation) There is one part to this indicator. The value is to be expressed as a percent of women (15 through 44) with a live birth whose observed to expected prenatal visits were greater than or equal to 80 percent on the Kotelchuck Index.

Systems Capacity Indicator #07A (Medicaid Services) There is one part to this indicator. The values are to be expressed as the percent of children who have received any service in the age range indicated.

Systems Capacity Indicator #07B (Medicaid [EPSDT] Dental Health Services) There is one part to this indicator. The values are to be expressed as the percent of children who have received any dental services in the age range indicated.

Systems Capacity Indicator #08 (Direct Health Service) There is one part to this indicator. The values are to be expressed as the percent of State SSI beneficiaries less than 16 years old who are receiving rehabilitative services from the State CSHCN program.

FORM 18
HEALTH SYSTEMS CAPACITY INDICATOR REPORTING FORM

HEALTH SYSTEMS CAPACITY INDICATOR #05 (Medicaid and Non-Medicaid Comparison)

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	**YEAR**	**POPULATION**		
		MEDICAID*	**NON-MEDICAID**	**ALL**
a) Percent of low birth weight (<2,500 grams) ☐ payment source from birth certificate ☐ matching data files				
b) Infant deaths per 1,000 live births ☐ payment source from birth certificate ☐ matching data files				
c) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester ☐ payment source from birth certificate ☐ matching data files				
d) Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index]) ☐ payment source from birth certificate ☐ matching data files				

*Please indicate your data source by checking the appropriate box

HEALTH SYSTEMS CAPACITY INDICATOR #06 (Medicaid and SCHIP Eligibility Levels)

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL**	
		MEDICAID	**SCHIP**
a) Infants (0 - 1)			
b) Medicaid Children (Age range _____ to _____) *SCHIP Children (Age range _____ to _____)*			
c) Pregnant Women			

INSTRUCTIONS FOR THE COMPLETION OF
HEALTH SYSTEMS CAPACITY INDICATOR FORM 18
HEALTH SYSTEMS CAPACITY INDICATORS #05 AND #06

General Instructions:

A glossary of terms applicable to this form is presented in Part Two, Section VIII of this document.

Complete all required data cells. If an actual number is not available make an estimate. Please explain all estimates in a footnote.

The purpose of this form is to show, annually, selected Medicaid and SCHIP indicators in the State. These health system capacity indicators deals with data that is to be shown every year. Indicator #05 has four parts and indicator #06 has three parts. Specific instructions are:

Specific Instructions:

Health Systems Capacity Indicator #05 (Medicaid and Non-Medicaid Comparison)

In the first column, under the health systems capacity indicator title, check the appropriate box that shows the data source. In the next column enter the specific year for the figures reported. Then:

For #05a, in the appropriate cells, enter the percentage of Medicaid infants, Non-Medicaid infants and all infants born at a low birth weight (<2,500 grams) in the reporting year.

For #05b, in the appropriate cells, enter the rate (per 1,000 infants) of Medicaid infant deaths, Non-Medicaid infant deaths, and all infant deaths in the reporting year.

For #05c, in the appropriate cells, enter the percentage of Medicaid covered infants, Non-Medicaid covered infants and all infants born to pregnant women who entered prenatal care in the first trimester in the reporting year.

For #05d, in the appropriate cells, enter the percentage of Medicaid covered pregnant women, Non-Medicaid covered pregnant women and all pregnant women with adequate prenatal care in the reporting year.

Health Systems Capacity Indicator #06

In the second column enter the specific year for the figures reported. Then:

For #06a, enter the percentages of poverty level required for Medicaid and SCHIP program eligibility for all infants 0-1 in the State.

For #06b, enter the percentages of the poverty level required for Medicaid and SCHIP program eligibility for all Medicaid and SCHIP children in the State. In the first column, under the health systems capacity indicator titles enter the age range used for the reported figures. Note that there can be multiple age ranges.

For #06c, enter the percentages of poverty level required for Medicaid and SCHIP program eligibility for pregnant women in the State.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR – REPORTING AND TRACKING FORM

General Instructions:

The purpose of this form is to show the State MCH data capacity and whether the MCH program has the ability to obtain timely analyses of certain data for programmatic and policy issues. A glossary of terms applicable to this form is presented in Part Two, Section VIII of this document.

HEALTH SYSTEMS CAPACITY INDICATOR #09A (General MCH Data Capacity)
The Ability of the State to Assure MCH Program Access to Policy and Program Relevant Information

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purpose in a timely manner? (Enter 1-3)*	Does your MCH program have direct access to the electronic database for analysis? (Enter Y/N)
ANNUAL DATA LINKAGES		
Annual linkage of infant birth and infant death certificates.	☐	☐
Annual linkage of birth certificates and Medicaid eligibility or paid claims files.	☐	☐
Annual linkage of birth records and WIC eligibility files.	☐	☐
Annual linkage of birth records and newborn screening files.	☐	☐
REGISTRIES AND SURVEYS		
Hospital discharge survey for at least 90% of in-State discharges.	☐	☐
Annual birth defects surveillance system.	☐	☐
Survey of recent mothers at least every two years (like PRAMS).	☐	☐

*Where:
1 = No, the MCH agency does not have this ability.
2 = Yes, the MCH agency sometimes has this ability, but not on a consistent basis.
3 = Yes, the MCH agency always has this ability.

FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR – REPORTING AND TRACKING FORM
(Continuation Page)

HEALTH SYSTEMS CAPACITY INDICATOR #09B **The ability of States to monitor tobacco use by children and youth.** **(Data Capacity – Adolescent Tobacco Use)** ***The Percent of Adolescents in Grades 9 through 12*** ***Who Reported Using Tobacco Products in the Past Month***		
DATA SOURCES	Does your State participate in the YRBS survey? (Enter 1-3)*	Does your MCH program have direct access to the State YRBS database for analysis? (Enter Y/N)
Youth Risk Behavior System (YRBSS)	☐	☐
Other:		
*Where: **1** = No. **2** = Yes, the State participates but the sample size is <u>not</u> large enough for valid statewide estimates for this age group. **3** = Yes, the State participates and the sample size is large enough for valid statewide estimates for this age group.		

INSTRUCTIONS FOR COMPLETION FORM 19
HEALTH SYSTEMS CAPACITY INDICATOR – REPORTING AND TRACKING FORM

Instructions:

The purpose of Part A of this form is to show, annually, the State MCH data capacity in terms of access to policy and program relevant data in a timely manner and whether the MCH program has direct access to the electronic database for analysis.

1. = **No**, the State MCH program the does NOT have the ability to obtain data for program planning or policy purposes in a timely manner.
2. = **Yes**, the State MCH program SOMETIMES has the ability to obtain data for program planning or policy purposes in a timely manner.
3. = **Yes**, the State MCH program ALWAYS has the ability to obtain data for program planning or policy purposes in a timely manner.

The purpose of Part B of this form is to determine the State's capacity to monitor Adolescent Tobacco Use by participating in the YRBSS or some other similar survey.

1. = **No**, the State does NOT participate in the YRBSS or a similar survey.
2. = **Yes**, the State participates but the sample size is not large enough for valid statewide
3. = **Yes**, the State participates and the sample size is large enough for valid statewide estimates.

VIID - Health Systems Capacity Indicators Detail Sheets

01
HEALTH SYSTEMS CAPACITY INDICATOR

The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 – 493.9) per 10,000 children less than five years of age.

GOAL

To reduce asthma hospitalization for children less than five years old.

DEFINITION

Numerator: Number of resident asthma (ICD-9 codes: 493.0 – 493.9) hospital discharges for children less than five years old.

Denominator: Estimate of all children less than five years old in the State.

Units: 10,000 **Text:** Rate per 10,000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 24-2a: Reduce hospitalization for asthma in children 0-5 to no more than 25 per 10,000. (Baseline: 1997, 60.9 per 10,000)

DATA SOURCES and DATA ISSUES

Numerator: State hospital discharge data.
Denominator: State population estimates, Bureau of Census data.

SIGNIFICANCE

Asthma is one of the few medical problems that may be used to measure the extent to which children are receiving quality disease preventive care and health promotion education. Access to and utilization of appropriate medical care can often prevent severe episodes of asthma. Increased asthma hospitalization rates may be a consequence of inadequate outpatient management and diminished access to a medical home.

02
HEALTH SYSTEMS CAPACITY INDICATOR

The percent Medicaid enrollees whose age is less than one year who received at least one initial or periodic screening.

GOAL

To increase the adequacy of primary care for Medicaid enrollees.

DEFINITION

Numerator: Number of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial or periodic screen.

