TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT TO STATES PROGRAM

GUIDANCE AND FORMS
FOR THE
TITLE V APPLICATION/ANNUAL REPORT

OMB NO: _____
EXPIRES: _____

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Health Resources and Services Administration
Maternal and Child Health Bureau
Division of State and Community Health
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PART ONE: BACKGROUND AND ADMINISTRATIVE INFORMATION

I. PURPOSE OF THE MATERNAL AND CHILD HEALTH (MCH) BLOCK GRANT PROGRAM

As defined in section 501(a)(1) of the Title V legislation, the purpose of the MCH Services Block Grant Program is to enable each state:

(A) To provide and to assure mothers and children (in particular those with low income or with limited availability of health services) access to quality MCH services;
(B) To reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially preschool children) appropriately immunized against disease and the number of low income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women, and to promote the health of children by providing preventive and primary care services for low income children;

(C) To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under title XVI, to the extent medical assistance for such services is not provided under title XIX; and

(D) To provide and to promote family-centered, community-based, coordinated care (including care coordination services, as defined in subsection (b)(3)) 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.

II. BACKGROUND AND BRIEF HISTORY

Since its original authorization in 1935, Title V of the Social Security Act has been amended several times to reflect an ongoing commitment to improving the health and well-being of our Nation's mothers, children and their families. Block-granted in 1981, with new accountability requirements added in 1989, Title V has remained a vitally important public health program specifically targeted to the MCH population. A more complete history of Title V can be found in Appendix A of the *Supporting Documents to the Title V MCH Block Grant Application/Annual Report Guidance*.

Changes in the nation’s public health care systems, population demographics, health care financing systems and information technology have created new opportunities for improving access to health care and delivering quality public health services to the nation’s MCH population (which includes women, mothers, infants,

children, adolescents, CSHCN and their families). This Guidance document for the state Title V MCH Block Grant programs capitalizes on the emerging opportunities and reflects a major transformative effort within the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), in conjunction with its partners and stakeholders, to restructure the Application and Annual Reporting process. The transformative changes that have been made are intended to facilitate an increased alignment of State Title V program efforts with other MCHB investments and to demonstrate the vital leadership role that state Title V programs provide in assuring and advancing public health systems that continually assess and readily respond to changing MCH population needs. Relative to the state's submission of a yearly Application, Annual Report and Five-year Needs Assessment, the aims of the MCH Block Grant to States program transformation are threefold: (1) reduce burden to states; (2) maintain state flexibility; and (3) improve accountability.

In addition to changes that will impact the preparation and submission of the state MCH Block Grant Application/Annual Report and Five-year Needs Assessment report, the transformation process called for redefining the working framework for MCH services. Figure 1 depicts the interim framework that was developed.

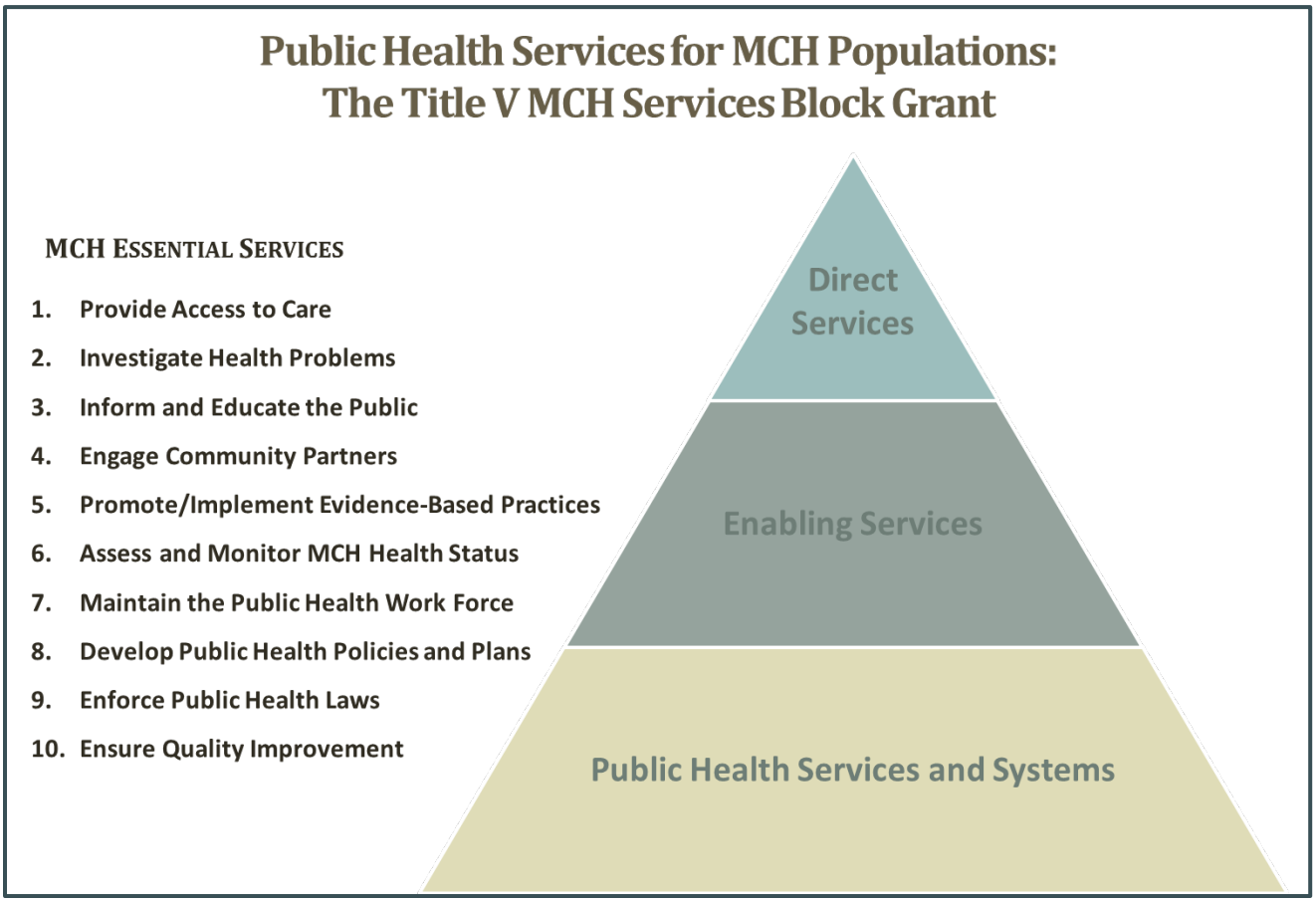
Relative to the changes occurring in public health systems and the delivery of health care, the Title V MCH Services Block Grant program will continue to provide critical support to assure the health of mothers, infants, children, including CSHCN, and their families. The services of the Title V MCH Block Grant program serve to complement the expanded health insurance coverage being provided through the Patient Protection and Affordable Care Act (ACA). Specifically, the Title V program will continue to serve as a safety-net provider for the MCH population by providing gap-filling health care services, as well as essential public health services, to the MCH population. These functions will lend valuable support to the successful implementation of the ACA. Without Title V, the public health system responsible for serving some of the nation's most vulnerable populations would be seriously jeopardized.

III. MCH TRANSFORMATION AND REVISION OF MCH BLOCK GRANT APPLICATION/ANNUAL REPORT GUIDANCE

A. Vision and Mission

While the purpose and goals of the Title V MCH Block Grant program are specified in the Title V legislation, as indicated above, clearly articulated Vision and Mission statements serve a useful role in helping to guide priority setting within the federal and state MCH programs. The following Vision/Mission statements were developed as part of the MCH Block Grant transformation process.

Figure 1



Vision of Title V

Title V envisions a nation where all mothers, children and youth, including CSHCN, and their families are healthy and thriving.

Mission of Title V

The Mission of Title V is to improve the health and well-being of the nation's mothers, infants, children and youth, including children and youth with special health care needs, and their families.

A 1988 Institute of Medicine (IOM) Report[1] defined the core functions of public health as assessment, policy development and assurance. In operationalizing the core public health functions and in ensuring that the unique needs of mothers and children were adequately addressed, the MCH community worked with the Public Health Service and the IOM to identify 10 "Essential Public Health

[1] Institute of Medicine. (1988). *The Future of Public Health*. Washington, D.C.: National Academy Press.

Services"[2] in 1994. Since that time, the 10 Essential Public Health Services have provided a framework for the delivery of MCH services, as reflected in Figure 1.

In considering potential strategies for implementing the new vision and mission statements, the 10 Essential Public Health Services were cross walked with the purpose of the MCH Block Grant to States Program, as defined in Section 501(a)(1) of Title V of the Social Security Act. The strategies presented below were developed as a result of this effort.

- Mobilize partners, including families, at the federal, state and community levels in promoting shared vision for leveraging resources, integrating and improving MCH systems of care, promoting quality public health services and developing supportive policies;

- Integrate systems of public health, health care and related community services to ensure access and coordination to assure maximum impact;

- Conduct ongoing assessment of the changing health needs of the MCH population (as impacted by cultural, linguistic, demographic characteristics) to drive priorities for achieving equity in access and positive health outcomes;

- Educate the MCH workforce to build the capacity to ensure innovative, effective programs and services and efficient use of resources;

- Inform and educate the public and families about the unique needs of the MCH population;

- Promote applied research resulting in evidence-based policies and programs;

- Promote rapid innovation and dissemination of effective practices through quality improvement and other emerging methods; and

- Provide services to address unmet needs in healthcare and public health systems for the MCH population (i.e. gap-filling services for individuals.)

B. National Performance Measurement Framework

With the MCH transformation and its emphasis on performance and accountability at both the state and national levels, this Guidance includes a transformed national performance measurement system that is intended to show more clearly the contributions of Title V programs in impacting health outcomes

[2] *Public Health in America*. (1994). Washington, D.C.: U.S. Public Health Service. Essential Public Health Services Working Group of the Core Public Health Functions Steering Committee.

while still maintaining flexibility for the states. The national performance measurement system adopted in this Guidance is a three-tiered framework, which includes the following measure categories: National Outcome Measures (NOMs), National Performance Measures (NPMs) and State-initiated Evidence-based or -informed Strategy Measures (ESMs).

In the revised national performance measure framework, the focus is on the establishment of a set of population-based measures (i.e., NPMs) which utilize state-level data derived from national data sources and for which state Title V programs will track prevalence rates and work towards demonstrated impact. The NPMs are intended to drive improved outcomes relative to one or more indicators of health status (i.e., NOMs) for the MCH population, so states will track the NOMs to monitor impact by the NPMs. ESMs are the final tier of the national performance measurement framework, and they are the measures by which states will directly measure their impact on the NPMs. State-specific and actionable, the ESMs seek to track a state Title V program's strategies and activities and to measure evidenced-based or evidenced-informed practices that will impact individual population-based NPMs. The ESMs are developed by the state, and they provide accountability for improving quality and performance related to the NPMs and to the MCH public health issues for which they are intended. While not part of the national performance measurement framework, states will also develop State Performance Measures (SPMs), in addition to the ESMs, to address the priorities they have identified based on the findings of their Five-year Needs Assessments and to the extent that a priority need has not been fully addressed through the selected NPMs and ESMs.

The 15 NPMs address key national MCH priority areas. Collectively, they represent six MCH population health domains: 1) Women's/Maternal Health; 2) Perinatal/Infant's Health; 3) Child Health; 4) CSHCN; 5) Adolescent Health; and 6) Cross-cutting or Life Course. The six population health domains are contained within the three legislatively-defined MCH populations [Section 505(a)(1).] For example, the first two domains are included under "preventive and primary care services for pregnant women, mothers and infants up to age one," which is the first of the three defined MCH populations. Child health is included in the second defined MCH population, specifically "preventive and primary care services for children." Services for CSHCN is the third legislatively-defined MCH population. Cross-Cutting or Life Course refers to public health issues that impact multiple MCH population groups.

The national MCH priority areas incorporate two significant concepts: first, Title V is responsible for promoting the health of all mothers and children, which includes an emphasis on CSHCN and their families; and second, the development of life course theory has indicated that there are critical stages, beginning before a child is born and continuing throughout life, which can influence lifelong health and wellbeing.

States should work closely with family/consumer partnerships as they develop the ESMs for their selected NPMs. For purposes of the Title V MCH Services Block Grant program and this Guidance, family/consumer partnership is defined as: "*The intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course*." Family engagement reflects a belief in the value of the family leadership at all levels from an individual, community and policy level." Relevant resources include the *National Consensus Standards for Systems of Care for Children and Youth with Special Health Care Needs*, which were released in March 2014. The report is available on the Lucille Packard Foundation for Children's Health website at http://lpfch-cshcn.org/publications/research-reports/developing-structure-and-process-standards-for-systems-of-care-serving-children-and-youth-with-special-health-care-needs. Examples of family/consumer partnership for Title V organizations are highlighted on the Family Voices website at: http://www.familyvoices.org/work/title_v?id=0012.

C. Changes to the Application/Annual Report Guidance

This Guidance is intended to enable states to tell a more cohesive and comprehensive Title V story, while reducing the reporting burden and duplication across sections of the Application/Annual Report. In addition, the revised narrative will allow state Title V programs to better reflect on their leadership role within the state and to demonstrate the program's contributions to the state's public health system in building improved and expanded systems of care for the MCH population.

Historically, the narrative reporting on state Title V activities has been organized by performance measure rather than by population group. The organizing framework for this guidance is based on six identified population health domains (i.e., Women's/Maternal Health; Perinatal/Infant's health; Child Health; CSHCN; Adolescent Health; and Cross-cutting or Life Course.) More specifically, throughout the course of the Application/Annual Report/Needs Assessment Summary, states will organize the discussion of their Title V program activities for each of the three legislatively-defined MCH populations (i.e., 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) in the context of these six identified MCH population health domains.

In reporting on their Five-year Needs Assessments, a Needs Assessment Summary will replace the more comprehensive, standalone document previously submitted by states. The Needs Assessment Summary will be integrated into the yearly MCH Block Grant Applications/Annual Reports. This integration will serve to reduce the duplication in reporting that has traditionally occurred between the Five-year Needs Assessment document and the first year Application/Annual Report. In the first year Application/Annual Report, states will now provide a summary report of their Five-year Needs Assessment process and findings.

Based on their ongoing needs assessment efforts, states will provide an update to the Needs Assessment Summary in each of the four interim year Applications/Annual Reports.

For the first time, states will be required to include an Executive Summary for each Application/Annual Report that they submit during the five-year reporting cycle. The Executive Summary shall briefly describe the key points presented in the state's Application/Annual Report and include, at a minimum, a brief summary of the following discussion points:

- Emergent needs based on the Five-year/ongoing Needs Assessment efforts and linked with the Title V program priorities and development of a five-year State Action Plan;

- Highest ranked priority needs for the state Title V program, including a discussion of key SPMs and ESMs which the state developed to address, respectively, the identified priority needs and selected NPMs; and

- Accomplishments relative to addressing the identified needs and a plan for the coming year that assures continued progress in achieving the desired health status and performance outcomes.

In addition to providing a summary overview of the state Title V program and the gains that have been realized relative to the state priority needs, the Executive Summary can serve as a standalone document for the state in marketing its Title V program's achievements to other state, community and family agencies and in soliciting programmatic input from families and other MCH stakeholders.

Revisions to the organizational framework of the state Applications/Annual Reports are intended to position the state and national MCH priorities, and the related Title V program activities, as the centerpiece of the narrative reporting. The revised instructions for the state Title V MCH Block Grant Application and reporting process are built on the premise that state priority needs and national MCH priority areas will serve as the "drivers" for state reporting on the Five-year (and ongoing) Needs Assessment findings, the selection of NPMs to address state-identified priorities, the development of evidence-based or –informed strategies with ESMs to address state and national priority areas (as reflected in the NPMs selected for programmatic focus) and the establishment of SPMs to address the state's unique needs.

As part of their first-year Application/Annual Report and in follow-up to the Five-year Needs Assessment, states will be required to develop an interim Five-year Action Plan Table. A sample table is provided, for the state's consideration, in Part Two, Section IIF.1.a of this Application/Annual Report Guidance and in Appendix B of the Supporting Documents. This Table is intended to serve as a planning tool and organizational framework for states in developing a five-year

Action Plan that aligns their planned Title V program strategies and activities with the identified priority needs and selected NPMs/SPMs. In the Year 02 Application/Annual Report (i.e., FY 2017/FY 2015), States will refine the objectives and strategies they identified in their interim Five-year Action Plan Table. The identified strategies should guide states in developing ESMs that address their selected NPMs. In addition to refining their program objectives and strategies, States will insert the ESMs and the SPMs they develop in the Five-year State Action Plan Table that will be included in the second year (i.e., FY 2017/FY 2015) Application/Annual Report.

As described above, the Five-year Action Plan Table is a tool for states to use in developing the five-year Action Plan. States will report on their five-year Action Plan in the narrative Applications/Annual Reports. In addition to providing updates to the five-year Action Plan for the Application year, States will report annually on their progress towards the implementation and achievement of the strategies/activities outlined in the State Action Plan and their success in meeting the established performance objectives for each of the NPMs, ESMs and SPMs. Specifically, states will provide a narrative discussion on the development of the five-year Action Plan in the initial Application year (i.e., FY 2016). The discussion should build on the summary information presented in the interim Five-year Action Plan Table. For the first two Annual Report years (i.e., FY 2014 and FY 2015), states will report out on the previous five-year cycle. In the following three interim year Applications/Annual Reports, states will refine their Title V program plan for the coming year (i.e., Application year) and report on the progress that has been achieved in implementing the five-year Action Plan (i.e., Annual Report.)

States will report annual performance indicators for the previous reporting cycle's 18 NPMs and 7-10 SPMs on Form 10D for FY 2014 and FY 2015. Using Form 10A, states will begin to report on the selected 8 NPMs, ESMs and SPMs for this five-year reporting cycle (i.e., FY 2016-FY 2020) in the FY 2016 Annual Report. While data reporting in the FY 2014 and the FY 2015 Annual Reports will focus on the previous reporting cycle's national and state performance measures, the state's narrative reporting will be incorporated into the five-year Action Plan. Rather than providing a description of Last Year/Current Year/Future Year program activities for each specific measure as required in previous Annual Reports, performance measure trends for the FY 2014 and FY 2015 Annual Report years will be analyzed and summarized as part of the discussion for the relevant population health domain(s).

Two additional changes to the Application/Annual Report Guidance for this five-year reporting cycle are the elimination of the Health System Capacity Indicators and the incorporation of some of the Health Status Indicators (HSIs) into the NOMs. Along with the other state data (OSD) reported on Form 11, the NOMs will serve as the monitoring tool for states in assessing their progress towards achieving the desired health outcomes. Effective with this Guidance,

data for the NOMs and OSD, as available, will be collected and provided to the state by MCHB.

IV. LEGISLATIVE REQUIREMENTS

The federal MCH Block Grant to States is authorized under Title V of the Social Security Act, which is the longest-standing public health legislation in American history. More than 75 years later, the law continues to support efforts to improve the health of the nation's women and children. The law can be viewed at: http://www.ssa.gov/OP_Home/ssact/title05/0500.htm.

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

The Application/Annual Report shall be developed by, or in consultation with, the state MCH 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 its Title V MCH Services Block Grant funds for the provision of health services and related activities (including planning, administration, education, and evaluation) consistent with its Application. In addition, the state may request supplemental funds from the Bureau to support identified technical assistance needs. Related to technical assistance, the state should plan for and allot funds for the MCH and CSHCN Directors to attend the required Block Grant Application/Annual Report review that is held at a site designated annually by the Division of State and Community Health (DSCH) in HRSA's MCHB. 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, as specified in Section 504(b).

C. Application for Block Grant Funds [Section 505]

Each state is required to conduct a statewide Needs Assessment every five years. Beginning in 2015, the result of that Needs Assessment will be integrated into the Application/Annual Report for that reporting year, and any updates will be provided in the Applications/Annual Reports that states submit in the interim years. By law, the Application/Annual Report will contain information that is consistent with the health status goals and national health objectives regarding the need for:

- Preventive and primary care services for all pregnant women, mothers, and infants up to age one;

- Preventive and primary care services for children; and

- 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"].

The state will organize its reporting on the three legislatively-defined MCH populations in the context of six population health domains: 1) Women's/Maternal Health; 2) Perinatal/Infant's Health; 3) Child Health; 4) CSHCN; 5) Adolescent Health; and 6) Cross-cutting or Life Course. In the Five-year Needs Assessment Application year (i.e., FY 2016), the state's Application shall include an interim Five-year Action Plan Table which serves as an organizing framework for the development of the five-year Action Plan.

In addition, states shall provide an expanded narrative description on the development of the five-year Action Plan and the identification of Title V program strategies/activities for addressing the priority needs that were identified by the statewide assessment in the narrative Action Plan section of their FY 2016 Application. The eight NPMs selected by the state should be addressed in this discussion and a clear plan presented for how the state plans to move forward in addressing each of the measures. Updates to the planned program strategies and activities for addressing the priority needs and improving performance around each of the performance measures will be discussed in the Action Plan narrative that is submitted by states in the subsequent four interim year Applications (i.e., FY 2017 - FY 2020.) Beginning with the second year Application (i.e., FY 2017), this discussion should include the ESMs developed for each of the selected NPMs and the three to five SPMs established by the state to respond to priority needs that are not adequately addressed by the NPMs and ESMs.

Each year, 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 letter of transmittal. 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's MCH programs at the level provided in fiscal year 1989. [Section 505(a)(4)].

Other requirements for allocation of funds, charging for services, maintenance of a toll-free hotline (and other appropriate methods) 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 the performance 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. For this five-year reporting cycle, the Action Plan will serve as the Annual Report narrative on the state's Title V program strategies and activities. As described in Part One, Section III.C., states will develop and submit an interim Five-year Action Plan Table as part of the first-year Application/Annual Report and in follow-up to the Five-year Needs Assessment. The Action Plan will identify program goals, objectives, key strategies and performance measures related to each of the six population health domains. In the four interim year Application/Annual Reports, States will utilize the Action Plan section of the Application/Annual Report to provide narrative discussion on the progress (by population health domain) achieved during the reporting year relative to the implementation of planned Title V program activities and gains in meeting the established performance measure targets. The standardized format of the Annual Report, as described, will allow for consistency in reporting and will facilitate the preparation of a report to Congress [Section 506(a)(3).] It should be noted that for the first two Annual Report years (i.e., FY 2014 and FY 2015) states will report on the national and state performance measures and Title V program activities that were implemented in the previous five-year cycle. As described in Part One, Section IIIC, states will report their FY 2014 and FY 2015 annual performance indicator data for the previous reporting cycle's NPMs and SPMs on Form 10D, while their narrative reporting will be incorporated into the State Action Plan.

As required in Section 509(a)(5), the MCHB has made a substantial effort to not duplicate other federal data collection efforts. This edition of the Application/Annual Report Guidance goes beyond previous editions in reducing duplication of federal and state data collection, maintenance and reporting efforts relating to the health status and health service needs of mothers and children in the United States. Effective with this five-year

reporting cycle, the MCHB will collect and provide national outcome and performance measure data, as well as available OSD, for the individual states. Data are not available from the National Center for Health Statistics (NCHS) or other Federal sources for Puerto Rico, Guam and the Marshall Islands, Federated States of Micronesia, Republic of Palau, Commonwealth of the Northern Mariana Islands, American Samoa and Virgin Islands. These jurisdictions must report their own vital statistics and health data.

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

The 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 Title V MCH Services Block Grant to States Program. Applicants may obtain additional information regarding administrative, technical and program issues concerning the Block Grant Application/Annual Report by contacting:

Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane, Room 5C-26
Rockville, Maryland 20857
Telephone: (301) 443-2204
Fax: (301) 443-9354

Within each state, the state health agency is responsible for the administration (or supervision of the administration) of programs carried out with Title V allotments.

PART TWO: APPLICATION/ANNUAL REPORT INSTRUCTIONS

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 Title V MCH Block Grant 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 to Section I.A. of the Application/Annual Report.

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/Annual Report.

C. Assurances and Certifications

The appropriate Assurances and Certifications for the state MCH Block Grant programs, which include Application Form Standard Form (SF)-424B, Assurances for Non-Construction Programs and Certifications for debarment and suspension, drug free work place, lobbying, program fraud and tobacco smoke are included in Appendix C. States do not have to submit these forms as part of the Application/Annual Report, but they must be maintained on file in the state's MCH program's central office. The assurance and certification forms may be attached to this section, but such an attachment is not required. Instead, the state can provide either the URL to access the assurances/certifications, or they can provide information on 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 the different Parts/Sections of this Guidance.

E. Application/Annual Report Executive Summary

As discussed in Part One, Section III.C., states will submit an Executive Summary with each Application/Annual Report. For each of the six identified population health domains, the Executive Summary shall present a brief description of the Title V program's major accomplishments and significant challenges relative to the cited priority and other emergent needs and the state's annual performance on the NOMs, NPMs, SPMs and ESMs that are specific to

that population health domain. In addition to the three required discussion points listed in Part One, Section III.C, the state should provide a statement for each population health domain which summarizes its progress on "moving the needle" around key MCH priority areas and national and state performance measures. The Executive Summary can be up to five pages in length, or 15,000 characters, including charts and graphs. This Summary should reflect only the key points that are presented in the state's Application/Annual Report.

II. COMPONENTS OF THE APPLICATION/ANNUAL REPORT

On July 15 of each year, states and jurisdictions are required to submit an Application/Annual Report for the federal funds they receive through the Title V MCH Services to States Program. In addition, states are required to conduct and report on a comprehensive, statewide Needs Assessment every five years. The findings of this Need Assessment and the priority needs identified as a result of this process provide the basis for the development of a five-year Action Plan for the state Title V program. As new findings become available through ongoing needs assessment efforts and the analyses of annual performance data, a state may refine its Action Plan in interim years to achieve targeted progress (i.e., performance objectives) related to the state and national MCH priority areas. These changes may include the substitution of new or revision of existing program strategies, ESMs linked to the selected NPMs and/or SPMs. States are encouraged not to change the selected NPMs during the five-year reporting cycle. If a state determines that a NPM needs to be changed, clear justification must be provided.

The state's narrative Application/Annual Report shall include the following sections:

- Descriptive overview of the state;

- Summary of the Five-year (and ongoing) Needs Assessment process and findings that speaks to the strengths/needs of the state's MCH population (as discussed by each of the six identified population health domains), Title V program capacity and established partnerships/collaborations, which should include a discussion on ongoing opportunities provided by the state for engaging families and other stakeholders in programming efforts (e.g., advisory councils, family/consumer partnerships, etc.)

- Listing of seven to ten priority needs for the state Title V program and rationale that links the identified priorities to the five-year Needs Assessment findings;

- Discussion on how the selected NPMs link with the identified state MCH priorities and rationale to demonstrate how the ESMs developed by the state will impact the selected NPMs.

- Discussion on how the SPMs (and state outcome measures (SOMs), if applicable) developed by a state address the identified state priority needs and/or the national MCH priority areas.

- Development and annual reporting on a Five-year State Action Plan.

States shall structure the narrative discussion in this segment of the Application to include the six sections cited above. A detailed explanation of the specific discussion points that the state should address is provided in Sections A-F of this Guidance.

For the first year's Application (i.e., FY 2016) of the five-year reporting cycle, states shall summarize the process that was used in conducting the Five-year Needs Assessments and their overall findings relative to the specific strengths/needs that were identified for the state's MCH population, Title V program capacity and partnerships/collaborations. States shall present their Needs Assessment findings by each of the six population health domains. In addition, states should address how their identified MCH strengths/needs link with the national MCH priority areas, as reflected in the federal Title V program's NHS/OMs and NPMs.

In the four subsequent interim years of the five-year reporting cycle (i.e., FY 2017-FY 2020 Applications/FY 2015-FY 2018 Annual Reports), states shall update the needs assessment information presented in the FY 2016 Application/FY 2014 Annual Report, as appropriate, to reflect improvements and/or changes in such areas as:

- State's health care delivery environment (e.g., implementation of the ACA);

- Identified strengths/needs of the state's MCH population and its Title V and other MCH program capacity;

- Level of commitment to consistently engaging family/consumer partnerships in Title V MCH and CSHCN programmatic and decision-making efforts; and

- Approaches to building and/or expanding the reach and effectiveness of the state's Title V partnerships and its collaborations with other federal, tribal, state and local entities that serve the MCH population.

A. Overview of the State

The introductory section of the Application narrative shall put into context the Title V program within the state's health care delivery environment. Applicants should discuss the principal characteristics that are important to understanding the health status and needs of the entire state's MCH population. The state health agency's current priorities or initiatives and the resulting Title V program's roles and responsibilities should also be described. States should address how

health care reform efforts and ACA implementation are impacting the health status of its MCH and CSHCN populations and the delivery of Title V-supported services.

Included in the state overview should be a description of the process used by the Title V administrator to determine the importance, magnitude, value, and priority of competing factors which impact health services delivery in the state. Current and emerging issues should be identified and discussed in terms of the other identified MCH issues.

This overview should also address 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 in the state. Specific state statutes and other regulations that have relevance to Title V program authority should be discussed and examined in terms of their impact on the state's Title V MCH and CSHCN programs.

B. Five-Year Needs Assessment Summary

The Title V legislation (Section 505(a)(1)) requires the state, as part of the Application, to prepare and transmit a statewide Needs Assessment every five years that identifies (consistent with the health status goals and national health objectives) the need for:

(1) Preventive and primary care services for pregnant women, mothers and infants up to age one;

(2) Preventive and primary care services for children; and

(3) Services for children with special health care needs.

The conceptual framework presented in Figure 2 depicts how the findings of the State Five-year Needs Assessment are expected to serve as the "drivers" in determining state Title V program priority needs and in developing a five-year Action Plan to address them.