Denominator: Number of Medicaid enrollees whose age is less than one year.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 Objective

DATA SOURCES and DATA ISSUES

Numerator: State Medicaid claims files or EPSDT visits for the reporting period.
Denominator: State Medicaid program enrollees for the reporting period. The assumption is that all Medicaid enrollees whose age is less than one year should have at least one initial well child or EPSDT visit.

SIGNIFICANCE

The EPSDT program is a national initiative to provide quality comprehensive services to all Medicaid eligible children. Increasing access to comprehensive, family-centered, community-based, culturally competent care for the medically under served populations of the State is the first step toward establishing a medical home and a regular source of care.

03
HEALTH SYSTEMS CAPACITY INDICATOR

The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

GOAL

To increase the adequacy of primary care for SCHIP enrollees.

DEFINITION

Numerator: Number of SCHIP enrollees whose age is less than one year during the reporting year who received at least one initial or periodic screen.

Denominator: Number of SCHIP enrollees whose age is less than one year.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 Objective.

DATA SOURCES and DATA ISSUES

Numerator: SCHIP program claims files for well child visits, or Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits for the reporting period.
Denominator: SCHIP program enrollees for the reporting period. The assumption is that all SCHIP enrollees whose age is less than one year should have at least one initial well child or EPSDT visit.

SIGNIFICANCE

The EPSDT program is a national initiative to provide quality comprehensive services to all Medicaid eligible children. Some states include the EPSDT program as part of the SCHIP coverage With the help of public/private partners, increasing access to comprehensive, family-centered, community-based, culturally competent care for the medically under served populations of the State is the first step toward establishing a medical home.

04 **HEALTH SYSTEMS CAPACITY INDICATOR**	**The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.**
GOAL	To increase the adequacy of prenatal care utilization.
DEFINITION	**Numerator:** Number of women (15 through 44) during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. **Denominator:** All women (15 through 44) with a live birth during the reporting year. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-16b: Increase to at least 90 percent the proportion of all live born infants whose mothers receive prenatal care that is adequate or more than adequate according to the Adequacy of Prenatal Care Utilization (Kotelchuck) Index. (Baseline: 74 percent of live births in 1995)
DATA SOURCES and DATA ISSUES	State vital statistic records are sources of this data.
SIGNIFICANCE	Adequate prenatal care is an effective intervention that improves pregnancy outcomes, including reducing infant mortality. The two-part (Kotelchuck) Adequacy of Prenatal Care Utilization Index combines independent assessment of the timing of prenatal care initiation and the frequency of visits received after initiation.

05
HEALTH SYSTEMS CAPACITY INDICATOR

Comparison of health system capacity indicators for Medicaid, Non-Medicaid, and all MCH populations in the State.

GOAL

To eliminate disparities in pregnancy health outcomes in Medicaid, non-Medicaid, and all populations in the State.

DEFINITION

The table for Health Systems Capacity Indicator 05 is on Form 18 (Medicaid and SCHIP data). The table compares low birth weight (<2,500 grams), infant deaths per 1,000 live births, initiation of prenatal care during first trimester of pregnancy, and adequacy of prenatal care (Kotelchuck Index) by the population groups; maternal Medicaid recipient, maternal non-Medicaid recipient, and total maternal population. The table is completed with the appropriate number in the Medicaid, non-Medicaid, and total State population cells for the specified reporting year.

HEALTHY PEOPLE 2010 OBJECTIVE

No specific HP 2010 objective.

DATA SOURCES and DATA ISSUES

Birth certificates with payment source, linked Medicaid files.

SIGNIFICANCE

Adverse health outcomes disproportionately affect the poor. Enrollment and participation in the State Medicaid, SCHIP, or other programs (food stamps, WIC, AFDC/TANF) may not eliminate the disparity in pregnancy outcomes by socioeconomic status, race and/or ethnicity. The quality of services provided to pregnant women and their newborns should be evaluated to identify barriers to comprehensive, family-centered, community-based, culturally competent care.

06
HEALTH SYSTEMS CAPACITY INDICATOR

The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.

GOAL

To increase State Medicaid and SCHIP enrollment for infants (0 to 1), children, and pregnant women.

DEFINITION

The table for Health Systems Capacity Indicator 06 is on Form 18 (Medicaid and SCHIP data). This table has cells for infants (0 to 1), children (specify age range), and pregnant women, by year and percent of poverty level required for program eligibility. Complete the cells with the appropriate percentage of poverty level for each of the three groups, and specify the reporting year.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 objective. Related Objective 1-1: Increase the proportion of persons with health insurance to 100 percent. (Baseline: 86 percent in 1997) Related Objective 1-4: Increase the proportion of children and youth aged 17 years and under who have a specific source of ongoing care to 96 percent. (Baseline 93 percent in 1997)

DATA SOURCES and DATA ISSUES

State Medicaid and SCHIP programs.

SIGNIFICANCE

Adverse health outcomes disproportionately affect the poor. Infants (0 to 1), children, and pregnant women without private health insurance may not have access to medical care. Participation in the State Medicaid or SCHIP programs may positively impact health outcomes. Important features of Maternal and Child Health (MCH) State program evaluations should include eligibility thresholds, enrollment volume, program retention, transitions in coverage, and access to care.

07A
HEALTH SYSTEMS CAPACITY INDICATOR

Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

GOAL

To enroll all Medicaid-eligible children in Medicaid ensuring better access to health care services.

DEFINITION

Numerator: Number of children 1 to 21 years of age who have received a service paid by Medicaid during the Federal fiscal year.

Denominator: The estimated number of children 1 to 21 years of age who are potentially eligible, by State definition, for Medicaid at the end of the Federal fiscal year.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 1-4b: Increase the proportion of children and youth aged 17 years and under who have a specific source of ongoing care to 96 percent. (Baseline: 93 percent in 1997). Related to Objective 1-6: Reduce the proportion of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members to 7 percent. (Baseline: 12 percent in 1996).

DATA SOURCES and DATA ISSUES

Numerator: The State Medicaid program counts participation monthly and estimates caseload. There are peaks and valleys in participation throughout the year. Most systems do not link the income of the family on the program records, but only the eligibility category (e.g., AFDC, expansion, etc.).
Denominator: States may not have these data readily available, and therefore estimates are made by using a variety of data from CPS, State programs, Census, and experience.

SIGNIFICANCE

Financial access to health care does not guarantee that all children will enroll and access care, but insured children are more likely to get care. Currently 3 million children are estimated to be eligible non-participants in Medicaid.

07B
HEALTH SYSTEMS CAPACITY INDICATOR

The percent of EPSDT eligible children Medicaid aged 6 through 9 years who have received any dental services during the year.

GOAL

To increase dental health services to EPSDT eligible children aged 6 through 9 years.

DEFINITION

Numerator: Total EPSDT eligible children aged 6 through 9 receiving any dental services in the reporting period.

Denominator: Total children aged 6 through 9 eligible for EPSDT in the State in the reporting period.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 objective. Related objective 21-1b: Reduce the proportion of children with dental caries experience either in their primary or permanent teeth to 42 percent. (Baseline: 52 percent of children aged 6 to 8 years had dental caries experience in 1988-94) Related Objective 21-2b: Reduce the proportion of children with untreated dental decay in primary and permanent teeth to 21 percent. (Baseline: 29 percent of children aged 6 to 8 years had untreated dental decay in1988-94)

DATA SOURCES and DATA ISSUES

Revised HCFA-416. Form element numbers 1 and 12a.

SIGNIFICANCE

Dental caries is perhaps the most prevalent disease known. Except in its early stages, it is irreversible and cumulative. Children aged 6 through 8 are at an important stage of dental development. The importance of optimal oral health for these children is not only to their current oral functioning, but also for long-term health. Community water fluoridation, use of preventive services (sealants and topical fluoride treatments) and appropriate oral health behaviors decrease the chance that children will develop caries. Many children, particularly those in high-risk groups, do not receive adequate fluoride exposure or adhesive sealants, regular professional care, or oral hygiene instruction. For children from low-income families, a significant hurdle is paying for services.

08
HEALTH SYSTEMS CAPACITY INDICATOR

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program.

GOAL

For the State CSHCN program to provide rehabilitative services for blind and disabled children less than 16 years old receiving benefits under Title SVI, to the extent medical assistance for such services is not provided by Medicaid.

DEFINITION

Numerator: The number of State SSI beneficiaries less that 16 years old receiving rehabilitative services from the State's CSHCN program during the Federal fiscal year.

Denominator: The number of SSI beneficiaries less than 16 years old in the State.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16-23. Increase the proportion of Territories and States that have service systems for Children with Special Health Care Needs to 100 percent. (Baseline: 15.7 percent of Territories and States met Title V for service systems for CSHCN in FY 1997)

DATA SOURCES and DATA ISSUES

State CSHCN and Medicaid programs and Federal Supplemental Security Income (SSI) program.