Findings from the Five-year Needs Assessment serve as a cornerstone for the development of a five-year Action Plan for the state Title V program. The Needs Assessment findings should inform the selection of the state's seven to ten highest priority needs for its MCH and CSHCN populations. Selected priority needs should reflect the work of the state's Title V program and address areas in which the supported services can have direct impact on the state and federal MCH priorities. Based on its priority needs, as identified in the Five-year Needs Assessment, the State will select eight of 15 possible NPMs for programmatic emphasis over the five-year reporting period.

Figure 2. TITLE V MCH BLOCK GRANT NEEDS ASSESSMENT FRAMEWORK LOGIC MODEL

The five-year Action Plan to be developed by the state in the first Application/Annual Report year (i.e., FY 2016/FY 2014) of the five-year reporting cycle will speak to the state's priority needs, the identified national MCH priority areas and the state-selected NPMs. Preliminary goals, objectives and strategies for achieving targeted progress in the specified priority areas should be clearly outlined in the state's Action Plan. In the second Application/Annual Report year (i.e., FY 2017/FY 2015), the State shall refine its goals, objectives and strategies in addition to developing ESMs for implementing the identified strategies to address the eight selected NPMs. The purpose of the ESMs is to identify state Title V program efforts which can contribute to improved performance relative to the selected NPMs. Most issues in MCH are multifactorial; therefore, while states are strongly encouraged to develop multiple strategies with a related ESM for each strategy to impact a selected NPM, states are required to submit at least one ESM for each of the NPMs selected. In addition, states will develop between three and five SPMs to address its unique needs to the extent that they are not addressed by the selected NPMs and ESMs. States will report annually on the progress that has been achieved relative to the ESMs and the SPMs. This framework is intended to more clearly reflect the work of the state Title V programs in addressing state and national MCH priority areas.

A more detailed overview of the MCH Five-year Needs Assessment process and its relationship to the planning and monitoring functions in Title V programs is presented in Appendix D.

In this section of the Application narrative, states shall present a concise summary of the Five-year Needs Assessment process and findings, as described below, with annual updates provided in the four interim year Applications/Annual Reports. The Needs Assessment Summary that is to be included in the Application/Annual Report is intended to emphasize only the key findings of the state's Five-year Needs Assessment as they relate to the state MCH priority needs and link with the national MCH priority areas. It is recognized that states engage in a thorough and comprehensive Five-year Needs Assessment process, with rich findings that go beyond the required content for the first year Application/Annual Report. In addition to the required Needs Assessment Summary, states may choose to develop a more detailed and complete Five-year Needs Assessment document that is tailored to meet their individual program needs, and they are encouraged to include links to state websites where such documents are posted in the Application/Annual Report. States may also choose to submit more detailed documentation on their Five-year Needs Assessment findings as an attachment to this section. The total length of the Needs Assessment Summary that is to be included in the first year Application/Annual Report (i.e., FY 2016/FY 2014) shall not exceed 60,000 characters (or 20 pages).

1. Process

In this section, states shall summarize the overall process that was used to conduct the Title V comprehensive Needs Assessment. States should describe the (1) goals, framework and methodology which guided the Needs Assessment process; (2) the level and extent of stakeholder involvement; (3) quantitative and qualitative methods that were used to assess the strengths and needs of each of the six identified population health domains, MCH program capacity and partnerships/collaborations; (4) data sources that were utilized to inform the Needs Assessment process; and (5) interface between the collection of Needs Assessment data, the finalization of the state's Title V priority needs and the development of the state's Action Plan.

In interim year Applications/Annual Reports, states should describe what actions are being taken to ensure that Needs Assessment is an ongoing process. These updates should include a brief description of ongoing needs assessment activities, such as data collection and analysis, program evaluations, focus groups, surveys and other selected approaches that enable the State to continue to monitor and assess, on an ongoing basis, the successes and continuing needs that have resulted from the implementation of the state's five-year Action Plan to address the national and state MCH priority needs.

2. Findings

In the first year Application/Annual Report (i.e., FY 2016/FY 2014), states shall present a focused Summary of the findings of its Five-year Needs Assessment. Highlighted in this Summary should be the health status of the MCH population relative to the state's noted MCH strengths/needs and the identified national MCH priority areas, with the discussion organized and presented by each of the six population health domains. In addition, the state shall summarize the adequacy and limitations of its Title V program capacity and partnership building efforts relative to addressing the identified MCH population groups and program needs. Specific partnership and collaborative efforts may include, but are not limited to, promotion of family/consumer engagement and leadership, coordination with other MCHB and federal, state and local MCH investments and established relationships with Tribes, Tribal Organizations and Urban Indian Organizations who reside within the state's geographic boundaries.

In the interim year Applications/Annual Reports (i.e., FY 2017-FY 2020/ FY 2015-FY 2018), States shall provide annual updates to the findings they presented in the Needs Assessment Application year (FY 2016 Application/ FY 2014 Annual Report.) These updates should clearly reflect ongoing needs assessment efforts and address changes in the state's MCH population, Title V program capacity and level of partnerships/collaborations. Such

updates may include, but are not limited to, a discussion of the following items.

- Changes in the strengths and needs of the MCH population, Title V program capacity and established program collaborations/partnerships since the last MCH Block Grant Application/Annual Report was submitted.

- Activities undertaken to operationalize the findings of the Five-year Needs Assessment, such as the establishment of an advisory group to monitor state progress in addressing a targeted priority need.

a. MCH Population Needs

Using both quantitative and qualitative methods, states shall present:

i. An overview of the health status of the state's MCH population for each of the six identified population health domains (i.e., Women's/ Maternal Health, Perinatal/Infant's Health, Child Health, CSHCN, Adolescent Health and Cross-cutting or Life Course) within the three legislatively-defined state MCH population groups (i.e., (a) pregnant women, mothers, and infants up to age 1; (b) children; and (c) children with special health care needs.)

ii. A summary of population-specific strengths/needs as well as strengths/needs that cross all three of the legislatively-defined population groups.

iii. A concise description of the state's successes, challenges, gaps and areas of disparity related to major morbidity, mortality, risk reduction or maintenance of health/wellness for each of the six population health domains. At a minimum, the discussion should include major health issues addressed in the state's priority needs and the national MCH priority areas 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.)

iv. An analysis of Title V-specific programmatic approaches to determine areas where current efforts work well and should be continued and areas in which new or enhanced strategies/program efforts are needed.

The discussion in this section should be organized by the six population health domains and address the state-identified priority needs and national MCH priority areas. For each population health domain, the state

should clearly discuss its strengths/needs relative to the state-specific MCH priority needs (identified through the Five-year Needs Assessment process) and the pertinent OSD, NOMs and NPMs. In the narrative discussion, states may include other identified strengths and needs for its MCH population (based on the findings of the Five-year Needs Assessment,) which are unique to the state and go beyond the national MCH priority areas. Detailed information on the performance measure framework is presented in Appendix E. Detail sheets for the NOMs and NPMs are included in Appendix F.

In the four interim year Applications/Annual Reports, states shall report by population health domain on any changes in the health status of its MCH populations, the identified strengths/needs and noted Title V program successes/issues/ gaps/disparities that have impacted MCH morbidity, mortality, risk reduction and/or health maintenance/wellness, based on the findings of its ongoing needs assessment efforts.

b. Title V Program Capacity

Based on the Five-year Needs Assessment findings, states shall structure the discussion of their Title V program capacity to include the sections outlined below. The findings presented in the Five-year Needs Assessment Application/Annual Report year should be updated annually in the state's four interim year Applications/Annual Reports, based on the findings of their ongoing needs assessment efforts and noted changes in the state's organizational structure and program capacity.

i Organizational Structure

In reporting on the organizational structure of the Title V program, the state should:

(a) Describe the organizational structure and placement of the Governor, state health agency and the Title V MCH and CSHCN programs in the state government.

(b) Clarify 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)]. This description should include all of the programs funded by the federal-state Title V MCH Block Grant.

(c) Include an organizational chart as an attachment to this section.

ii. Agency Capacity

In reporting on Title V program capacity, the state should:

(a) Describe the state Title V agency's capacity to promote and protect the health of all mothers and children, including CSHCN. Included in this description should be a discussion of the state's capacity for providing Title V services by each of the six population health domains. In describing the state's capacity for providing services to CSHCN, the state should address its ability 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) Describe the steps that state MCH and CSHCN programs have taken to ensure a statewide system of services, which reflect the principles of comprehensive, community-based, coordinated, family-centered care. Highlighted in this description is the extent to which the state effectively uses its Title V funds to support:

(1) State program collaboration with other state agencies and private organizations;

(2) State support for communities;

(3) Coordination with health components of community-based systems; and

(4) Coordination of health services with other services at the community level.

iii. MCH Workforce Development and Capacity

(a) Describe the strengths and needs of the state MCH and CSHCN workforce, including the number, location and full-time equivalents of state and local staff who work on behalf of the state Title V programs. Included in this description should be the names and qualifications (briefly described) of senior level management employees who serve in lead MCH-related positions and program staff who contribute to the state's planning, evaluation, and data analysis capabilities. States should also report on the number of parent and family members, including CSHCN and their families, who are on the

state Title V program staff and their roles (e.g., paid consultant or volunteer.) In addition, states are encouraged to provide additional MCH workforce information which may be available, such as the tenure of the state MCH workforce and projected shifts in the MCH and CSHCN workforce over the five-year reporting period.

(b) Provide examples of the mechanisms that the state has developed and utilized to promote and provide culturally competent approaches in its services delivery. Examples of such activities may include:

(1) 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.

(2) 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.

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

(4) Secure allocation of resources to adequately meet the unique access, informational and service needs of culturally diverse groups.

(5) Develop and implement performance standards for staff and contractors that incorporate cultural competence practices and policies.

(6) Provide policies and guidelines that support the above identified items and approaches.

c. Partnerships, Collaboration, and Coordination

Based on the Five-year Needs Assessment findings, states shall describe relevant organizational relationships which serve the legislatively-defined MCH populations and contribute to, or expand, the capacity and reach of the state Title V MCH and CSHCN programs. Specifically, the discussion in this section should focus on partnerships, collaborations, and

cross-program coordination established by the state Title V program with public and private sector entities; federal, state and local government programs; Tribes, Tribal Organizations and Urban Indian Organizations; families/consumers; primary care associations; tertiary care facilities; academia; and other primary and public health organizations across the state that address the priority needs of the MCH population but are not funded by the state Title V program.

The findings presented in the Five-year Needs Assessment Application/Annual Report year should be updated annually in the state's subsequent four interim year Applications/Annual Reports, based on the findings of ongoing needs assessment efforts and noted changes in the state's partnership, collaboration, and coordination efforts.

In reporting on the Title V program's ongoing commitment and efforts to build, sustain and expand partnerships, to work collaboratively and to coordinate with other MCH-serving organizations, the state should describe its relationships with such programs as:

i. Other MCHB investments (e.g., State System Development Initiative (SSDI) Grants, CSHCN State Implementation Grants, Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Grants, Healthy Start Grants, Early Childhood Systems of Care (ECCS) Grants, MCH Training programs and other MCHB efforts relating to injury prevention, autism, developmental disabilities, adolescent health, workforce development, oral health, bullying and emergency medical services for children);

ii. Other Federal investments (e.g., ACF, CDC and USDA-funded programs, such as the Personal Responsibility Education Program (PREP) teen pregnancy grants, family planning, immunizations, infant and child death reviews and WIC);

iii. Other HRSA programs (e.g., federally qualified health centers and HIV/AIDS);

iv. State and local MCH programs (e.g., local health departments and urban MCH programs);

v. Other programs within the State Department of Health (e.g., chronic disease, prevention and health promotion, immunization, vital records and health statistics, injury prevention, behavioral and mental health and substance abuse);

vi. Other governmental agencies (e.g., Medicaid, CHIP, Education, Social Services/Child Welfare, Corrections and Rehabilitation Services);

vii. Tribes, Tribal Organizations and Urban Indian Organizations;

viii. Public health and health professional educational programs and universities;

ix. Family/consumer partnership and leadership programs; and

x. Other State and local public and private organizations that serve the state's MCH population.

States must include, as an attachment to this section, a current copy of the Inter-Agency Agreement (IAA) that was developed between the state's Medicaid agency and the Title V agency, as cited in Section 509(a)(2) of Title V and referenced in Section 1902(a)(11)(b) of Title XIX of the Social Security Act.

In their Five-year Needs Assessment Summary, states should include qualitative and quantitative information on their established family/consumer partnerships. This description should include, but is not limited to, the following discussion points:

i. Nature and substance of the established family/consumer partnership;

ii. Diversity of members engaged in the family/consumer partnership;

iii. Number of families/consumers engaged in the family/consumer partnership, the degree of their engagement, the compensation that is provided to them and the number of families/consumers that were trained on MCH core competencies;

iv. Evidence and range of issues being addressed through the family/consumer partnership;

v. Impact of family/consumer partnership on programs and policies, including the development of promising practices; and

vi. Description of the state's efforts to build and strengthen family consumer partnerships for all MCH populations, including CYSHCN.

C. State Selected Priorities

In this section, states shall list the seven to ten highest priority needs they identified based on the findings of the Five-Year Needs Assessment. The priority needs selected by a state for its Title V program during the five-year reporting period should be determined by a thorough examination of the findings from the state's Five-year Needs Assessment, as highlighted in the Needs Assessment Summary of the first year Application/Annual Report. States must assure that the selected priorities address the defined MCH population groups that were discussed in the Needs Assessment Summary.

In addition to listing the seven to ten selected priority needs on Form 9, states should provide a rationale for how these priority needs were determined. This rationale should include pertinent discussions on other priority needs that were strongly considered by the state and its stakeholders and why these needs were not included among the final priority list. In addition, states should describe the methodologies that were used for ranking the broad set of identified needs and the process for selecting its final seven to ten priorities. States should also discuss factors that have contributed to changes in the priority needs since the previous five-year reporting cycle and note if: (1) Priorities were continued; (2) Priorities were replaced; or (3) Priorities were added. For each priority need, the state should discuss why a priority need was continued, replaced, or added.

Updates relative to the selected priority needs should be provided by the state in the subsequent four interim year narrative Applications/Annual Reports.

D. Linkage of State Selected Priorities with National Performance and Outcome Measures

The priority needs identified by the state based on the findings of its Five-year Needs Assessment shall inform the state's selection of the national performance and outcome measures for programmatic focus by its Title V program. In partnership with the state Title V program leadership and other MCH stakeholders, the MCHB identified 15 national priority areas for the Title V MCH program. Detail sheets for each of the 15 national performance measures are provided in Appendix F. Based on the identified state priority needs, states shall select eight of the 15 national measures to be addressed over the five-year period in their Title V program.

In this section of the Five-year Needs Assessment Application/Annual Report year (i.e., FY 2016/FY 2014), states should list the selected eight national performance measures with a rationale for why these measures were selected. The discussion should clearly link the selected national measures with the state's identified priorities. In the second year Application/Annual Report year (i.e., FY 2017/FY 2015), states will develop and submit ESMs to address each of the selected national measures. States can replace or revise one or more of the

ESMs developed in the subsequent interim year Applications/Annual Reports (i.e., FY 2018-FY 2020/FY 2016-FY 2018) based on its effectiveness in achieving the targeted progress for the corresponding national measure(s). With justification, the state can change the NPM that it selected based on the Five-year Needs Assessment findings during the five-year reporting cycle.

In addition to developing their structural measures, states will establish a performance objective for each ESM as part of the second year Application/Annual Report (i.e., FY 2017/FY 2015). States will begin reporting on the structural measure in the Year 03 through 05 interim Applications/Annual Reports (i.e., FY 2018-FY 2020/FY 2016-FY 2018). Annual performance data for the NPMs, the NOMs, and the OSD will be pre-populated, as available, for the state in the Title V information System (TVIS.)

E. Linkage of State Selected Priorities with State Performance and Outcome Measures

In addition to the NPMs selected by the state, the state shall develop between three and five SPMs to address its unique MCH needs to the extent that these needs are not addressed by the national measures and ESMs. Determination of the SPMs should be based on the findings of the Five-year Needs Assessment. States should develop a detail sheet on Form 10b, similar to the detail sheets provided for the national measures, for each SPM.

States will identify the established three to five SPMs on Form 10B as part of the second year Application/Annual Report (i.e., FY 2017/2015.) In addition, they will establish performance objectives for each of the SPMs. Annual reporting of performance data for the SPMs will begin with the submission of the FY 2016 Annual Report. While not encouraged for reporting purposes, states may change or revise a SPM during one of the interim reporting years in the five-year cycle.

A state may also develop (but is not required to develop) one or more SOMs based on the MCH priorities determined as a result of the Five-year Needs Assessment, provided that none of the NOMs address the same priority area for the state. A SOM should be linked with a performance measure to show the impact of performance on the intended outcome. For any SOMs developed by the state, five-year performance objectives should be established for each of the reporting years.

States will develop a detail sheet for any identified SOMs. On the detail sheets, States shall define the measures; goal; the indicator, numerator, and denominators; data source; and significance. The SOM detail sheets will be submitted by the state as part of the second year Application/Annual Report (i.e., FY 2017/FY 2015.) A state will track a SOM during the five-year reporting cycle, and the state can retire an SOM if it chooses. Data for the SOMs (indicator/numerator/denominator) will be entered annually by the state.

A timeline and the required components of the three Applications/Annual Reports (i.e., FY 2016/FY 2014 through FY 2018/FY 2016) that are due to be submitted under this Guidance instruction are presented in Appendix G.

F. Five-Year State Action Plan

States shall develop a five-year State Action Plan in follow-up to the Five-year Needs Assessment. This Action Plan will serve as the Application/Annual Report narrative discussion for the state on their planned activities for the Application year and the activities that were implemented in the Annual Report year. Activities should be discussed in terms of the state's targeted performance and its achievements around the NOMs, NPMs, ESMs and SPMs. The State Action Plan shall include a robust discussion of the health status/outcome and performance measures for each of the six population health domains.

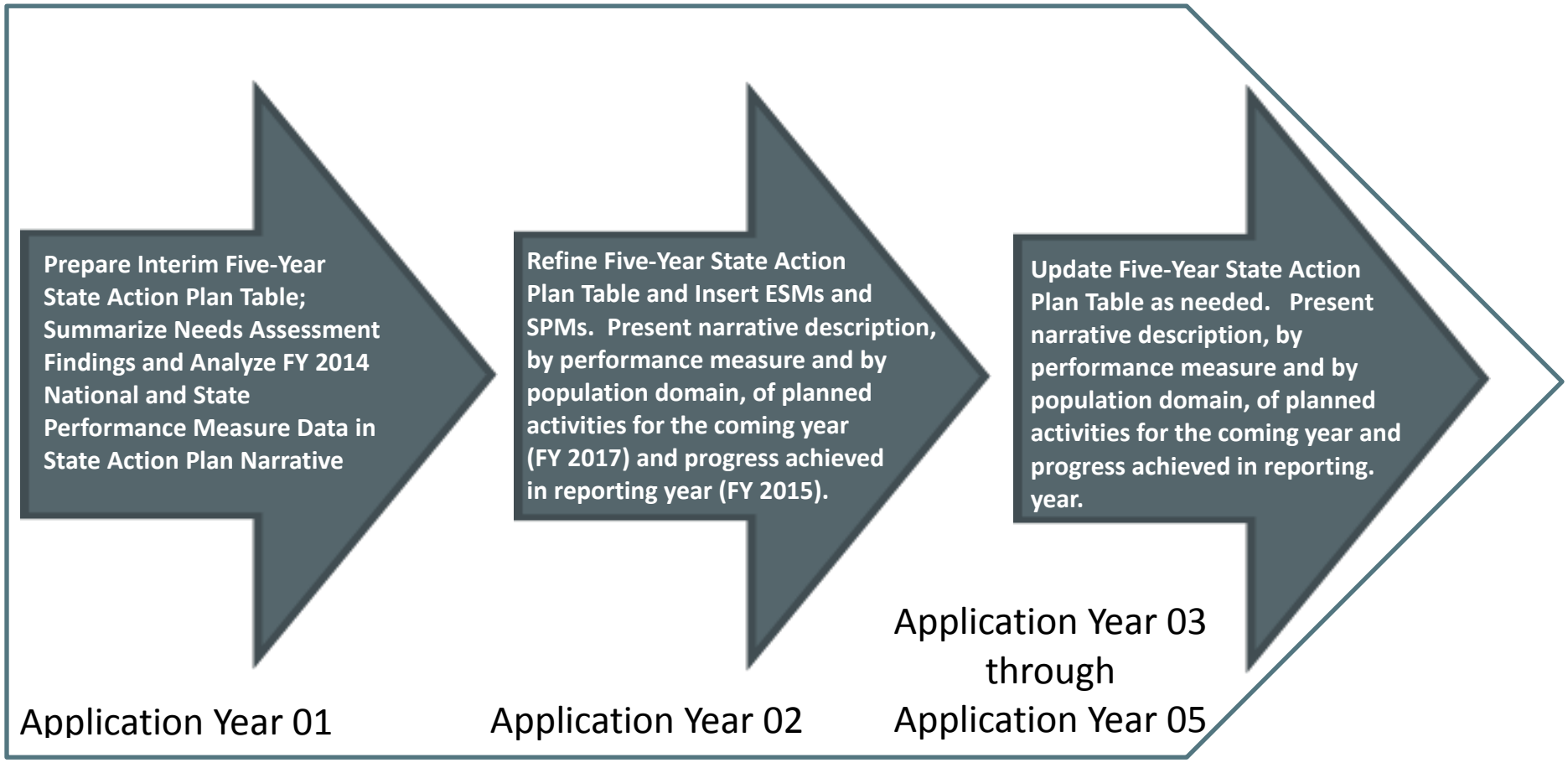
In developing the Action Plan, the state shall complete an interim Five-year State Action Plan Table (see sample on page 32 (Figure 4) of this Guidance and in Appendix B) as part of the first year Application/ Annual Report (i.e., FY 2016/ FY 2014). This Table is a tool to assist states in aligning their program strategies, NPMs, ESMs and SPMs with the priority needs that were identified in the Five-year Needs Assessment. States will refine the objectives and strategies, insert the ESMs for the selected NPMs and add the SPMs to the Five-year Action Plan Table in the second year Application/Annual Report (i.e., FY 2017/FY 2015). Updates to the strategies and activities will be provided by the state, as needed, in subsequent interim year Applications/Annual Reports. Figure 3 depicts the steps involved in the development of and the annual reporting on the implementation of the five-year State Action Plan.

1. State Action Plan and Strategies by MCH Population

This section will serve as the state's narrative plan for the Application year and as the Annual Report for the reporting year. States should describe their planned activities for the Application year and summarize the programmatic efforts that have been undertaken for the Annual Report year, with primary emphasis placed on the performance impacts that have been achieved. The discussion should be specific to how priorities identified in the Needs Assessment Summary are being addressed through the strategies and activities that were described in the Five-year Action Plan Table. The narrative discussion shall be organized in the following order and grouped by the listed population health domains:

- Women's/Maternal Health
- Perinatal/Infant's Health

Figure 3. Development and Implementation of Five-Year State Action Plan



- Child Health
- CSHCN
- Adolescent Health
- Cross-cutting or Life Course

Within the description of each population domain, states shall include the following sections:

a. Five-year State Action Plan Table

In accordance with the relevant priorities identified through the Five-year Needs Assessment process for each of the six population health domains, the state shall complete a State Action Plan Table. This Table should be considered a planning tool for states to use in developing a five-year Action Plan that aligns the identified priority needs with the program strategies and performance measures. It is recognized that the Five-year Action Plan Table submitted by the state in the first Application/Annual Report year (i.e., FY 2016/FY 2014) should be considered as an interim plan, which will be further refined and completed in the second Application/Annual Report year (i.e., FY 2017/FY 2015.)

The Five-year Action Plan Table should include priority needs as the starting point with objectives, key strategies and relevant performance measures selected for each of the six population health domains to address the identified needs. While states are not required to use the sample format that is presented in Figure 4 on page 32 and also in Appendix B for their State Action Plan Table, similar information must be provided in tabular form. A description or definition of each of the categories to be included in the State Action Plan Table is provided below.

i Priority Needs – Title V legislation directs states to conduct a state-wide MCH Needs Assessment every 5 years to identify the need for preventive and primary care services for pregnant women, mothers, infants, children, and CSHCN. From this assessment, states select seven to ten priorities for focused programmatic efforts over the five-year reporting cycle.

ii Objectives – A statement of intention with which actual achievement and results can be measured and compared. SMART objectives are specific, measurable, achievable, relevant and time-phased.

iii Key Strategies – Strategies are the general approaches taken to achieve the objectives; activities are specific actions to implement the strategies. Strategies are defined as part of the interim Five-year State Action Plan Table and further refined in the second Application/Annual Report year. Program activities for implementing the identified program strategies will be discussed and updated annually as part of the State Action Plan narrative.

iv Performance Measures – List the NPMs, ESMs and SPMs (beginning in interim year 02) that align to the identified strategies, and to the NOMs.

States should update the Five-year State Action Plan Table as needed in the interim year Applications/Annual Reports.

Figure 4. Five-Year State Action Plan Table – SAMPLE

Domains	***State Priority Needs***	***Objectives***	***Strategies***	***National Outcome Measures****	***National Performance Measures****	***Evidence-Based or –Informed Strategy Measures***	***State Performance Measures***
Maternal/ Women's Health							
Perinatal/ Infant's Health							
Child Health							
CSHCN							
Adolescent/ Health							
Cross-Cutting or Life Course							
Other							

* Data to be provided by MCHB

b. State Action Plan

The State Action Plan will serve as the narrative reporting for each year's Application/Annual Report. For each population health domain, states will complete each of the sections outlined below.

i Plan for the Application Year and Annual Report

In the State Action Plan narrative, states should include a Plan for the coming year (i.e., Application year) and an Annual Report that provides greater detail on the information that is presented in the Five-year State Action Plan Table. For each population domain, states should provide necessary narrative about the previous year's activities, accomplishments, challenges and revisions as well as a plan for the coming year. States should primarily describe activities for which the Title V program provides primary leadership in administering the activity. Activities for which the state Title V program has a partnership role, but does not have the primary responsibility for implementing the activity, should be discussed in Section 2.2.

The State Action Plan narrative should include an analysis of factors contributing to progress made, challenges that have impeded progress, and a description of the plan for the coming year in response to both the successes and the challenges. The narrative discussion should focus on the six identified population domains and be organized around the planned activities for the Application year, interpretation of the performance data provided on Form 10D for reporting years FY 2014 and FY 2015 and on Form 10A for reporting years FY 2016-FY 2020, analyses of the effectiveness of the current program activities and strategies and initiation of new efforts if adequate progress has not been achieved. In years that states are reporting on ESMs, the Action Plan should address how the established ESMs have contributed to progress in achieving the performance targets that were set for the NPMs.

For each population health domain, states will discuss how they are addressing the related legislative requirements outlined in Sections 501(a)(1) and 505. States should describe critical partnerships with other MCHB-supported programs, such as the MIECHV, Training Programs and Healthy Start programs.

ii Other Programmatic Activities

If there are investments of federal MCH Block Grant funds for a population health domain that do not directly align with the State priorities that were identified through the Five-year Needs Assessment, these investments should be described in this section. The state should provide a rationale for these investments, including an explanation of their role in supporting the state's overall system of care for the MCH population. For example, if the state uses MCH Block Grant funds to support newborn screening,

but newborn screening does not fit within the state priorities for perinatal/infant health that were identified through the Five-year Needs Assessment, the newborn screening investment should be described in this section. The state should provide an explanation for the role and importance of this work to the system of care provided by Title V in supporting perinatal/infant health.

If applicable, states should describe in this section Title V program activities that are included in the State Plan but do not fall directly within any of the population domains (e.g., development and/or enhancement of MCH data infrastructure; and priorities related to underserved areas/workforce shortages.) States should also describe critical partnerships to advance maternal and child health, including partnerships with other MCHB-supported programs (e.g., MIECHV, MCH Training Programs, Healthy Start programs and MCHB-supported Collaborative for Innovation and Improvement Networks (CoIINs) in which the State has been involved.)

2. MCH Workforce Development and Capacity

States should use this section to describe actions taken to improve the capacity of the MCH workforce in the state, including changes in noted strengths and needs. The state's description of the MCH workforce should identify any changes to the workforce funded by Title V, as well as the current capacity of the workforce within the state to address the needs of the MCH population. States should also describe critical workforce development and training needs of state Title V staff.

3. Family/Consumer Partnership

Building the capacity of women, children and youth, including those with special health care needs, and families to partner in decision making with Title V programs at the federal, state and community levels is a critical strategy in helping states to achieve national outcomes. States should include a description of the state's efforts and initiatives to build and strengthen family/consumer partnerships for all MCH populations, to assure cultural and linguistic competence and to promote health equity in the work of the state Title V program. For purposes of the Title V MCH Services Block Grant program and this guidance, as previously noted, family/consumer partnership is defined as: "The intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course. Family engagement reflects a belief in the value of the family leadership at all levels from an individual, community and policy level." States will describe efforts to support Family/Consumer Partnerships, including family/consumer engagement in the following strategies and activities:

- Advisory Committees;
- Strategic and Program Planning;
- Quality Improvement;
- Workforce Development;
- Block Grant Development and Review;
- Materials Development; and
- Advocacy.

4. Health Reform

States should describe the actions taken and the evolving role that state Title V agencies have in supporting health reform efforts. In addition, states should describe ways in which the Title V MCH Services Block Grant Program is providing services that help to advance the implementation of the ACA, as appropriate. For example, states may discuss roles in supporting the health insurance marketplace and consumer assistance, collaboration with accountable care organizations (ACOs) or similar entities, or any roles in working with hospital organizations on community health needs assessments. If relevant, states should also describe ways in which the Title V MCH Block Grant Program is providing gap-filling health care services to MCH populations, as noted on Form 3b. Efforts to assure cultural and linguistic competence and to promote health equity through the state's health care reform efforts should also be discussed, if relevant.