SIGNIFICANCE

Title V legislative requirements mandate the provision of rehabilitative services for blind and disable individuals under the age of 16 receiving benefits under the SSI Program to the extent medical assistance for such services is not provided by promoting family-centered, community-based care. This requirement serves as the basis for States to establish a policy whereby all SSI disabled children are eligible to participate in or benefit from the State Title V CSHCN Program.

09A
HEALTH SYSTEMS CAPACITY INDICATOR

The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.

GOAL

To assure MCH program and Title V agency access to essential policy and program relevant information from key public health data sets relating to women, children, and families. To demonstrate core MCH data capacity.

DEFINITION

Form 19 for this Health Systems Capacity Indicator is a table with two questions about important databases that document the MCH programs' ability to obtain essential program and policy relevant information. Following the instructions, enter the degree to which these functions are implemented (1-3) and whether the State MCH program has direct access to the databases (Y/N).

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 Objective. Related Objective 23-5: Increase the proportion of Leading Health Indicators, Health Status Indicators, and Priority Data Needs for which data – especially for select populations – are available at the Tribal, State and local levels.

DATA SOURCES and DATA ISSUES

The State Title V Agency.

SIGNIFICANCE

To carry out the 10 essential public health services, MCH programs need access to relevant program and policy information. This requires basic data capacity on the part of the Title V agency including the ability to monitor health status, to investigate health problems, and to evaluate programs and policies. One measure of this capacity is the availability and use by State MCH programs of key public health data sets related to women, children, and families.

09B
HEALTH SYSTEMS CAPACITY INDICATOR

The ability of States to monitor tobacco use by children and youth.

GOAL

To assure MCH program and Title V agency access to essential policy and program relevant information from key public health data sets relating to women, children, and families. To demonstrate core MCH data capacity.

DEFINITION

Form 19 for this Health Systems Capacity Indicator is a table with two questions about important databases that document the MCH programs' ability to obtain essential program and policy relevant information. Following the instructions, enter the degree to which the State participating in the surveys (1-3) and whether the State has direct access to the databases (Y/N).

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 Objective. Related Objective 23-5: Increase the proportion of Leading Health Indicators, Health Status Indicators, and Priority Data Needs for which data – especially for select populations – are available at the Tribal, State and local levels.

DATA SOURCES and DATA ISSUES

Youth Risk Behavior Surveillance System or State survey data.

SIGNIFICANCE

To carry out the 10 essential public health services, MCH programs need access to relevant program and policy information. This requires basic data capacity on the part of the Title V agency including the ability to monitor health status, to investigate health problems, and to evaluate programs and policies. One measure of this capacity is the availability and use by State MCH programs of key public health data sets related to women, children, and families.

FORM 20
HEALTH STATUS INDICATORS #01 - 05
MULTI-YEAR DATA

Annual Indicator Data

	FY _____	FY _____	FY _____	FY _____	FY _____
HEALTH STATUS INDICATOR #01A (Low Birth Weight) *The percent of live births weighing less than 2,500 grams. (Risk)*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
HEALTH STATUS INDICATOR #01A (Low Birth Weight - Singleton Births) *The percent of live singleton births weighing less than 2,500 grams. (Risk)*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 20
HEALTH STATUS INDICATORS #01 - 05
MULTI-YEAR DATA (Continuation Page)

Annual Indicator Data

	FY _____	FY _____	FY _____	FY _____	FY _____
HEALTH STATUS INDICATOR #02A (Low Birth Weight) *The percent of live births weighing less than 1,500 grams. (Risk)*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
HEALTH STATUS INDICATOR #01A (Low Birth Weight - Singleton Births) *The percent of live singleton births weighing less than 1,500 grams. (Risk)*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 20
HEALTH STATUS INDICATORS #01 - 05
MULTI-YEAR DATA (Continuation Page)

Annual Indicator Data

	FY _____	FY _____	FY _____	FY _____	FY _____
HEALTH STATUS INDICATOR #03A (Fatal Unintentional Injuries) *The death rate per 100,000 due to unintentional injuries among children aged 14years and younger. (Injuries)*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
HEALTH STATUS INDICATOR #03B (Fatal Unintentional Injuries) *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes. (Injuries)*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
HEALTH STATUS INDICATOR #03C (Fatal Unintentional Injuries) *The death rate per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes. (Injuries)*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 20
HEALTH STATUS INDICATORS #01 - 05
MULTI-YEAR DATA (Continuation Page)

Annual Indicator Data

	FY _____	FY _____	FY _____	FY _____	FY _____
HEALTH STATUS INDICATOR #04A (Nonfatal Unintentional Injuries) *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger. (Injuries)*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
HEALTH STATUS INDICATOR #04B (Nonfatal Unintentional Injuries) *The rate per 100,000 of all nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger (Injuries)*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
HEALTH STATUS INDICATOR #04C (Nonfatal Unintentional Injuries) *The rate per 100,000 of all nonfatal injuries due to motor vehicle crashes among youth aged 15 years through 24 years. (Injuries)*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

FORM 20
HEALTH STATUS INDICATORS #01 - 05
MULTI-YEAR DATA (Continuation Page)

Annual Indicator Data

	FY _____	FY _____	FY _____	FY _____	FY _____
HEALTH STATUS INDICATOR #05A **(Sexually Transmitted Disease – Chlamydia)** *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia. (Prevention)*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
HEALTH STATUS INDICATOR #05B **(Sexually Transmitted Disease – Chlamydia)** *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia. (Prevention)*					
Annual Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

INSTRUCTIONS FOR THE COMPLETION OF HEALTH STATUS INDICATOR FORM 20
TRACKING HEALTH STATUS INDICATORS #01 THROUGH #05

General Instructions:

A glossary of terms applicable to this form is presented in Part Two, Section VIII of this document.

Complete all required data cells. If an actual number is not available make an estimate. Please explain all estimates in a footnote.

The purpose of this form is to show, annually, selected measurements (indicators) of MCH health status in the State and to track those indicators over a five year period. The first five health status indicators deal with data that is to be tracked and displayed over five years. Some of these set of indicators have two or three parts resulting in a total of twelve data elements that are to be completed. Specific instructions, by Health Status Indicator number, are provided below.

For each of the Health Status Indicators, on the lines labeled "Annual Indicator," enter the numerical value that shows the status for the indicator for the appropriate reporting year. Note that the indicator data is to go in the years column from which it was actually derived even if the data is a year behind the "reporting" year. This value is to be expressed in the units that are described on the health status indicator detail sheets which, for these indicators, are either a rate or a percentage.

If there are numerator and denominator data for the indicator value, enter those data on the appropriate lines for the appropriate fiscal year. If there are no numerator and denominator data, leave these lines empty.

Specific Instructions:

Indicator #01 (Low Birth Weight) There are two parts to this indicator (A and B). The values are to be expressed as percents of total or singleton live births weighing less than 2,500 grams.

Indicator #02 (Very Low Birth Weight) There are two parts to this indicator (A and B). The values are to be expressed as percents of total or singleton live births weighing less than 1,500 grams.

Indicator #03 (Fatal Unintentional Injuries) There are three parts to this indicator (A-C). The value is to be expressed as a death rate per 100,000 in the age ranges indicated.

Indicator #04 (Nonfatal Unintentional Injuries) There are three parts to this indicator (A-C). The values are to be expressed as an injury rate per 100,000 in the age ranges indicated.

Indicator #05 (Sexually Transmitted Disease [Chlamydia]) There are two parts to this indicator (A and B). The values are to be expressed as Chlamydia case rates per 1,000 women in the age ranges indicated.

FORM 21
HEALTH STATUS INDICATORS DEMOGRAPHIC DATA

HSI #06A – Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

For both parts A and B: Reporting Year _____ Is this data from a State Projection? ☐ YES ☐ NO

CATEGORY TOTAL POPULATION BY RACE	TOTAL ALL RACES	WHITE	BLACK OR AFRICAN AMERICAN	AMERICAN INDIAN OR NATIVE ALASKAN	ASIAN	NATIVE HAWAIIAN OR OTHER PAC. IS.	MORE THAN ONE RACE REPORTED	OTHER AND UNKNOWN
Infants 0 to 1								
Children 1 through 4								
Children 5 through 9								
Children 10 through 14								
Children 15 through 19								
Children 20 through 24								
Children 0 through 24								

HSI #06B – Demographics (Total Population) *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	TOTAL NOT HISPANIC OR LATINO	TOTAL HISPANIC OR LATINO	EHTNICITY NOT REPORTED
Infants 0 to 1			
Children 1 through 4			
Children 5 through 9			
Children 10 through 14			
Children 15 through 19			
Children 20 through 24			
Children 0 through 24			

FORM 21
HEALTH STATUS INDICATORS DEMOGRAPHIC DATA (Continuation page)

HSI #07A – Demographics (Total live births) *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*
For both parts A and B: Reporting Year _____ Is this data from a State Projection? ☐ YES ☐ NO

CATEGORY TOTAL LIVE BIRTHS BY RACE	TOTAL ALL RACES	WHITE	BLACK OR AFRICAN AMERICAN	AMERICAN INDIAN OR NATIVE ALASKAN	ASIAN	NATIVE HAWAIIAN OR OTHER PAC. IS.	MORE THAN ONE RACE REPORTED	OTHER AND UNKNOWN
Women <15								
Women 15 through 17								
Women 18 through 19								
Women 20 through 34								
Women 35 or older								
Women of all ages								

HSI #07B – Demographics (Total live births *Live births to women (of all ages) enumerated by maternal age and ethnicity. (Demographics)*

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	TOTAL NOT HISPANIC OR LATINO	TOTAL HISPANIC OR LATINO	EHTNICITY NOT REPORTED
Women <15			
Women 15 through 17			
Women 18 through 19			
Women 20 through 34			
Women 35 or older			
Women of all ages			

FORM 21
HEALTH STATUS INDICATORS DEMOGRAPHIC DATA (Continuation page)

HSI #08A – Demographics (Total deaths) *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*
For both parts A and B: Reporting Year _____ Is this data from a State Projection? ☐ YES ☐ NO

CATEGORY TOTAL DEATHS BY RACE	TOTAL ALL RACES	WHITE	BLACK OR AFRICAN AMERICAN	AMERICAN INDIAN OR NATIVE ALASKAN	ASIAN	NATIVE HAWAIIAN OR OTHER PAC. IS.	MORE THAN ONE RACE REPORTED	OTHER AND UNKNOWN
Infants 0 to 1								
Children 1 through 4								
Children 5 through 9								
Children 10 through 14								
Children 15 through 19								
Children 20 through 24								
Infants and children 0 through 24								

HSI #08B – Demographics (Total deaths) *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity. (Demographics)*

CATEGORY TOTAL DEATHS BY HISPANIC ETHNICITY	TOTAL NOT HISPANIC OR LATINO	TOTAL HISPANIC OR LATINO	EHTNICITY NOT REPORTED
Infants 0 to 1			
Children 1 through 4			
Children 5 through 9			
Children 10 through 14			
Children 15 through 19			
Children 20 through 24			
Infants and Children 0 - 24			

FORM 21
HEALTH STATUS INDICATORS DEMOGRAPHIC DATA (Continuation page)

HSI #09A – Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

CATEGORY MISCELLANEOUS DATA BY RACE	**TOTAL ALL RACES**	**WHITE**	**BLACK OR AFRICAN AMERICAN**	**AMERICAN INDIAN OR NATIVE ALASKAN**	**ASIAN**	**NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**	**MORE THAN ONE RACE REPORTED**	**OTHER AND UNKNOWN**	**SPECIFIC REPORTING YEAR**
All children 0 through 19									
Percent in household headed by single parent									
Percent in TANF (Grant) families									
Number enrolled in Medicaid									
Number enrolled in SCHIP									
Number living in foster home care									
Number enrolled in food stamp program									
Number enrolled in WIC									
Rate (per 100,000) of juvenile crime arrests									
Percentage of high school drop-outs (grade 9 through 12)									

FORM 21
HEALTH STATUS INDICATORS DEMOGRAPHIC DATA (Continuation page)

HSI #09B – Demographics (Miscellaneous Data) *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity. (Demographics)*

CATEGORY MISCELLANEOUS DATA BY HISPANIC ETHNICITY	**TOTAL NOT HISPANIC OR LATINO**	**TOTAL HISPANIC OR LATINO**	**ETHNICITY NOT REPORTED**	**SPECIFIC REPORTING YEAR**
All children 0 through 19				
Percent in household headed by single parent				
Percent in TANF (Grant) families				
Number enrolled in Medicaid				
Number living in foster home care				
Number enrolled in SCHIP				
Number enrolled in food stamp program				
Number enrolled in WIC				
Rate (per 100,000) of juvenile crime arrests				
Percentage of high school drop-outs (grade 9 through 12)				

FORM 21
HEALTH STATUS INDICATORS
DEMOGRAPHIC DATA (Continuation page)

HSI #10 – Demographics (Geographic Living Area) *Geographic living area for all resident children aged 0 through 19 years old. (Demographics)*
Reporting Year _____ Is this data from a State Projection? ☐ YES ☐ NO

GEOGRAPHIC LIVING AREAS	TOTAL
Living in metropolitan areas	
Living in urban areas	
Living in rural areas	
Living in frontier areas	
Total – all children 0 through 19	

HSI #11 – Demographics (Poverty Levels) *Poverty levels for the total State Population.(Demographics)*
Reporting Year _____ Is this data from a State Projection? ☐ YES ☐ NO

POVERTY LEVELS	TOTAL
Total Population	
Percent Below: 50% of poverty	
100% of poverty	
200% of poverty	

HSI #12 – Demographics (Poverty Levels) *Poverty levels for all children aged 0* ***through 19 years.****(Demographics)*
Reporting Year _____ Is this data from a State Projection? ☐ YES ☐ NO

POVERTY LEVELS	TOTAL
Children 0 through 19 years old	
Percent Below: 50% of poverty	
100% of poverty	
200% of poverty	

INSTRUCTIONS FOR THE COMPLETION OF HEALTH STATUS INDICATOR FORM 21
HEALTH STATUS INDICATORS #06 THROUGH #12

General Instructions:

A glossary of terms applicable to this form is presented in Part Two, Section VIII of this document.

The purpose of this form, which contains 11 tables for 6 indicators, is to provide, annually, selected demographic data in the State. Indicators 13, 14, 15, and 16 each have two parts (A and B) and indicators 17, 18, and 19 each have one part. The racial and ethnic population categories included in these tables are from the most current Office of Management and Budget guidelines.

At the top of each table [EXCEPT FOR THE TABLES FOR HIS 16A AND 16B] enter the year for which the data is being reported and check the appropriate box to indicate if the data is from a State projection. For Health Status Indicators 13 through 15 the Reporting Year will be the same for parts A and B of each form. See specific instructions below for dating the data on tables HIS 16A and 16B.

Specific Instructions:

Health Status Indicators 13-20 (Demographics)

For Table #06A (Total Population): In the column labeled "TOTAL ALL RACES" enter the total population of the State in the age groups specified. In the next seven columns enter the population of the State in the racial categories indicated at the head of each column and in the age groups specified. In the column headed "MORE THAN ONE RACE REPORTED" enter the population figure for instances where more than one race is reported. In the column headed "OTHER AND UNKNOWN" enter the population figure for other racial categories not shown and/or population figures where the racial category is not known. The population figures in the columns for the racial categories must equal the figures in the "TOTAL ALL RACES" column.

For Table #06B: In the column headed "TOTAL NOT HISPANIC OR LATINO" enter the total of the population of the State, in the age groups specified, that are not of Hispanic or Latino ethnicity. In the column headed "TOTAL HISPANIC OR LATINO" enter the total population figures for those that are of Hispanic or Latino ethnicity. IN the column headed "EHTNICITY NOT REPORTED" enter the total of the population whose ethnicity is not reported. The sum of these three figures must equal the figures in the "TOTAL ALL RACES' column of Table 06A.

INSTRUCTIONS FOR THE COMPLETION OF HEALTH STATUS INDICATOR FORM 21
HEALTH STATUS INDICATORS #06 THROUGH #12 (Continued)

For Table #07A (Total live births): In the column labeled "TOTAL ALL RACES" enter the number of live births in the Sate for the age groups specified. IN the next seven columns enter the number of live births in the racial categories indicated at the head of each column and in the age groups specified. In the column headed "MORE THAN ONE RACE REPORTED" enter the number of live births for instances where more than one race is reported. In the column headed "OTHER AND UNKNOWN" enter the number of live births for other racial categories not shown and/or live birth figures where the racial category is not known. The live birth figures in the columns for the racial must equal the figures in the "TOTAL ALL RACES" column.