5. Emerging Issues

States should describe any emerging issues that were not addressed as part of the State Action Plan narrative, but they are significant for understanding current or projected strengths and needs of the MCH population.

6. Public Input [Section 505a]

In its Application/Annual Report, the state shall describe its process for making the Application/Annual Report available to the public for comment during its development and after its transmittal. This discussion should include efforts by the state to solicit public comments during the development of the Application/Annual Report. The number and nature of the comments received and how they were addressed in the final Application/Annual Report should be noted for each year.

The state should clearly identify specific activities for engaging families and other stakeholders prior to, during and after the Application process. Such activities may include:

- Public Hearings
- Advisory Council Review
- Web Posting
- Social Media
- Public Notices
- Other Use of Media
- Outreach to Specific Stakeholders (e.g., MCH Training Grantees)

Further information regarding public input can be found by opening the section titled "Technical Assistance to States" on the MCHB website, http://www.mchb.hrsa.gov. See the resource document entitled "Facilitating Public Comment on the Title V MCH Block Grant."

7. Technical Assistance

States should give consideration to potential areas of needed technical assistance as they complete their five-year Action Plan. In accordance with the responsibilities prescribed in Section 509 of the Title V legislation, the MCHB works with the states and jurisdictions to identify the types of technical support and resources that are needed. To receive MCHB-supported technical assistance, the state must complete and submit a Technical Assistance Request Form. This form is available upon request from the MCHB Project Officer.

III. 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. Significant variations (i.e., greater than 10%) in the expenditure data that are reported by the state on Forms 2 and 3, as compared to previous years' reporting, should be discussed. In this five-year reporting cycle, states will report federal and non-federal MCH Block Grant expenditures separately. Expenditures for Direct Services, as defined in the Glossary in Appendix H, should be broken out by each of the three legislatively-defined MCH

populations on Form 3b. Such Direct Service expenditures should be further clarified by listing the amount expended for each specific service type that is listed in Section 4 on Form3b. It should be noted that Title V is the payer of last resort, by legislation, and the services listed by the state reflect services that were not covered or reimbursed through another provider.

B. Budget

The budget narrative is intended to reflect how federal support complements the State's total effort and what amounts will be spent 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. The state should describe how satisfaction of the required match is achieved. Adequate discussion should be provided for significant year-to-year variations in budget or expenditures. In this five-year reporting cycle, the state will submit separate budget estimates for federal and non-federal MCH Block Grant funds.

In this section, the state shall also briefly describe the maintenance of effort from 1989 [Section 505(a)(4)]; any continuation funding for special projects [Section 505(a)(5)(C)(i)]; or special consolidated projects noted in Section 501(b)(1) [Section 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 in its Title V program. Significant variations in the budgeted amounts reported by the state on Forms 2 and 3, as compared to previous years' reporting, should be discussed.

States are reminded 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)].

PART THREE: REPORTING FORMS

Form 1	Application for Federal Assistance (Standard Form - 424)
Form 2	MCH Budget/Expenditure Details (Federal and State) for FY_
Form 3a	Federal and State Budget and Expenditure Details by Types of Individuals Served
Form 3b	Federal and State Budget and Expenditure Details by Types of Services
Form 4	Number and Percentage of Newborns and Others Screened, Cases Confirmed and Treated
Form 5a	Unduplicated Count of Individuals Served under Title V
Form 5b	Total Recipient Count of Individuals Served by Title V
Form 6	Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX
Form 7	State MCH Toll-Free Telephone Line and Other Appropriate Methods Data
Form 8	State MCH and CSHCN Directors Contact Information
Form 9	List of MCH Priority Needs
Form 10A	Tracking Measures for NOMs, NPMs, SPMs and ESMs
Form 10B	State Performance/Outcome Measure Detail Sheet
Form 10C	Evidence-Based or –Informed Strategy Measure (ESM) Detail Sheet
Form 10D	Tracking Performance Measures (FY 2011 - FY 2015)
Form 11	Other State Data #01 - #03

View Burden Statement

OMB Number: 4040-0004
Expiration Date: 8/31/2016

Application for Federal Assistance SF-424

* 1. Type of Submission:
- Preapplication
- Application
- Changed/Corrected Application

* 2. Type of Application:
- New
- Continuation
- Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received:

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name:

* b. Employer/Taxpayer Identification Number (EIN/TIN):

* c. Organizational DUNS:

d. Address:

* Street1:
Street2:
* City:
County/Parish:
* State:
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code:

e. Organizational Unit:

Department Name:

Division Name:

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:

* First Name:

Middle Name:

* Last Name:

Suffix:

Title:

Organizational Affiliation:

* Telephone Number:

Fax Number:

* Email:

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

11. Catalog of Federal Domestic Assistance Number:

CFDA Title:

*** 12. Funding Opportunity Number:**

* Title:

13. Competition Identification Number:

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant * b. Program/Project

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: * b. End Date:

18. Estimated Funding ($):

* a. Federal
* b. Applicant
* c. State
* d. Local
* e. Other
* f. Program Income
* g. TOTAL

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

a. This application was made available to the State under the Executive Order 12372 Process for review on .

b. Program is subject to E.O. 12372 but has not been selected by the State for review.

c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

Yes No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: * First Name:

Middle Name:

* Last Name:

Suffix:

* Title:

* Telephone Number: Fax Number:

* Email:

* Signature of Authorized Representative: * Date Signed:

Instructions for Application for Federal Assistance (SF-424)

This is a standard form required for use as a cover sheet for submission of pre-applications and applications and related information under discretionary programs. Some of the items are required and some are optional at the discretion of the applicant or the federal agency (agency). Required fields on the form are identified with an asterisk (*) and are also specified as "Required" in the instructions below. In addition to these instructions, applicants must consult agency instructions to determine other specific requirements.

Item	Field Name	Information
1.	Type of Submission:	(Required) Select one type of submission in accordance with agency instructions. • Pre-application • Application • Changed/Corrected Application - Check if this submission is to change or correct a previously submitted application. Unless requested by the agency, applicants may not use this form to submit changes after the closing date.
2.	Type of Application:	(Required) Select one type of application in accordance with agency instructions. • New - An application that is being submitted to an agency for the first time. • Continuation - An extension for an additional funding/budget period for a project with a projected completion date. This can include renewals. • Revision - Any change in the federal government's financial obligation or contingent liability from an existing obligation. If a revision, enter the appropriate letter(s). More than one may be selected. If "Other" is selected, please specify in text box provided. A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration E. Other (specify)
3.	Date Received:	Leave this field blank. This date will be assigned by the Federal agency.
4.	Applicant Identifier:	Enter the entity identifier assigned buy the Federal agency, if any, or the applicant's control number if applicable.
5a.	Federal Entity Identifier:	Enter the number assigned to your organization by the federal agency, if any.
5b.	Federal Award Identifier:	For new applications leave blank. For a continuation or revision to an existing award, enter the previously assigned federal award identifier number. If a changed/corrected application, enter the federal identifier in accordance with agency instructions.
6.	Date Received by State:	Leave this field blank. This date will be assigned by the state, if applicable.
7.	State Application Identifier:	Leave this field blank. This identifier will be assigned by the state, if applicable.
8.	Applicant Information:	Enter the following in accordance with agency instructions:
	a. Legal Name:	(Required) Enter the legal name of applicant that will undertake the assistance activity. This is the organization that has registered with the Central Contractor Registry (CCR). Information on registering with CCR may be obtained by visiting www.Grants.gov.

	b. Employer/Taxpayer Number (EIN/TIN):	(Required) Enter the employer or taxpayer identification number (EIN or TIN) as assigned by the Internal Revenue Service. If your organization is not in the US, enter 44-4444444.
	c. Organizational DUNS:	(Required) Enter the organization's DUNS or DUNS+4 number received from Dun and Bradstreet. Information on obtaining a DUNS number may be obtained by visiting www.Grants.gov.
	d. Address:	Enter address: Street 1 (Required); city (Required); County/Parish, State (Required if country is US), Province, Country (Required), 9-digit zip/postal code (Required if country US).
	e. Organizational Unit:	Enter the name of the primary organizational unit, department or division that will undertake the assistance activity.
	f. Name and contact information of person to be contacted on matters involving this application:	Enter the first and last name (Required); prefix, middle name, suffix, title. Enter organizational affiliation if affiliated with an organization other than that in 7.a. Telephone number and email (Required); fax number.
9.	Type of Applicant: (Required) Select up to three applicant type(s) in accordance with agency instructions.	A. State Government B. County Government C. City or Township Government D. Special District Government E. Regional Organization F. U.S. Territory or Possession G. Independent School District H. Public/State Controlled Institution of Higher Education I. Indian/Native American Tribal Government (Federally Recognized) J. Indian/Native American Tribal Government (Other than Federally Recognized) K. Indian/Native American Tribally Designated Organization L. Public/Indian Housing M. Nonprofit N. Private Institution of Higher Education O. Individual P. For-Profit Organization (Other than Small Business) Q. Small Business R. Hispanic-serving Institution S. Historically Black Colleges and Universities (HBCUs) T. Tribally Controlled Colleges and Universities (TCCUs) U. Alaska Native and Native Hawaiian Serving Institutions V. Non-US Entity W. Other (specify)
10.	Name Of Federal Agency:	(Required) Enter the name of the federal agency from which assistance is being requested with this application.
11.	Catalog Of Federal Domestic Assistance Number/Title:	Enter the Catalog of Federal Domestic Assistance number and title of the program under which assistance is requested, as found in the program announcement, if applicable.
12.	Funding Opportunity Number/Title:	(Required) Enter the Funding Opportunity Number and title of the opportunity under which assistance is requested, as found in the program announcement.
13.	Competition Identification Number/Title:	Enter the competition identification number and title of the competition under which assistance is requested, if applicable.
14.	Areas Affected By Project:	This data element is intended for use only by programs for which the area(s)

		affected are likely to be different than the place(s) of performance reported on the SF-424 Project/Performance Site Location(s) Form. Add attachment to enter additional areas, if needed.
15.	Descriptive Title of Applicant's Project:	(Required) Enter a brief descriptive title of the project. If appropriate, attach a map showing project location (e.g., construction or real property projects). For pre-applications, attach a summary description of the project.
16.	Congressional Districts Of:	15a. (Required) Enter the applicant's congressional district. 15b. Enter all district(s) affected by the program or project. Enter in the format: 2 characters state abbreviation - 3 characters district number, e.g., CA-005 for California 5th district, CA-012 for California 12 district, NC-103 for North Carolina's 103 district. If all congressional districts in a state are affected, enter "all" for the district number, e.g., MD-all for all congressional districts in Maryland. If nationwide, i.e. all districts within all states are affected, enter US-all. If the program/project is outside the US, enter 00-000. This optional data element is intended for use only by programs for which the area(s) affected are likely to be different than place(s) of performance reported on the SF-424 Project/Performance Site Location(s) Form. Attach an additional list of program/project congressional districts, if needed.
17.	Proposed Project Start and End Dates:	(Required) Enter the proposed start date and end date of the project.
18.	Estimated Funding:	(Required) Enter the 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 parentheses.
19.	Is Application Subject to Review by State Under Executive Order 12372 Process?	(Required) 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. Select the appropriate box. If "a." is selected, enter the date the application was submitted to the State.
20.	Is the Applicant Delinquent on any Federal Debt?	(Required) Select the appropriate box. This question applies to the applicant organization, not the person who signs as the authorized representative. Categories of federal debt include; but, may not be limited to: delinquent audit disallowances, loans and taxes. If yes, include an explanation in an attachment.
21.	Authorized Representative:	To be signed and dated by the authorized representative of the applicant organization. Enter the first and last name (Required); prefix, middle name, suffix. Enter title, telephone number, email (Required); and fax number. A copy of the governing body's authorization for you to sign this application as the 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.)

FORM 2
MCH BUDGET/EXPENDITURE DETAILS
[SECTIONS 504(d) AND 505(a)(3),(4)]

	FY__ Application Budgeted	FY__ Annual Report Expended
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$_____	$_____
Of the Federal Allocation, the amount earmarked for:		
A. Preventive and Primary Care for Children:	$_____ (__%)	$_____ (__%)
B. Children with Special Health Care Needs:	$_____ (__%)	$_____ (__%)
C. Title V Administrative Costs:	$_____ (__%)	$_____ (__%)
2. UNOBLIGATED BALANCE (Item 18b of SF- 424)	$_____	$_____
3. STATE MCH FUNDS (Item 18c of SF-424)	$_____	$_____
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$_____	$_____
5. OTHER FUNDS (Item 18e of the SF-424)	$_____	$_____
6. PROGRAM INCOME (Item 18f of SF-424)	$_____	$_____
7. TOTAL STATE MATCH (Lines 3 through 6)	$_____	$_____
A. Enter your State's FY 1989 Maintenance of Effort Amount **$_____**		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 through 6. Same as line 18g of SF-424)	$_____	$_____
9. OTHER FEDERAL FUNDS [Select Appropriate Funding Sources from the Drop-Down Box] (Report only funds under the control of the Title V Program Administrator)		
Select the Appropriate Federal Department ⇩		
Select the Appropriate Federal Agency. ⇩		
Select the Appropriate Federal Grant Program. ⇩	$_____	$_____
10. OTHER FEDERAL FUNDS (SUBTOTAL of all funds under item 9)	$_____	$_____
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$_____	$_____

INSTRUCTIONS FOR COMPLETION OF FORM 2
MCH BUDGET/EXPENDITURE 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 funds 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: This form provides details of the State's MCH budget and the fulfillment of certain spending requirements under Title V for a given year. A Glossary that contains terms applicable to this form is provided in Appendix H of the Supporting Documents, which accompany the Application/Annual Report Guidance.

LINE NUMBER	INSTRUCTIONS
1	Enter the amount of the Federal Title V allocation for both the budget (Application) and expenditure (Annual Report) years.
1A	Enter the amount of the Federal allotment for preventive and primary care for children. The percentage of the total (Line 1) that this amount represents will be calculated by the Title V Information System (TVIS).
1B	Enter the amount of the Federal allotment for children with special health care needs. The percentage of the total (Line 1) that this amount represents will be calculated by the Title V Information System (TVIS).
1C	Enter the amount of the Federal allotment for the administration of the allotment. The percentage of the total (Line 1) that this amount represents will be calculated by the Title V Information System (TVIS).
2	Enter the amount of carryover from the previous fiscal year's MCH Block Grant Allocation (the unobligated balance). Any unspent funds for the expenditure year should also be noted.
3	Enter the amount of your State total funds for the Title V allocation (match).
4	Enter the amount of total MCH dedicated *matching* funds garnered from local jurisdictions within your State.
5	Enter the total of MCH funds available from other sources such as foundations.
6	Enter the amount of MCH program income funds collected by your State's MCH agencies from insurance payments, MEDICAID, HMO's, etc.
7	The TVIS will calculate the sum total of Lines 3, 4, 5, and 6 for the total of your State match and overmatch.
7A	Enter your State's FY 1989 Maintenance of Effort amount.
8	The TVIS will calculate the total for Lines 1, 2, and 7. This amount is the "Federal-State Title V Block Grant "Partnership."
9	Enter Federal funds **other** than the Title V Block Grant that are directly under the control of the Title V Program Administrator.
10	The TVIS will calculate the sum of all lines in item 9.
11	The TVIS will calculate the sum of Lines 8 and 10. This amount is the total of all MCH funds administered by your State's MCH program.