For Table #07B: In the column headed "TOTAL NOT HISPANIC OR LATINO" enter the number of live births in the State, in the age groups specified, that are not of Hispanic or Latino ethnicity. In the column headed "TOTAL HISPANIC OR LATINO" enter the number of live births for the population that are of Hispanic or Latino ethnicity. In the column headed "ETHNICITY NOT REPORTED" enter live birth figures for the total of the population whose ethnicity is not reported. The sum of these three figures must equal the figures in the "TOTAL ALL RACES" column of Table 07A.

For Table #08A (Total deaths): In the column labeled "TOTAL ALL RACES" enter the number of deaths to infants and children in the State for the age groups specified. In the next seven columns enter the number of deaths to infants and children in the racial categories indicated at the head of each column and in the age groups specified. In the column headed "MORE THAN ONE RACE REPORTED" enter the number of deaths to infants and children for instances where more than one race is reported. In the column headed "OTHER AND UNKNOWN" enter the number of deaths to infants and children for other racial categories not shown and/or infant/child death figures where the racial category is not known. The infant/child death figures in the columns for the racial categories must equal the figures in the "TOTAL ALL RACES' column.

For Table #08B: In the column headed "TOTAL NOT HISPANIC OR LATINO" enter the number of deaths to infants and children in the State, in the age groups specified, that are not of Hispanic ethnicity. In the column headed "TOTAL HISPANIC OR LATINO" enter the infant/child death figures for those that are of Hispanic or Latino ethnicity. In the column headed "ETHNICITY NOT REPORTED" enter the population data for those instances where the ethnic category is not reported. Enter in the column headed "SPECIFIC REPORTING YEAR" the year for which the data is reported.

For Table #09A (Miscellaneous Data): In the column labeled "ALL RACES" enter the population data requested for the categories listed in the first column. IN the next seven columns enter the population data for the categories listed and for the racial categories indicated at the head of each column. In the column headed "MORE THAN ONE RACE REPORTED" enter the population data for the categories listed where more than one race is reported. In the column headed "OTHER AND UNKNOWN" enter the population data for the categories listed for other racial categories not shown and/or for those instances where the racial category is not known. Enter in the column headed "SPECIFIC REPORTING YEAR" the year for which the data is reported.

For Table #09B: In the column headed "TOTAL NOT HISPANIC OR LATINO" enter the population data for the categories listed in the first column that are not of Hispanic or Latino ethnicity. In the column headed "TOTAL HISPANIC OR LATINO" enter the population data for those that are of Hispanic or Latino ethnicity. In the column headed "ETHNICITY NOT REPORTED" enter the population data for those instances where the ethnic category is not reported. Enter in the column headed "SPECIFIC REPORTING YEAR" the year for which the data is reported.

INSTRUCTIONS FOR THE COMPLETION OF HEALTH STATUS INDICATOR FORM 21
HEALTH STATUS INDICATORS #06 THROUGH #12 (Continued)

For Table #10 (Geographic Living Area):
In the second column of the first four rows enter the number of children aged 0 through 19 residing in the State for each geographic region listed in the first column. If the State already has figures for these geographic breakouts they may use those. In such cases specify in a footnote the parameters that are used for the geographic locations. For States that do not have these breakouts, the following information is provided:

METROPOLITAN areas are defined by the Office of Management and Budget (OMB) according to published standards that are applied to U.S. Census Bureau data. The most current list of Metropolitan Areas is available in PDF downloadable file format http://www.census.gov/population/www/metroareas/metrodef.html or can be acquired by contacting the Bureau of the Census at 1-866-758-1060.

URBAN areas are defined by the Bureau of the Census and can be found at http://www.census.gov/geo/www/ua/ua_2k.html or can be acquired by contacting the Bureau of the Census at ua@geo.census.gov. "Urban" consists of territory, persons and housing units in: 1. Places of 2,500 or more persons incorporated as cities, villages, boroughs (except in Alaska and New York), and towns (except in the six New England States, New York, and Wisconsin), but excluding the rural portion of "extended cities"; 2. Census designated places of 2,500 or more persons; and , 3. Other territory, incorporated or unincorporated, included in urbanized areas.

RURAL areas are defined as territory, population, and housing units not classified as urban.

FRONTIER areas, for the purposes of this table, are defined as counties with population densities of 6 persons or fewer per square mile.

In the second column of the last row enter the total State population of children aged 0 through 19.

For Table #11 (Poverty Levels – Total Population)
In the second cell of the first row enter the total of the State population living at or below the Federal Poverty Level. In the second cell of the remaining rows enter the percent of the total population living at or below the percentages indicated in the first column.

For Table #12 (Poverty Levels – Children 0 through 19)
In the second cell of the first row enter the number of the State population aged 0 through 19 living at or below the Federal Poverty Level. In the second cell of the remaining rows enter the percent of the State population aged 0 through 19 living at or below the percentages indicated in the first column.

VIIE - Health Status Indicators Detail Sheets

01A
HEALTH STATUS INDICATOR

The percent of live births weighing less than 2,500 grams.

GOAL

To reduce proportion of all live deliveries with low birth weight.

DEFINITION

Numerator: Number of resident live births less than 2,500 grams.

Denominator: Number resident live births in the State in the reporting period.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-10a: Reduce low birth weights (LBW) to no more than 5 percent of all live births. (Baseline: 7.6 percent 1998)

DATA SOURCES and DATA ISSUES

State vital records and census data are source.

SIGNIFICANCE

The general category of low birth weight infants includes pre-term infants and infants with intrauterine growth retardation. Many risk factors have been identified for low birth weight babies including: both young and old maternal age, poverty, late prenatal care, smoking, substance abuse, and multiple births.

01B
HEALTH STATUS INDICATOR

The percent of live singleton births weighing less than 2,500 grams.

GOAL

To reduce the proportion of all live singleton deliveries with low birth weight.

DEFINITION

Numerator: Number of resident live singleton births weighing less than 2,500 grams.

Denominator: Number resident live singleton births in the State in the reporting period.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 objective. Related to Objective 16-10a: Reduce low birth weights (LBW) to no more than 5 percent of all live births. (Baseline: 7.6 percent in 1998)

DATA SOURCES and DATA ISSUES

State vital records and census data are source.

SIGNIFICANCE

In vitro fertilization has increased the number of multiple births. Multiple births often result in shortened gestation and low or very low birth weight infants.

02A **HEALTH STATUS INDICATOR**	**The percent of live births weighing less than 1,500 grams.**

GOAL	To reduce proportion of all live deliveries with low birth weight.
DEFINITION	**Numerator:** Number of resident live births weighing less than 1,500 grams. **Denominator:** Number resident live births in the State in the reporting period. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-10b: Reduce very low birth weight births to no more than 0.9 percent of all live births. (Baseline: 1.4 percent in 1998)
DATA SOURCES and DATA ISSUES	State vital records and census data are source.
SIGNIFICANCE	Very low birth weight births are usually associated with pre-term birth. The primary risk factors for pre-terms births are prior preterm birth, prior spontaneous abortion, low pre-pregnancy weight, cigarette smoking, and multiple births.

02B
HEALTH STATUS INDICATOR

The percent of live singleton births weighing less than 1,500 grams.

GOAL

To reduce the proportion of all live singleton deliveries with very low birth weight.

DEFINITION

Numerator: Number of resident singleton births weighing less than 1,500 grams.

Denominator: Number resident singleton births in the State in the reporting period.

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 objective. Related to Objective 16-10b: Reduce very low birth weights to no more than 0.9 percent of all live births. (Baseline: 1.4 percent in 1998)

DATA SOURCES and DATA ISSUES

State vital records and census data are source.

SIGNIFICANCE

In vitro fertilization has increased the number of multiple births. Multiple births may result in shortened gestation and low or very low birth weight infants.

03A **HEALTH STATUS INDICATOR**	**The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.**

GOAL	To reduce the number of deaths among children aged 14 years and younger due to unintentional injuries.
DEFINITION	**Numerator:** Number of deaths from all unintentional injuries for children aged 14 years and younger. **Denominator:** Number of children aged 14 years and younger in the State for the reporting period. **Units:** 100 **Text:** Rate per 100,000
HEALTHY PEOPLE 2010 OBJECTIVE	No specific Healthy People 2010 objective. Related objective 15-13: Reduce deaths caused by unintentional injuries to no more than 20.8 per 100,000 population. (Baseline: 33.3 deaths per 100,000 in 1998)
DATA SOURCES and DATA ISSUES	Child death certificates are collected in State vital records. Data on total number of children comes from the Fatality Analysis Reporting Systems (FARS), the U.S. Department of Transportation and Vital Statistics Systems are further sources.
SIGNIFICANCE	Injuries are the leading cause of death among persons aged 1 through 34 years and a significant health problem affecting the nation's children. About 50 percent of all deaths of children aged 1-14 years are due to injuries, and around 80 percent of these are from motor vehicle crashes.

03B **HEALTH STATUS INDICATOR**	**The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.**
GOAL	To reduce the number of deaths to children aged 14 years and younger due to motor vehicle crashes.
DEFINITION	**Numerator:** Number of unintentional fatalities to children aged 14 years and younger from motor vehicle crashes in the reporting year. **Denominator:** Number of children aged 14 years and younger in the State in the reporting year. **Units:** 100,000 **Text:** Rate per 100,000
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 15-15a: Reduce deaths caused by motor vehicle crashes. (Target 9.0 deaths per 100,000 population). (Baseline for children aged 14 years and younger, 4.2 in 1998)
DATA SOURCES and DATA ISSUES	Child death certificates are collected in State vital records. Data on total number of children comes from the Bureau of the Census. The Fatality Analysis Reporting System (FARS), the U.S. Department of Transportation and Vital Statistics Systems are further sources.
SIGNIFICANCE	Injuries are the leading cause of death among persons aged 1 through 34 years and a significant health problem affecting the Nation's children. About 50 percent of all deaths of children aged 1 through 14 years are due to injuries, and around 80 percent of these are from motor vehicle crashes.
GOAL	To reduce the number of deaths to children aged 14 years and younger due to motor vehicle crashes.

03C
HEALTH STATUS INDICATOR

The death rate per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes.

GOAL

To reduce the number of deaths to youth aged 15 through 24 years due to motor vehicle crashes.

DEFINITION

Numerator: Number of unintentional fatalities to youth aged 15 through 24 years due to motor vehicle crashes in the reporting year.

Denominator: Number of youths aged 15 through 24 years in the State in the reporting year.

Units: 100,000 **Text:** Rate per 100,000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 15-15a: Reduce deaths caused by motor vehicle crashes. (Target 9.0 deaths per 100,000 population). (Baseline for persons aged 15 through 24 years, 25.4 deaths per 100,000 in 1998)

DATA SOURCES and DATA ISSUES

Child deaths certificates are collected in State vital records. Data on total number of children comes from the Bureau of the Census. The Fatality Analysis Reporting System (FARS), the U.S. Department of Transportation and Vital Statistics Systems are further sources.

SIGNIFICANCE

Injuries are the leading cause of death among persons aged 1 through 34 years and a significant health problem affecting the Nation's children. About 50 percent of all deaths of children aged 1 through 14 years are due to injuries, and around 80 percent of these are from motor vehicle crashes.

04A
HEALTH STATUS INDICATOR

The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.

GOAL

To reduce the number of hospitalizations of children aged 14 years and younger due to non-fatal injuries.

DEFINITION

Numerator: Number of children aged 14 years and younger who have a hospital discharge for non-fatal injuries.

Denominator: Number of children aged 14 years and younger in the State for the reporting period.

Units: 100,000 **Text:** Rate per 100,000

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 objective. Related objective 15-14 (Developmental): Reduce non-fatal unintentional injuries.

DATA SOURCES and DATA ISSUES

Numerator: State E-coded hospital discharge data.
Denominator: Census data, State population estimates.
Potential Data Source: National Hospital Discharge Survey (NHDS), CDC, HCHS.

SIGNIFICANCE

Serious non-fatal unintentional injuries account for 84 percent of injury-related hospitalizations and result in an estimated $108 billion in lifetime medical costs. (A lifetime cost is defined as the total cost of an injury from onset until either complete cure or death. Twenty-eight percent of these lifetime costs due to unintentional injury are attributable to motor vehicle crashes.)[1]

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1 Rice, DP, MacKenzie EJ, et al. *Cost of Injury in the United States: A Report to Congress, 1989.* San Francisco, CA: Institutes for Health and Aging of the University of California San Francisco and Injury Prevention Center, The Johns Hopkins University, 1989.

04B
HEALTH STATUS INDICATOR

The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.

GOAL

To reduce the number of hospitalizations among children aged 14 years and younger due to motor vehicle crashes.

DEFINITION

Numerator: Number of children aged 14 years and younger with a hospital discharge for non-fatal injuries due to motor vehicle crashes in the reporting year.

Denominator: Number of children aged 14 years and younger in the State for the reporting year.

Units: 100,000 **Text:** Rate per 100,000

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 objective by age group. Related objective 15-17: Reduce non-fatal injuries caused by motor vehicle crashes to 1,000 non-fatal injuries per 100,000 population. (Baseline: 1,270 non-fatal injuries per 100,000 in 1997.

DATA SOURCES and DATA ISSUES

Numerator: State E-coded hospital discharge data.
Denominator: Census data, State population estimates.

SIGNIFICANCE

Serious non-fatal unintentional injuries account for 84 percent of injury-related hospitalizations and result in an estimated $108 billion in lifetime medical costs. (A lifetime cost is defined as the total cost of an injury from onset until either complete cure or death. Twenty-eight percent of these lifetime costs due to unintentional injury are attributable to motor vehicle crashes.[2]

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2 Rice, DP, MacKenzie EJ et al. *Cost of Injury in the United States: A Report to Congress, 1989.* San Francisco, CA: Institute for Health and Aging of the University of California-San Francisco and Injury Prevention Center, The Johns Hopkins University, 1989.

04C
HEALTH STATUS INDICATOR

The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

GOAL

To reduce the number of hospitalizations among youth aged 15 through 24 years due to motor vehicle crashes.

DEFINITION

Numerator: Number of youths aged 15 through 24 years with a hospital discharge for non-fatal injuries due to motor vehicle crashes in the reporting year.

Denominator: Number of youths aged 15 through 24 years in the State for the reporting year.

Units: 100,000 **Text:** Rate per 100,000

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 objective by age group. Related objective 15-17: Reduce non-fatal injuries caused by motor vehicle crashes to 1,000 non-fatal injuries per 100,000 population. (Baseline: 3,116 non-fatal injuries per 100,000 persons aged 16 through 20 and 2,496 non-fatal injuries per 100,000 persons aged 21 to 24 years in 1997).

DATA SOURCES and DATA ISSUES

Numerator: State E-coded hospital discharge data.
Denominator: Census data, State population estimates.

SIGNIFICANCE

Serious non-fatal unintentional injuries account for 84 percent of injury-related hospitalizations and result in an estimated $108 billion in lifetime medical costs. (A lifetime cost is defined as the total cost of an injury from onset until either complete cure or death. Twenty-eight percent of these lifetime costs due to unintentional injury are attributable to motor vehicle crashes.)[3]

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3 Rice DP, MacKenzie EJ, et al. *Cost of Injury in the United States: A Report to Congress, 1989.* San Francisco, CA: Institute for Health and Aging of the University of California-San Francisco and Injury Prevention Center, The Johns Hopkins University, 1989.

05A
HEALTH STATUS INDICATOR

The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

GOAL

To decrease the sexually transmitted disease (chlamydia) rates among women aged 15 through 19 years.

DEFINITION

Numerator: Number of women aged 15 through 19 years with a reported case of chlamydia.

Denominator: Number of women aged 15 through 19 years in the State in the reporting year.

Units: 1,000 **Text:** Rate per 1,000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 25-1: Reduce the proportion of adolescents and young adults with *Chlamydia Trachomatitis* infections. Objective 25-1a: Reduce the proportion of females aged 15 through 24 years attending family planning clinics to 3.0 percent. (Baseline: 5.0 percent in 1997) Objective 25-1b: Reduce the proportion of females aged 15 to 24 years attending STD clinics to 3.0 percent. (Baseline: 12.0 percent in 1997).

DATA SOURCES and DATA ISSUES

State STD Program Surveillance, State Communicable Disease Registry.

SIGNIFICANCE

1n 1997, chlamydia was the most frequently reported communicable disease in the United States. Chlamydia is common in sexually active adolescents and young adults. The highest annual rates are reported in females aged 15 through 19 years.

05B
HEALTH STATUS INDICATOR

The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

GOAL

To decrease the sexually transmitted disease (chlamydia) rates among women aged 20 through 44 years.

DEFINITION

Numerator: Number of women aged 20 through 44 years with a reported case of chlamydia.

Denominator: Number of women aged 20 through 44 years in the State in the reporting year.

Units: 1,000 **Text:** Rate per 1,000

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 objective for this age group or gender.
Related Objective 25-18: Increase the proportion of primary care providers who treat patients with sexually transmitted diseases and who manage cases according to recognized standards.
Related Objective 25-1a: Reduce the proportion of families aged 15 to 24 years attending family planning clinics to 3.0 percent. (Baseline: 5.0 percent in 1997)
Related Objective 25-1b: Reduce the proportion of females aged 15 to 24 years attending STD clinics to 3.0 percent. (Baseline 12.0 percent in 1997)

DATA SOURCES and DATA ISSUES

State STD Program Surveillance, State Communicable Disease Registry.