FORM 3a
BUDGET AND EXPENDITURE DETAILS BY TYPES OF INDIVIDUALS SERVED (IA and IB)
[Section 506(a)(2)(A)(iv), Section 505(a)(2)(A-B) and Section 506(a)(1)(A-D)]

I. TYPES OF INDIVIDUALS SERVED

	FY ____ Application	FY ____ Annual Report
IA. Federal MCH Block Grant	**Budgeted**	**Expended**
1. Pregnant Women	$_____	$_____
2. Infants < 1 year	$_____	$_____
3. Children 1-22 years	$_____	$_____
4. CSHCN	$_____	$_____
5. All Others	$_____	$_____
Federal TOTAL	**$_____**	**$_____**

	FY ____ Application	FY ____ Annual Report
IB. Non-Federal MCH Block Grant	**Budgeted**	**Expended**
1. Pregnant Women	$_____	$_____
2. Infants < 1 year	$_____	$_____
3. Children 1-22 years	$_____	$_____
4. CSHCN	$_____	$_____
5. All Others	$_____	$_____
Non-Federal TOTAL	**$_____**	**$_____**

	FY ____ Application Budgeted	FY ____ Annual Report Expended
FEDERAL-STATE MCH BLOCK GRANT PARTNERSHIP TOTAL	**$_____**	**$_____**

INSTRUCTIONS FOR COMPLETION OF FORM 3a
BUDGET/EXPENDITURE DETAILS BY TYPES OF INDIVIDUALS SERVED

Title V Citation: *Section 506(a)(2)(A)(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: Complete all required data cells. If an actual number is not available, the State should provide an estimate. All estimates should be explained in a footnote. A Glossary that contains terms applicable to this form is provided in Appendix H of the Supporting Documents, which accompany the Application/Annual Report Guidance.

LINE NUMBER	INSTRUCTIONS
I.A.1 – I.A.5	Enter the budgeted (Application year) and expended (Annual Report year) amounts for the **Federal** MCH allocation.
I.A.1 Federal TOTAL	The TVIS will calculate the sum of the amounts entered for Lines I.A.1 through I.A.5.
I.B.1 - I.B.5	Enter the budgeted (Application year) and expended (Annual Report year) amounts for the **non-Federal** Title V program funds.
I.B.1 Non-Federal TOTAL	The TVIS will calculate the sum of the amounts entered for Lines I.B.1 through I.B.5.
Federal-State MCH Block Grant Partnership TOTAL	The TVIS will calculate the sum of the amounts entered for the I.A.1 TOTAL and I.B.1 TOTAL.

FORM 3b
BUDGET AND EXPENDITURE DETAILS BY TYPES OF SERVICES (IIA and IIB)
[Section 506(a)(2)(A)(iv), Section 505(a)(2)(A-B) and Section 506(a)(1)(A-D)]

II. TYPES OF INDIVIDUALS SERVICES

	FY ____ Application	FY ____ Annual Report
IIA. Federal MCH Block Grant	**Budgeted**	**Expended**
1. Direct Services	**$_____**	**$_____**
a. Preventive and primary care services for all pregnant women, mothers, and infants up to age one	$_____	$_____
b. Preventive and primary care services for children	$_____	$_____
c. *Services for CSHCN*	$_____	$_____
2. Enabling Services	**$_____**	**$_____**
3. Public Health Services and Systems	**$_____**	**$_____**

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

1. Pharmacy	_____(Yes)	($)_____
2. Physician/Office Charges	_____(Yes)	($)_____
3. Hospital Charges (Includes Inpatient and Outpatient Services)	_____(Yes)	($) _____
4. Dental Care (Does Not Include Orthodontic Services)	_____(Yes)	($)_____
5. Durable Medical Equipment and Supplies	_____(Yes)	($)_____
6. Laboratory Services	_____(Yes)	($)_____
7. Other _____	_____(Yes)	($)_____

Select Service Type

	FY ____ Application Budgeted	FY ____ Annual Report Expended
FEDERAL TOTAL	**$_____**	**$_____**

FORM 3b
BUDGET AND EXPENDITURE DETAILS BY TYPES OF SERVICES (IIA and IIB)
[Section 506(a)(2)(A)(iv), Section 505(a)(2)(A-B) and Section 506(a)(1)(A-D)]

II. TYPES OF INDIVIDUALS SERVICES (Continued)

IIB. Non-Federal MCH Block Grant	FY ____ Application Budgeted	FY ____ Annual Report Expended
1. Direct Services	**$_____**	**$_____**
a. *Preventive and primary care services for all pregnant women, mothers, and infants up to age one*	$_____	$_____
b. *Preventive and primary care services for children*	$_____	$_____
c. *Services for CSHCN*	$_____	$_____
2. Enabling Services	**$_____**	**$_____**
3. Public Health Services and Systems	**$_____**	**$_____**

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

1. Pharmacy	_____(Yes)	($) _____
2. Physician Office Services	_____(Yes)	($) _____
3. Hospital Charges (Includes Inpatient and Outpatient Services)	_____(Yes)	($) _____
4. Dental Care (Does Not Include Orthodontic Services)	_____(Yes)	($) _____
5. Durable Medical Equipment and Supplies	_____(Yes)	($) _____
6. Laboratory Services	_____(Yes)	($) _____
7. Other _____	_____(Yes)	($) _____

Select Service Type

	FY ____ Application Budgeted	FY ____ Annual Report Expended
NON-FEDERAL TOTAL	**$_____**	**$_____**

INSTRUCTIONS FOR THE COMPLETION OF FORM 3b
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

Title V Citation: *Section 505(a)(2) 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) states, "Each State shall prepare and submit to the Secretary annual reports on its activities under this title. Among the items required to be reported (Section 506(a)(2)(A)(i-iv)) are, "...the number of individuals served by the State under this title (by class of individuals), the proportion of each class of such individuals which has health coverage, the types (as defined by the Secretary) of services provided under this title to individuals within each such class and the amounts spent under this title on each type of services, by class of individuals served."

Instructions: Complete all required data cells. If an actual number is not available, the State should make an estimate. All estimates should be explained in a footnote. A Glossary that contains terms applicable to this form is provided in Appendix H of the Supporting Documents, which accompany the Application/Annual Report Guidance.

LINE NUMBER	INSTRUCTIONS
II.A.1	Of the **Federal MCH allocation**, enter the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Direct Services**.
II.A.1.a – II.A.1c	Of the **Federal** MCH allocation, enter the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Direct Services by types of services and MCH population group**.
II.A.2	Of the **Federal MCH allocation**, enter the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Enabling Services**.
II.A.3	Of the **Federal MCH allocation**, enter the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Public Health Services and Systems.**
II.A.4	Using the list of services provided in the drop down box, select any direct service that the State supports through its Federal Title V funds. Check "Yes" and enter the amount of Federal funds expended for this service. Additional services may be included by checking "Other" and entering the type of service that is supported.
Federal TOTAL	The TVIS will calculate the sum of the **Federal** amounts entered for Line II.A.1, Line II.A.2 and Line II.A.3.

INSTRUCTIONS FOR THE COMPLETION OF FORM 3b (Continued)
STATE TITLE V PROGRAM BUDGET AND EXPENDITURES BY TYPES OF SERVICES

LINE NUMBER	INSTRUCTIONS
II.B.1	Of the **non-Federal MCH allocation**, enter the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Direct Services**.
II.B.1.a – II.B.1c	Of the **non-Federal** MCH allocation, enter the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Direct Services by types of services and MCH population group**.
II.B.2	Of the **non-Federal MCH allocation**, enter the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Enabling Services**.
II.B.3	Of the **non-Federal MCH allocation**, enter the **Total** budgeted (Application year) and expended (Annual Report year) amounts for **Public Health Services and Systems.**
II.B.4	Using the list of services provided in the drop down box, select any direct service that the State supports through its non-Federal Title V funds. Check "Yes" and enter the amount of non-Federal funds expended for this service. Additional services may be included by checking "Other" and entering the type of service that is supported.
Non-Federal TOTAL	The TVIS will calculate the sum of the **non-Federal** amounts entered for Line II.B.1, Line II.B.2 and Line II.B.3.

FORM 4
NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED AND TREATED
[SECTION 506(a)(2)(B)(iii)]

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

Type of Screening Tests	(A) Number Receiving at Least One Screen([1])		(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases([2])	(D) Number Referred for Treatment ([3])	
	No.	%			No.	%
1. Newborn Screening Program Select all applicable screening tests from the core and secondary conditions in the Recommended Uniform Screening Panel (RUSP) using the drop down list.						
2. Other Newborn Screening Tests (Specify by Name) 1. Newborn Hearing 2. _____ 3. _____						
3. Screening Programs for Older Children & Women 1) _____ 2) _____ 3) _____						

4. Long-term follow-up (follow-up beyond referring an infant for treatment) varies based on State policy and practice. Please describe your State's practice for monitoring infants with confirmed diagnoses, including what information is obtained and for how long infants are monitored.

[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 4
NUMBER AND PERCENTAGE OF NEWBORNS AND OTHERS SCREENED, CASES CONFIRMED, AND TREATED

Title V Citation: *Section 506(a)(1) requires each State to submit an annual report on its activities under Title V. Included in this requirement is the following: (2)(B)(iii) "... information on such other indicators of maternal, infant, and child health care status as the Secretary may specify."*

Instructions: Complete all required data cells. If an actual number is not available, make an estimate. All estimates should be explained in a footnote. A Glossary that contains terms applicable to this Form is provided in Appendix H of the Supporting Documents, which accompany the Application/Annual Report Guidance.

LINE NUMBER	INSTRUCTIONS
Lines: "Total Births by Occurrence" and "Reporting Year"	Enter the total number of occurrent births for the State and the year for which the data apply. Total births by occurrence are to be defined as "all births that occur in the State regardless of residency." States should use the number submitted by the Vital Records program to the National Center for Health Statistics. The reporting year is to be defined as calendar year, January 1 – December 31. Please note that the "Total Births..." figure is related to the "Total infants < 1 year of age" row in Form 5a and 5b, and the "TOTAL INFANTS IN STATE" row in section I of Form 6. While these figures are not expected to match, there should be a fairly close relationship between them.
1. Newborn Screening Program	All States now require screening for at least 29 out of the 31 conditions on the Recommended Uniform Screening Panel (RUSP). All tests done during the reporting year should be listed along with the number of infants screened and followed. Using the drop down box, States should select the names of any screening tests specific to its newborn population and complete Columns A through D for each of the selected conditions. a. 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. b. In column B, enter the number of presumptive positive screens. c. In column C, enter the number of confirmed cases discovered. Use only those from resident births. d. In column D, enter the number and percent of those confirmed cases that were referred for treatment. Use confirmed cases as the denominator.
2. Other Newborn Screening Tests	States should enter additional screening tests specific to its newborn population, such as newborn hearing screening or screenings for other conditions that are not listed in the RUSP. Complete Columns A through D for each of the listed screenings.
3. Screening Programs for Older Children and Women	Using the drop down box, States should list any screening tests that are specific to older children and women. Complete Columns A through D for each of the listed screenings. Note that the % (percentage) portion of Column A is not to be completed since the denominator of Total Births by Occurrence does not apply. Enter the specific names of any other screens that are not listed and complete Columns A through D.

FORM 5a
UNDUPLICATED COUNT OF INDIVIDUALS SERVED UNDER TITLE V
(By Class of Individuals and Percent of Health Coverage)
[Section 506(a)(2)(A)(i-ii)]

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

FORM 5b
TOTAL RECIPIENT COUNT OF INDIVIDUALS SERVED BY TITLE V
(By Class of Individuals)
[Section 506(a)(2)(A)(i-ii)]

Reporting Year _____	
Type of Individuals Served by Title V	**Total Served**
1. Pregnant Women	_____
2. Infants < 1 year of age	_____
3. Children 1 to 22 years of age	_____
4. Children with Special Health Care Needs	_____
5. Others	_____
TOTAL	_____

INSTRUCTIONS FOR THE COMPLETION OF FORM 5a and Form 5b
UNDUPLICATED COUNT OF INDIVIDUALS SERVED UNDER TITLE V
AND
TOTAL RECIPIENT COUNT OF INDIVIDUALS SERVED BY TITLE V
[Section 506(a)(2)(A)(i-ii)]

Title V Citation: *Section 506(a)(1) 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: Complete all required data cells. If an actual number is not available, the State should make an estimate. All estimates should be explained in a footnote. A Glossary that contains terms applicable to this form is provided in Appendix H of the Supporting Documents, which accompany the Application/Annual Report Guidance.

The purpose of Form 5a and Form 5b is two-fold.

Form 5a, *Unduplicated Count of Individuals Served Under Title V*, enables the State to track and report on the number of individuals who were served by the Title V program within the top level of the MCH Pyramid.

Form 5b, *Total Recipient Count of Individuals Served by Title* V, enables the State to track and report on the number of individuals who received a Title V service within the top two service levels of the MCH Pyramid.

Since States began to report Title V program participant data in the 1990's, MCH programs have seen a shift in the delivery of services from direct primary care MCH services to public health and preventive services within well-coordinated and comprehensive systems of care that are designed for the MCH population. This shift has resulted in a need for more complete reporting of individuals served by Title V, which goes beyond an unduplicated count of individuals served (often derived from reimbursement data for MCH direct services).

It is recognized that precisely quantifying the number of individuals reached through population-based services (e.g., preventive health screenings, outreach, immunizations and health education) is difficult, and informed estimates are often required. Relying only on reimbursement data for the individual services supported by Title V, however, can lead to serious underestimates of the number of individuals in a State who actually received and benefitted from a Title V-supported service. For this reason, Form 5b was developed to better capture the full "reach" of the State's Title V program in serving its MCH population.

INSTRUCTIONS FOR THE COMPLETION OF FORM 5a and Form 5b
UNDUPLICATED COUNT OF INDIVIDUALS SERVED UNDER TITLE V
AND
TOTAL RECIPIENT COUNT OF INDIVIDUALS SERVED BY TITLE V
[Section 506(a)(2)(A)(i-ii)]

FORM/LINE NUMBER	INSTRUCTIONS
Form 5a	States should report an *unduplicated* number of the individuals served by Title V in each of the listed MCH population groups.
Reporting Year	Enter the reporting year for which the data apply at the top of Form 5a on the designated line.
1 – 5, Column A	Enter the best possible estimate for an unduplicated count of individuals served by the Title V program across the top level (i.e., Direct Services) of the MCH Pyramid, regardless of the primary source of coverage. These services would include all individuals served by total dollars reported on line 8 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 4.
1 -5, Columns B - F	Report the percentages of individuals who were served by Title V within the listed classes and their primary source of coverage. These counts may be estimates. If individuals are covered by more than one source, the primary source of coverage should be reported.
Form 5b	States should report an estimate for the *total number of individuals* who received a Title V service in each of the listed MCH population groups. This estimate should include the public health services that are described in the top two levels (i.e., Direct Services and Enabling Services) of the MCH Pyramid and include individuals who receive services supported by other Federal programs (e.g., Title X) which are under the control of the Title V Administrator, as reported on Line 9 of Form 2. It is recognized that some individuals will receive services under multiple Title V-supported programs (e.g., local clinics and school-based screenings) and, thus, may be counted more than once. The purpose of this form is to better capture the breadth of the State's Title V program and its reach in serving the MCH population. Derivation of estimates should be properly explained in a data note, as needed. For example, if a State is implementing a media campaign under Title V that targets adolescents, estimates of the number of adolescents reached may be derived from sample data or market surveys.
Reporting Year	Enter the reporting year for which the data apply at the top of Form 5b on the designated line.
1-5	Enter the best possible estimate for a total count of individuals served by the Title V program across the top two levels of the MCH Pyramid. These services would include all individuals served by the total dollars reported on line 8 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 4.

FORM 6
DELIVERIES AND INFANTS SERVED BY TITLE V
AND ENTITLED TO BENEFITS UNDER TITLE XIX
(By Race and Ethnicity)
[Section 506(a)(2)(C-D)]

I. UNDUPLICATED COUNT BY RACE

Reporting Year: _____

	(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
1. TOTAL DELIVERIES IN STATE								
TITLE V SERVED								
ELIGIBLE FOR TITLE XIX								
2. 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
1. TOTAL DELIVERIES IN STATE			
TITLE V SERVED			
ELIGIBLE FOR TITLE XIX			
2. TOTAL INFANTS IN STATE			
TITLE V SERVED			
ELIGIBLE FOR TITLE XIX			

INSTRUCTIONS FOR THE COMPLETION OF FORM 6
DELIVERIES AND INFANTS SERVED BY TITLE V
AND ENTITLED TO BENEFITS UNDER TITLE XIX

Title V Citation: *Section 506 (a)(1) requires each State to submit an Annual Report on its activities under Title V. Included in this requirement is the following:*

(2)(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.*

(2)(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: Complete all required data cells. If an actual number is not available, the State should make an estimate. All estimates should be explained in a footnote. A Glossary that contains terms applicable to this form is provided in Appendix H of the Supporting Documents, which accompany the Application/Annual Report Guidance. It is recognized that there will be overlap between the reported totals for "Title V Served" and "Eligible for Title XIX", due to an individual's changing insurance eligibility status during the course of a year (i.e., "churning".) Form 6 asks for all individuals who are served by Title V and an estimate of the individuals in the State who are eligible for Title XIX. The form does not ask for a report on those individuals served by Title V who are also eligible for Title XIX.

LINE NUMBER	INSTRUCTIONS
Section I: Unduplicated Count by Race	
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.
Total Infants in State	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 4, and the "Total infants < 1 year of age" row in Form 5. While these figures are not expected to match, they should show a fairly close relationship to each other). For columns B-H, the State should enter the number of infants who were eligible by race.
Section II: Unduplicated Count by Ethnicity	
Total Deliveries in State	Enter the total number of deliveries in the State by ethnicity, specifically Hispanic or Latino in Column A, Not Hispanic or Latino in Column B or Ethnicity Not Reported in Column C.
Total Infants in State	Enter the total number of infants in the State by ethnicity, specifically Hispanic or Latino in Column A, Not Hispanic or Latino in Column B or Ethnicity Not Reported in Column C.

FORM 7
STATE TITLE V MCH SERVICES BLOCK GRANT
STATE PROFILE FOR FY___

A. State MCH Toll-Free Telephone Line [*Sections 505(a)(5)(E) and 509(a)(8)]*:

STATE: _____

	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" in this Reporting Period	_____

B. Other Appropriate Methods [*Sections 505(a)(5)(E) and 509(a)(8)]*:

	FY__
1. Other Toll-Free "Hotline" Names (e.g., 2-1-1 Infoline)	_____
2. Number of Calls on the State 2-1-1 Infoline or Other Relevant Hotlines in this Reporting Period	_____
3. State Title V Program Website Address	_____
4. Number of Hits to Title V Program Website	_____
5. State Title V Social Media Websites	_____
6. Number of Hits to Title V Program Social Media Websites	_____

INSTRUCTIONS FOR THE COMPLETION OF FORM 7
STATE MCH TOLL-FREE TELEPHONE LINE AND OTHER APPROPRIATE METHODS DATA FORM

Title V Citation: *Section 505(a)(5)(E) states, in part, "the State agency (or agencies) administering the State's program under this title will provide for a toll-free telephone 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 of calls received or hits to the website is not available, the State should make an estimate. All estimates should be explained in a footnote.

LINE NUMBER	INSTRUCTIONS
State	Enter the name of the State.
Fiscal Year (FY)	Enter the reporting year at the top of the column.
A.1	Enter the State's primary toll-free MCH information line telephone number.
A.2	Enter the name of the State's primary toll-free MCH information line.
A.3	Enter the name of the person who should be contacted with any concerns about the State's primary toll-free MCH information line.
A.4	Enter the telephone number of the contact person that is listed on Line A.3.
A.5	For the reporting year, enter the number of calls received on the State's primary toll-free MCH information line.

LINE NUMBER	INSTRUCTIONS
B.1	Enter the names of other toll-free information lines that are administered by the State.
B.2	For the reporting year, enter the number of calls received by the other toll-free MCH information lines administered by the State.
B.3	Enter the URL for the State Title V Program website.
B.4	For the reporting year, enter the number of hits to the State Title V Program website address listed on Line B.3.
B.5	Enter the URLs for the State Title V Social Media Websites
B.6	For the reporting year, enter the number of hits to the State Title V Program social media website addresses listed on Line B.5.

FORM 8
STATE TITLE V MCH SERVICES BLOCK GRANT
STATE PROFILE FOR FY___

STATE: _____

1. Title V Maternal and Child Health (MCH) Director	
Name:	_____
Title	_____
Street Address:	_____
Room Number:	_____
City/State/Zip:	_____
Telephone:	_____
Email:	_____

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name:	_____
Title	_____
Street Address:	_____
Room Number:	_____
City/State/Zip:	_____
Telephone:	_____
Email:	_____

3. State Family or Youth Leader (Optional):	
Name:	_____
Title	_____
Street Address:	_____
Room Number:	_____
City/State/Zip:	_____
Telephone:	_____
Email:	_____

Instructions: Enter the name of the Title V MCH Director, CSHCN Director and, at the option of the State, the Family and/or Youth Leader. For each of the listed contacts, provide the title, address, telephone number and e-mail address.

FORM 9
LIST OF MCH PRIORITY NEEDS
[Section 505(a)(1)]

Your state's Five-Year Statewide 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. The established priorities should guide the activities that are included in the State's Five-year Action Plan. In order to evaluate success in meeting the goals of the priority needs, the State should determine, at the time of priority setting, its plan for assessing if priority needs have been addressed. This assessment should include the development of State Performance Measures (SPMs), which are specifically tailored to a priority need to the extent that such need is not fully addressed by the National Performance Measures (NPMs) or the State Evidence-based or –informed Strategy Measures (ESMs).

With each year's Block Grant Application, the State should provide a list, (whether or not the priority needs change) of its top maternal and child health needs and crosslink the identified priorities with the existing National Outcome Measures (NOMs), NPMs, SPMs and ESMs. Use a simple sentence or phrase to list your State's needs below. 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." For each priority, indicate if it a new priority need for this five-year reporting cycle or if it is being continued from the previous five-year cycle. A rationale should be provided for any identified priority that is not linked to a specific performance/outcome measure.

MCHB will capture annually every State's top 7 to 10 priority needs in an information system for comparison, tracking, and reporting purposes. The State must list at least 7 priority needs, and the form will only accept up to 10. If desired, the State may list and describe additional priority needs in a form note. Note that the numerical listing below is for computer tracking only and is not meant to indicate a priority order.

STATE_____ **FY**_____

PRIORITY NEEDS	NEW (N), REPLACED (R) OR CONTINUED (C) PRIORITY NEED FOR THIS FIVE-YEAR REPORTING PERIOD			RATIONALE IF PRIORITY NEED DOES NOT HAVE A CORRESPONDING STATE OR NATIONAL PERFORMANCE/ OUTCOME MEASURE
	N	R	C	
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

FORM 10A
TRACKING MEASURES
(for National Outcome, National Performance, State Performance, and Evidence-based or –Informed Strategy Measures)
[Sections 505(a)(2)(B)(i),(iii) and 506(a)(2)(A)(iii)]

Annual Reporting Year: Objective and Performance Data

MEASURE #__ (Measure Title)	**FY__ (Reporting Year)**	**FY__**	**FY__**	**FY__**	**FY__**	**FY__**
Annual Objective		_____	_____	_____	_____	_____
Annual Indicator	_____					
Numerator	_____					
Denominator	_____					
Data Source (Reporting Year): _____						
Note (Reporting Year): _____						

Description: As the standard form to be used by States in tracking all measurement types [National Outcome Measures (NOMs), National Performance Measures (NPMs), State Performance Measures (SPMs) and Evidence-based or –informed Strategy Measures (ESMs)] specified in this Guidance, this form serves a dual purpose: 1) Displays 5-year planned objectives (targets) for each NPM, SPM and ESM as part of the Application, and 2) Reports Annual Indicators, values actually achieved during a reporting year, for each NOM, NPM, SPM and ESM as part of the Annual Report. States are not required to establish performance targets for the NOMs. A Glossary that contains terms applicable to this form is provided in Appendix H of the Supporting Documents, which accompany the Application/Annual Report Guidance.

INSTRUCTIONS FOR THE COMPLETION OF FORM 10A
TRACKING MEASURES
(for National Outcome, National Performance, State Performance and Evidence-Based or –Informed Strategy Measures)

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: For the Application Year, States will establish five-year performance targets for each selected NPM, SPM and ESM. Within the five-year period, performance targets that were established by the State in previous years' Applications will be pre-populated on the form.

For the Annual Reporting year, States will complete the required data cells (i.e., Annual Indicator, Numerator, Denominator, Data Source and Reporting Note) for the SPMs and ESMs. If the final data are not available, the State should provide provisional or estimated data. All provisional or estimated data should be explained in a footnote. If neither the 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 Objective" and "Annual Indicator," lines should be left blank. SPMs are automatically assigned when a State creates the detail sheet (Form 10B) for each of its established SPMs. ESMs are automatically assigned when a State creates the detail sheet (Form 10C) for each of the measures that are developed to address a selected NPM.

While not responsible for entering an Annual Indicator, States will be responsible for tracking their annual progress on the NPMs and their related NOMs. For the NPMs and the NOMs, the Annual Indicator data will be populated annually by the Maternal and Child Health Bureau, as available, using the referenced national data source identified on the detail sheet for each specific NPM and NOM.

LINE NUMBER	INSTRUCTIONS
Measure Number	The measure number will be populated from the number that is defined on the Measure Detail Sheet.
Fiscal Year (FY)	Enter the reporting year at the top of the appropriate column.
Annual Objective	For the Application year, complete five-year Annual Objectives for each of the selected NPMs, SPMs and ESMs.
Annual Indicator	For the Annual Reporting year, enter the Annual Indicator, including the Numerator and Denominator, for each SPM and ESM.
Data Source	For the Annual Reporting year, enter the data source for the reported Annual Indicator for each SPM and ESM.
Note	For the Annual Reporting year, enter a data note to clarify any estimated or provisional data and to describe other limitations which impact the reporting of an Annual Indicator for each of the SPMs and the ESMs.

FORM 10B
STATE PERFORMANCE/OUTCOME MEASURE DETAIL SHEET

SPM ☐ SOM ☐ **SPM/SOM # _____** **PERFORMANCE MEASURE TITLE:**	
CHOOSE THE POPULATION DOMAIN TO WHICH THIS MEASURE LINKS (Choose one):	Women's/Maternal Health Perinatal/Infant Health Child Health Adolescent Health Children with Special Health Needs Cross-cutting or Life Course
GOAL	
DEFINITION	Numerator: Denominator: Units: _____ _____ (Number) (Text)
HEALTHY PEOPLE 2020 OBJECTIVE	
DATA SOURCES and DATA ISSUES	
SIGNIFICANCE	

INSTRUCTIONS FOR THE COMPLETION OF FORM 10B
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: This form is to be used for creating both a State Performance Measure (SPM) and a State Outcome Measure (SOM), if the State chooses to add one. Complete each section as appropriate for the measure being described. Note that the Performance or Outcome Measure's title and numerator and denominator data will be displayed on Form 10A as they are defined on this form. A Glossary that contains terms applicable to this form is provided in Appendix H of the Supporting Documents, which accompany the Application/Annual Report Guidance.

LINE NUMBER	INSTRUCTIONS
SPM/SOM Checkboxes	Please check the appropriate box for the type of measure being created.
SPM or SOM #	The measure number will be automatically generated by TVIS when the State creates this detail sheet.
Performance Measure	Enter the narrative description of the performance or outcome measure.
Choose the Population Domain to which to which this measure links	Select the related population domain from the displayed pick list.
Goal	Enter a short statement indicating what the State hopes to accomplish by tracking this measure.
Definition	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., 10,000; 1,000; 100) by selecting a choice in pick list for the "Number" field. Select the type of measure from the pick list (e.g., percentage, rate, ratio, scale, yes/no) on "Text" field.
Healthy People 2020 Objective	If the measure is related to a *Healthy People 2020* 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. Describe also how the value of the measure is determined from the data. If the value of the measure is a scale or a "yes/no," a clear description of what those values mean and how they are determined should be provided.

FORM 10C
EVIDENCE-BASED OR –INFORMED STRATEGY MEASURE (ESM) DETAIL SHEET

ESM # _____ **PERFORMANCE MEASURE TITLE:**	
CHOOSE THE NATIONAL PERFORMANCE MEASURE TO WHICH THIS ESM IS LINKED: (Choose one)	1. Percent of women with a past year preventive visit 2. Percent of cesarean deliveries among low-risk first births 3. Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) 4. A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months 5. Percent of infants placed to sleep on their backs 6. Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool 7. Rate of injury-related hospital admissions per population ages 0 through 19 years 8. Percent of children ages 6 through 11 years and adolescents ages 12 through 17 years who are physically active at least 60 minutes per day 9. Percent of adolescents, ages 12 through 17 years, who are bullied 10. Percent of adolescents with a preventive services visit in the last year 11. Percent of children with and without special health care needs having a medical home 12. Percent of children with and without special health care needs who received services necessary to make transitions to adult health care 13. A) Percent of women who had a dental visit during pregnancy and B) Percent of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year 14. A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes 15. Percent of children 0 through 17 years who are adequately insured
GOAL	
DEFINITION	Numerator: Denominator: Units: _____ _____ (Number) (Text)
DATA SOURCES and DATA ISSUES	
SIGNIFICANCE	

INSTRUCTIONS FOR THE COMPLETION OF FORM 10C
EVIDENCE-BASED OR –INFORMED STRATEGY MEASURE (ESM) 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: This form is to be used for creating an Evidence-based or –informed Strategy Measure (ESM). Complete each section as appropriate for the measure being described. Note that the ESM title and numerator and denominator data will be displayed on Form 10A as they are defined on this form. A Glossary that contains terms applicable to this form is provided in Appendix H of the Supporting Documents, which accompany the Application/Annual Report Guidance.