SIGNIFICANCE

In 1997, chlamydia was the most frequently reported communicable disease in the United States. Chlamydia is common in sexually active adolescents and young adults. The highest annual rates are reported in females aged 15 through 19 years.

06 A & B
HEALTH STATUS INDICATOR

Infants and children aged 0 through 24 years enumerated by age subgroup, race, and ethnicity.

GOAL

To enumerate the total population of children aged 0 through 24 years by age subgroup, race, and ethnicity.

DEFINITION

Tables 06 A & B on Health Status Indicator Form 21 have cells for populations of subgroups of children aged 0 through 24 years aggregated by race and ethnicity. In each cell of the two tables enumerate the population figures requested.

Unit: Counts of State residents aged 0 through 24 years old.

Text: Number

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 Objective.

DATA SOURCES and DATA ISSUES

Census data, State projections, Vital Records and Health Statistics.

SIGNIFICANCE

Demographers predict that, by the end of the year 2000, one of every Americans will be African American, Asian/Pacific Islander, Middle Eastern, or Hispanic. Maternal and Child Health (MCH) professionals and policy makers must develop strategies and programs to address the needs of this growing segment of the population. Data reveals marked variations in morbidity and mortality by race and/or ethnicity. Reaching the goal of eliminating racial and ethnic disparities in health outcomes will necessitate identifying barriers to accessing family-centered, community-oriented, culturally-competent, and comprehensive care for all Americans. Improved collection and use of standardized demographic data will identify high-risk populations and monitor the effectiveness of health promotion and disease prevention interventions targeting these groups.

07 A & B
HEALTH STATUS INDICATOR

Live births to women (of all ages) enumerated by maternal age, race, and ethnicity.

GOAL

To enumerate total live births by maternal age, race, and ethnicity.

DEFINITION

Tables 07 A & B on Health Status Indicator Form 21 have cells for population subgroups of women aggregated by race and ethnicity. In each cell on the two tables enumerate the live births to the groups of women indicated.

Units: Count of State live births. **Text:** Number

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 objective.

DATA SOURCES and DATA ISSUES

Vital Records.

SIGNIFICANCE

Younger or older mothers, and mothers belonging to racial and/or ethnicity minority groups may be at increased risk of adverse maternal outcomes. Identifying populations of women and their infants at risk, and implementing coordinated systems of pre-conceptual/perinatal services that assures receipt of risk-appropriate health care delivery is essential for healthy mothers and babies.

08 A & B
HEALTH STATUS INDICATOR

Deaths of infants and children aged 0 through 24 years enumerated by age subgroup, race, and ethnicity.

GOAL

To enumerate deaths of infants and children aged 0 through 24 years by age subgroup, race, and ethnicity.

DEFINITION

Tables 08 A & B on Health Status Indicator Form 21 have cells for population subgroups of children aged birth through 24 6ears aggregated by race and ethnicity. In each cell on the two tables enumerate the deaths in each sub-population.

Units: Count of State residents aged 0 through 24 years.

Text: Number

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 objective.

DATA SOURCES and DATA ISSUES

Vital Records.

SIGNIFICANCE

The greatest racial and ethnic disparities are seen in the following causes of death in infants: disorders relating to pre-term birth and unspecified low birth weight; respiratory distress syndrome; infections specific to the perinatal period; complications of pregnancy; and sudden infant death syndrome (SIDS). In some American Indian/Alaskan Native populations, the incidence of SIDS is three times that of white populations. African American adolescent males have the highest homicide rates in the country. Suicide among adolescent males in certain American Indian/Alaskan Native tribes has reached epidemic proportions. Identifying at-risk populations and implementing and monitoring prevention/intervention programs will play an integral role in eliminating disparities in mortality.

09 A & B
HEALTH STATUS INDICATOR

Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity.

GOAL

To determine number/percentage of infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs.

DEFINITION

Tables 09 A & B on Health Status Indicator Form 21 have cells for populations of subgroups of infants and children aged 0 through 19 years in miscellaneous situations and/or State programs by race and ethnicity. Complete each of the cells in the tables with a percentage or count as appropriate.

Units: 100 or count **Text:** Percent, number or rate

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 objective.

DATA SOURCES and DATA ISSUES

AFDC/TANF, Medicaid, SCHIP, food stamp, and WIC files; State juvenile criminal justice and Board of Education files, Linked child health data files, Census data.

SIGNIFICANCE

Adverse health outcomes disproportionately affect infants and children in foster care or in single parent homes. In 1995, 14 million infants and children aged 0 through 18 years lived below the Federal poverty level; 59 percent of these families were single parent families. Leaving high school before graduation can lead to continued poverty and a higher incidence of juvenile arrests. Many infants and children eligible for Medicaid and other State programs are not enrolled. Data linkage of State program files with Medicaid may identify factors associated with State program eligibility without full participation.

10
HEALTH STATUS INDICATOR

Geographic living area for all resident children aged 0 through 19 years.

GOAL

To determine the number of children in the State aged 0 through 19 years by geographic living area.

DEFINITION

Table 10 on Health Status Indicator Form 21 includes cells for children in sub-population groups ranging from birth through 19 years of age. Complete the cells with the number of children in those age ranges living in metropolitan, urban, rural, or frontier geographic areas.

Units: Count **Text:** Number

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 objective.

DATA SOURCES and DATA ISSUES

Census data or State population projections.

SIGNIFICANCE

Child health outcomes and the patterns of utilization of health care services can differ greatly by geographic area of living. Poor families living in metropolitan and urban areas without a regular source of coordinated health services may over utilize emergency services or present as frequent walk-ins to community or public health clinics. Access to care for the poor and under-served in rural and frontier areas is largely dependent on the number of providers available and willing to see the uninsured or accept Medicaid or CHIP. Barriers to quality health care may also include inadequate transport to care and ill-equipped health care facilities.

11
HEALTH STATUS INDICATOR

Poverty levels for the total State population.

GOAL

To determine the percentage of the State population at 50 percent, 100 percent, and 200 percent of the federal poverty level.

DEFINITION

Table 11 on Health Status Indicator Form 21 has cells for the population at various poverty levels. Please complete the cells with the count of total population and the percentages of the population living at the 50 percent, 100 percent or 200 percent poverty level.

Units: Count for population and 100.

Text: Number for population and percent.

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 Objective.

DATA SOURCES and DATA ISSUES

Census data or State population projections.

SIGNIFICANCE

Eligibility for Medicaid, SCHIP and other State programs is in part determined by family income as a percentage of federally defined poverty levels. States have some discretion in determining which groups their Medicaid and SCHIP programs will cover and the financial criteria for Medicaid and SCHIP eligibility.

12
HEALTH STATUS INDICATOR

Poverty levels for all children aged 0 through 19 years.

GOAL

To determine the percentage of all children aged 0 through 19 years at 50 percent, 100 percent, and 200 percent of the federal poverty level.

DEFINITION

Table 12 on Health Status Indicator Form 21 has cells for the State population aged 0 through 19 years and percentages of that population at various poverty levels. Please complete the cells with the count of the population in that age range and the percentages of that population living at the 50 percent, 100 percent or 200 percent poverty level.

Units: Count for population and 100.

Text: Number for population and percent.

HEALTHY PEOPLE 2010 OBJECTIVE

No specific Healthy People 2010 Objective.

DATA SOURCES and DATA ISSUES

Census data or State population projections.

SIGNIFICANCE

Eligibility for Medicaid, SCHIP and other State programs is in part determined by family income as a percentage of federally defined poverty levels. States have some discretion in determining which groups their Medicaid and SCHIP programs will cover and the financial criteria for Medicaid and SCHIP eligibility.

VIII - GLOSSARY

Adequate prenatal care - Prenatal care where the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index)**.**

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment – (see "Needs Assessment").

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Children - A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. ***(For planning and systems development)*** -

Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination - (see Care Coordination Services).

Cultural Competence – a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals and which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs, language, inter-personal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. At a systems, organizational, or program level, cultural competence requires a comprehensive and coordinated plan that includes interventions at all the levels from policy-making to the individual, and is a dynamic, ongoing, process that requires a long-term commitment. A component of cultural competence is linguistic competence, the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who are not literate or have low literacy skills, and individuals with disabilities.

Regarding the principles of cultural competence, an organization should value diversity in families, staff, providers and communities; have the capacity for cultural self-assessment; be conscious of the dynamics inherent when cultures interact, e.g. families and providers; institutionalize cultural knowledge; and develop adaptations to service delivery and partnership building reflecting an understanding of cultural diversity. An individual should examine one's own attitude and values; acquire the values, knowledge, and skills for working in cross cultural situations; and remember that every one has a culture.

Sources: Maternal and Child Health Bureau (MCHB), Guidance and Performance Measures for Discretionary Grants, Health Resources and Services Administration, U.S. Department of Health and Human Services, Denboba and Goode, 1999 and 2004.

Cross, Bazron, Dennis and Isaacs, Towards a Culturally Competent System of Care, 1989.

Goode and Jones, Definition of Linguistic Competence, National Center for Cultural Competence, Revised 2004.

Denboba, "Federal Viewpoint," Special Additions Newsletter for Children with Special Health Care Needs, Spring/Summer 2005.

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Early Neonatal – Infants less than or equal to 6 days of age.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment **-** a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care – Approach that assures the health and well-being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-Centered Care is the standard of practice which results in high quality services.

Family/Professional Partnerships – The foundation of family-centered care is the partnership between families and professionals. The following key principles to this partnership are:

- Families and professionals work together in the best interest of the child and the family. As the child grows, s/he assumes a partnership role;
- Everyone respects the skills and expertise brought to the relationship;
- Trust is acknowledged as fundamental;
- Communication and information sharing are open and objective;
- Participants make decisions together; and
- There is a willingness to negotiate.

Based on this partnership, family-centered care:

- Acknowledges the family as the constant in a child's life;
- Builds on family strengths;
- Supports the child in learning about and participating in his/her care and decision-making;
- Honors cultural diversity and family traditions;
- Recognizes the importance of community-based services;
- Promotes an individual and developmental approach;
- Encourages family-to-family and peer support;
- Supports youth as they transition to adulthood;
- Develops policies, practices, and systems that are family-friendly and family-centered in all settings; and
- Celebrates successes.

Sources: National Center for Family-Centered Care. Family-Centered Care for Children with Special Health Care Needs. (1989). Bethesda, MD: Association for the Care of Children's Health.

Bishop, Woll and Arango (1993). Family/Professional Collaboration for Children with Special Health Care Needs and their Families. Burlington, VT: University of Vermont, Department of Social Work.

Family-Centered Care Projects 1 and 2 (2002-2004). Bishop, Woll, Arango. Algodones, NM; Algodones Associates.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children less than one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care.*

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”).

Measures - (see “Performance Measures”).

National Children with Special Health Care Needs (CSHCN) Survey – National survey conducted every four years which serves as the primary data source for reporting on National Performance Measures 2-6.

National Survey of Children’s Health – National survey conducted every four years which provides a snapshot of the status of children’s health in each State and in the Nation.

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining:1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing.

Neonatal – Infants less than 28 days of age.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC, and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Perinatal – Period from gestation of 28 weeks or more to 7 days or less after birth.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, Medicaid reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title V – The authorizing legislation for the Maternal and Child Health Block Grant to States program, which is found in Title V of the Social Security Act.

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Title XIX – The authorizing legislation for the Medicaid program, which is found in Title XIX of the Social Security Act.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (Medicaid) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (Medicaid) program.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the ***Federal*** Title V Block grant allocation, the ***Applicant's*** funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the ***State*** funds (the total matching funds for the Title V allocation - match and overmatch), ***Local*** funds (total of MCH dedicated funds from local jurisdictions within the state), ***Other*** federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and ***Program Income*** (those collected by State MCH agencies from insurance payments, Medicaid, HMO's, etc.)

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services" and "Direct Medical Services."

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

IX - TECHNICAL NOTE: GUIDELINES FOR CALCULATING PERFORMANCE MEASURES USING SMALL SAMPLES *

The procedures outlined below are intended to assist States and territories in displaying data on required Title V Performance Measures. When the number of events in any one year is very small, other approaches are needed to compare results and determining statistical significance. The following guidelines are intended to provide a consistent approach for those jurisdictions confronting "the small numbers" situation.

GUIDELINES

Number of Events	Calculate Rate?	Calculate Confidence Interval?	Suggested Approach
A. If at least 20 events (numerator)	Yes	Yes	Use calculated rate
B. If fewer than 20 events (numerator)	Yes	Yes	First, calculate a three year average rate, then calculate a confidence interval
C. If 3 year average is fewer than 20 events but greater than 4 events (numerator)	Yes	Yes	Calculate a standardized ratio
D. If fewer than 5 events (numerator)	No	No	Use the low number checkbox provided in the electronic application and include a note that further explains the data.
E. Special Case: Infant and Fetal Mortality: If fewer than 1000 live births (denominator)	No	No	Apply above alternatives and consider using a standardized mortality ratio
F. Special Case: Childhood Mortality: If fewer than 5 events (numerator)	No	No	Apply above alternatives and consider using a standardized mortality ratio

*Source: Family Health Outcomes Project

PROCEDURES

A. Calculate rates (at least 20 events)

Example #1: 25 infant deaths and 860 live births

- calculate rate:

$$\frac{\text{25 infant deaths}}{\text{860 live births}} \times 1{,}000 = 29.1 \text{ (rate)}$$

- calculate 95% confidence interval:

$$= \text{rate} \pm 1.96 \times \sqrt{\text{rate/denominator}} \times 1{,}000$$

$$= 29.1 \pm 1.96 \times \sqrt{.029/860} \times 1{,}000$$

- $= 29.1 \pm 1.96 \times 5.82 = 29.1 \pm 11.4$
- $= (17.7, 40.5)$

B. Calculate 3 year annual average rates (fewer than 20 events)

- To calculate the numerator:

  Add up the number of events for the current year and the number of events for the previous 2 years.

- To calculate the denominator:

  Method 1: Add the population denominator for the current year combined with the population denominators for the previous 2 years.

  OR

  Method 2: Use the population statistic for the middle year only.

- For a three year average rate, divide the numerator by the denominator and multiply by 1,000 for a rate per 1,000. Calculate XYZ state's average annual death rate per 1,000 for 1989-1991 as follows:

  Method 1:

$$\frac{(D_1 + D_2 + D_3)}{(P_1 + P_2 + P_3)} \times 1{,}000 = \text{Three Year Average Rate}$$

  OR

  Method 2:

$$\frac{1/3 \times (D_1 + D_2 + D_3)}{(P_1 + P_2 + P_3)} \times 1{,}000 = \text{Three Year Average Rate}$$

Where:

D = the number of deaths in years 1, 2, and 3, respectively
P = the total population in years 1, 2, and 3, respectively

Example #2: 5 infant deaths in 1989, 6 in 1990, 7 in 1991; and 1,520 live births in 1989, 1,530 in 1990, and 1,525 in 1991

Calculate three year average using method 1:

$$\frac{(5 + 6 + 7)}{(1{,}520 + 1{,}530 + 1{,}525)} \times 1{,}000 = 3.93$$

OR

Calculate three year average using method 2:

$$\frac{1/3 \times (5 + 6 + 7)}{1{,}530} \times 1{,}000 = 3.92$$

Note: The actual number of events for each year should be documented along with the three year total and the calculated annual average rate.

C. Calculate a Standardized Ratio

A standardized ratio is the relationship between the observed number of events versus the expected number of events.

To calculate the expected number of events, National rates are applied to the State denominator to generate an expected number of events if the State was the same as the national rate.

$$\frac{\text{State Denominator} \times \text{U.S. Rate}}{1{,}000} = \text{Expected Number of Events}$$

Example 3: In 1993, the national infant mortality rate was 6.8 per 1,000 and XYZ State had 500 births.

- calculate standardized ratio:

Calculate the expected number of infant deaths by multiplying 500 by 6.8 and dividing by 1,000 (even though, the actual observed number of deaths was 6):

$$\frac{500 \times 6.8}{1{,}000} = \text{Expected Number of Events}$$

Dividing the observed number of events by the expected number and multiplying by 100:

$$\frac{\text{Observed Number of Events}}{\text{Expected Number of Events}} \times 100 = \text{Standardized Ratio}$$

$$\frac{6}{3.3} \times 100 = 181.8$$

If the Standardized Ratio is:	It means that the State rate is:
Less than 100	Lower than the U.S. rate
Equal to 100	Same as the U.S. rate
Greater than 100 but ≤ 200	Higher than the U.S. rate
Greater than 200	Significantly higher than the U.S. rate

When the standardized ration is greater than 100, further investigation by the State or Territory MCH office may be indicated. Follow-up analysis can be conducted by **examining the characteristics of individual cases, or by performing case studies.**

X - APPENDICES AND STATE SUPPORTING DOCUMENTS

A. The Needs Assessment

B. The Reporting Forms

C. Organizational Charts and all other State supporting documents