LINE NUMBER	INSTRUCTIONS
ESM #	The measure number will be automatically generated by TVIS when the State creates this detail sheet.
Strategy Measure	Enter the narrative description of the strategy measure.
Choose the National Performance Measure to which this ESM is linked	Select the related national performance measure from the displayed pick list.
Goal	Enter a short statement indicating what the State hopes to accomplish by tracking this measure.
Definition	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., 10,000; 1,000; 100) by selecting a choice in pick list for the "Number" field. Select the type of measure from the pick list (e.g., percentage, rate, ratio, scale, yes/no) on "Text" field.
Healthy People 2020 Objective	If the measure is related to a *Healthy People 2020* 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. Describe also how the value of the measure is determined from the data. If the value of the measure is a scale or a "yes/no," a clear description of what those values mean and how they are determined should be provided.

FORM 10D
TRACKING PERFORMANCE MEASURES
(FY 2011 – 2015)
[Sections 505(a)(2)(B)(i),(iii) and 506(a)(2)(A)(iii)]

Annual Reporting Year:
Objective and Performance Data

STATE: _____

NATIONAL PERFORMANCE MEASURE #__	FY 2015	FY 2014
(Select from Table Below)		
_____		
_____		
_____		
_____		
_____		
Annual Objective	_____	_____
Annual Indicator	_____	_____
Numerator	_____	_____
Denominator	_____	_____
Data Source	_____	_____
Data Note	_____	_____

STATE PERFORMANCE MEASURE #__	FY 2015	FY 2014
_____		
_____		
_____		
_____		
_____		
Annual Objective	_____	_____
Annual Indicator	_____	_____
Numerator	_____	_____
Denominator	_____	_____
Data Source	_____	_____
Data Note	_____	_____

FORM 10D
TRACKING PERFORMANCE MEASURES
(FY 2011 – 2015)
[Sections 505(a)(2)(B)(i),(iii) and 506(a)(2)(A)(iii)]

NUMBER	FY 2011 – FY 2015 NATIONAL PERFORMANCE MEASURES
1	The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.
2	The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)
3	The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)
4	The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)
5	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)
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.
7	Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
8	The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
9	Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
10	The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
11	The percent of mothers who breastfeed their infants at 6 months of age.
12	Percentage of newborns who have been screened for hearing before hospital discharge.
13	Percent of children without health insurance.
14	Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
15	Percentage of women who smoke in the last three months of pregnancy.
16	The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
17	Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
18	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

INSTRUCTIONS FOR THE COMPLETION OF FORM 10D
TRACKING PERFORMANCE MEASURES
(FY 2011-2015)

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: For the appropriate Annual Reporting year (i.e., fiscal year (FY) 2014 or FY 2015), complete the data cells for the Annual Indicator (including the Numerator and Denominator), Data Source and Data Note for each of the previous reporting cycle's 18 National Performance Measures (NPMs) and the 7-10 State Performance Measures (SPMs) that were developed by the State. If final data are not available, the State should provide provisional or estimated data. All provisional or estimated data should be explained in a footnote. The Annual Objectives for FY 2014 and for FY 2015 that were established by the State in previous Application years will be pre-populated on the reporting form. In addition, the previously reported Annual Indicators will also be pre-populated on this form. This reporting form addresses the legislative requirement in Section 506(a)(1) for States to submit an Annual Report on their Title V program expenditures and activities.

LINE NUMBER	INSTRUCTIONS
State	Enter the name of the State/jurisdiction.
Annual Objective	Performance targets previously established by the State for FY 2014 and FY 2015 will be pre-populated for the State on the reporting form.
Annual Indicator	For the appropriate Annual Reporting year (i.e., FY 2014 or FY 2015), enter the Annual Indicator, including the Numerator and Denominator, for each of the National Performance Measures and the State Performance Measures.
Data Source	Enter the data source for the reported Annual Indicators for each of the National and State Performance Measure.
Note	Enter a data note to clarify estimated or provisional data and to describe other limitations which impact the reporting of an Annual Indicator for each of the National and State Performance Measures.

FORM 11
OTHER STATE DATA (OSD) - #01- #03

OSD #01A – Infant mortality rate and rate of low birth weight by race and ethnicity [SECTION 506 [42 U.S.C. 705] (a)(2)(B)(i)]

Reporting Year _____ Are these data from a State Projection? ◯ YES ◯ NO (Parts A and B)

CATEGORY RATE BY RACE	STATE RACE	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
Infant Mortality Rate								
Rate of Low Birth Weight								

OSD #01B – Infant mortality rate and rate of low birth weight by race and ethnicity [Section 506 [42 U.S.C. 705] (a)(2)(B)(i)]

CATEGORY RATE BY HISPANIC ETHNICITY	TOTAL NOT HISPANIC OR LATINO	TOTAL HISPANIC OR LATINO	ETHNICITY NOT REPORTED
Infant Mortality Rate			
Rate of Low Birth Weight			

OSD #02 – Infant mortality rate and rate of low birth weight by county [SECTION 506 [42 U.S.C. 705] (a)(2)(B)(i)]

Reporting Year _____ Are these data from a State Projection? ◯ YES ◯ NO (Parts A and B)

COUNTY (List each County)	INFANT MORTALITY	RATE OF LOW BIRTH WEIGHT

FORM 11
OTHER STATE DATA (OSD) - #01- #03
(Continuation Page)

OSD #03 –State MCH Workforce [SECTION 506 [42 U.S.C. 705] (a)(2)(E)(i-vi)]

Reporting Year _____ Are these data from a State Projection? ◯ YES ◯ NO

WORKFORCE CATEGORY	TOTAL NUMBER
OBSTETRICIANS	
FAMILY PRACTITIONERS	
CERTIFIED FAMILY NURSE PRACTITIONERS	
CERTIFIED NURSE MIDWIVES	
PEDIATRICIANS	
CERTIFIED PEDIATRIC NURSE PRACTITIONERS	

INSTRUCTIONS FOR THE COMPLETION OF FORM 11
OTHER STATE DATA (OSD) - #01- #03

Title V Citation: See OSD reporting tables above.

Instructions: A glossary of terms applicable to this form is presented in Appendix H of the Supporting Documents, which accompany the Application/Annual Report Guidance.

States are not required to collect or report on any of the OSD elements. The purpose of this form is to make available, annually, other State data required by the Title V legislation. Required data elements on this form will be pre-populated by the Maternal and Child Health Bureau (MCHB), as available, for the States. States should review and monitor the annual data.

The OSD #01 data form has two parts (A and B), and the OSD #02 and #03 data forms each have one part. The racial and ethnic population categories included in these tables are based on the Office of Management and Budget guidelines. More specific instructions are provided below.

At the top of each table, enter the year for which the data are being reported and check the appropriate box to indicate if the data are from a State projection. For OSD 1, the reporting year will be the same for parts A and B of each form

FORM NUMBER	INSTRUCTIONS
OSD #01A:	In the column labeled "STATE RATE," the rate for the State is entered in the category specified. In the next seven columns the rate of the State in the racial categories indicated at the head of each column and in the categories specified is entered. In the column headed "OTHER AND UNKNOWN" the rate for other racial categories not shown and/or population figures where the racial category is not known is entered. Since these data are reported by rates, these data are not totaled.
OSD #01B	In the column headed "TOTAL NOT HISPANIC OR LATINO," the rate for the category specified, that are not of Hispanic or Latino ethnicity is entered. In the column headed "TOTAL HISPANIC OR LATINO" the rate for those that are of Hispanic or Latino ethnicity is entered. In the column headed "EHTNICITY NOT REPORTED" the rate whose ethnicity is not reported is entered. Since these data are reported by rates, these data are not totaled.
OSD #02	Data are collected in this table for the infant mortality rate and rate of low birth weight by each county in the State. In the first column of the first row, the name of the county is entered. In the second cell of the first row, the rate of infant mortality for that county is entered. In the third cell of the first row, the rate of low birth weight for that county is entered. In subsequent rows, the names of each county and the rates requested are entered. Depending on the size of the population being reported for each county, rates may need to use a three-year moving average. Since these data are reported by rates, these data are not totaled.
OSD #03	Data are collected in this table for the numbers of MCH workforce professionals noted that are licensed in the State in the reporting year identified. In the second cell of the first row, the number of obstetricians is entered. In the second cell of the each remaining rows, the number of family practitioners, certified family nurse practitioners, certified nurse midwives, pediatricians, and certified pediatric nurse practitioners are entered, as noted.

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT TO STATES PROGRAM

GUIDANCE AND FORMS
FOR THE
TITLE V APPLICATION/ANNUAL REPORT

APPENDIX OF SUPPORTING DOCUMENTS

U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
Division of State and Community Health
Room 5C-26
5600 Fishers Lane, Rockville, MD 20857
(Phone 301-443-2204 FAX 301-443-9354)

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APPENDIX A: HISTORY AND ADMINISTRATIVE BACKGROUND

As one of the largest Federal block grant programs, Title V is a 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 (CSHCN.)

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 (HHS). MCHB's mission is to provide national leadership through working in partnership with states, communities, public/private partners, tribal entities 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 integrated public health services and coordinated systems of care for the MCH population.

Within the MCHB, the Division of State and Community Health (DSCH) has the administrative responsibility for the Title V MCH 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 who have an interest in and contribute to the provision of a wide range of MCH programs and community-based service systems.

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

Under Title V, MCHB administers a Block Grant and competitive Discretionary Grants. The purpose of the Title V MCH Services Block Grant Program is to create federal/state partnerships in all 59 states for developing service systems that address MCH challenges, such as:

- Significantly reducing infant mortality;
- Providing comprehensive care for all 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, Special Projects of Regional and National Significance (SPRANS) and Community Integrated Service Systems (CISS) grants. SPRANS funds projects (through grants, contracts, and other mechanisms) in research, training, genetic services and newborn screening/follow-up, sickle cell disease, hemophilia, and MCH improvement. CISS projects (through grants, contracts, and other mechanisms) seek to increase the capacity for service delivery at the local level and to foster formation of comprehensive, integrated, community level service systems for mothers and children.

In addition to SPRANS and CISS grants, the MCHB also administers the following categorical programs:

- Emergency Medical Services for Children;

- Traumatic Brain Injury;

- Healthy Start Initiative;

- Universal Newborn Hearing Screening;

- Autism; and

- Home Visiting Program

In recent years, some state Title V programs have begun to utilize the life course model as an organizing framework for addressing identified MCH needs. The life course approach points to broad social, economic, and environmental factors as underlying contributors to health and social outcomes. This approach also focuses on persistent inequalities in the health and well-being of individuals and how the interplay of risk and protective factors at critical points of time can influence an individual's health across his/her lifespan and potentially across generations.

C. Maternal and Child Health Block Grant to States Program

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 was 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 (Section 1651(c) of the Social Security Act);
- Lead-based paint poisoning prevention programs (Section 316 of the Public Health Service (PHS) Act);
- Genetic disease programs (Section 101 of the PHS Act);
- Sudden infant death syndrome programs (Section 1121 of the PHS Act);
- Hemophilia treatment centers (Section 1131 of the PHS Act); and
- Adolescent pregnancy grants (Public Law PL 95-626).

Another significant change in the Title V MCH Block Grant came as a result of the Omnibus Budget Reconciliation Act (OBRA) of 1989, which specified new requirements for accountability. The 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 their 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 state-specific MCH needs and to develop targeted interventions and solutions for addressing them. This theme of assisting states in the design and implementation of MCH programs to meet state and local needs, while at the same time asking them to account for the use of federal/state Title V funds, was embodied

in the requirements contained in the Guidance documents for the state MCH Block Grant Applications/Annual Reports.

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 MCH Block Grant Guidance. As a result, the MCH 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 to ensure that the states and jurisdictions could clearly, concisely, and accurately tell their MCH "stories." This Application/Annual Report became the basis by which MCHB met its GPRA reporting requirements for the MCH Block Grant to States Program.

In 1996, the MCHB began a process of programmatic assessments and planning activities aimed at improving the Title V MCH Block Grant Application/Annual Report Guidance document for states. Since that time, the *Maternal and Child Health Services Title V Block Grant Program - Guidance and Forms for the Title V Application/Annual Report* (Guidance) has been revised, submitted to and approved by the Office of Management and Budget (OMB) six times. Revisions to each subsequent edition were based on changes in MCH priorities, availability of new national data sources and continuing efforts to refine and streamline the Application/Annual Report preparation and submission process for states. The reduced burden that resulted from this latter commitment was largely achieved through efficiencies that were created by the electronic reporting vehicle for the state MCH Block Grant Applications/Annual Reports, specifically the Title V Information System (TVIS.)

D. Title V Information System

The development of an electronic reporting package in 1996 was a significant milestone for the Title V MCH Block Grant to States Program. Advances in technology allowed for the development of an electronic information system (TVIS) within the next several years. The TVIS is designed to capture the performance data and other program and financial information contained in the state Applications/Annual Reports. While descriptive information is available on state Title V-supported efforts, state MCH partnership efforts and other program-specific initiatives of the state in meeting its MCH needs, TVIS primarily serves as an online, Web-accessible interface for the submission of the 59 state and jurisdictional Title V MCH Block Grant Applications/Annual Reports

each year on July 15th. Developed in conjunction with the program requirements outlined in the Title V MCH Block Grant Application/Annual Report Guidance, the TVIS is available to the public on the World Wide Web at: https://mchdata.hrsa.gov/TVISReports/. Over the years, the TVIS has increasingly become recognized as a powerful and useful tool for a number of audiences. The transformational changes to the Title V MCH Block Grant to States Program outlined in this revised Application/Annual Report Guidance mandate the development of a new data collection and web report system for the TVIS. HRSA is providing funding support for a contract to develop, implement and operate this new information system.

Integrated with HRSA's grants management system (i.e., the HRSA Electronic Handbooks (EHB),) the TVIS makes available to the public through its web reports the key financial, program, performance, and health indicator data reported by states in their yearly MCH Block Grant Applications/Annual Reports. Examples of the data that are collected include information on populations served; budget and expenditure breakdowns by source of funding, service and program; program data, such as individuals served and breakdowns of MCH populations by race/ethnicity, other state data (OSD), and performance and outcome measure data for the national and state measures. Reporting on performance relative to the national measures is used to assess national progress in key MCH priority areas and to facilitate the Bureau's annual GPRA reporting.

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APPENDIX B: SAMPLE OF FIVE-YEAR STATE ACTION PLAN TABLE

States will prepare a Five-year State Action Plan Table in follow-up to the Five-Year Needs Assessment and submit an interim State Action Plan Table as part of the first year Title V MCH Block Grant Application/Annual Report. (Note: States will refine the interim State Action Plan Table in the second year Application/Annual Report by further clarifying the identified objectives and strategies and by adding the Evidence-based or –informed Strategy Measures (ESMs) and the State Performance Measures (SPMs).) The following sample is provided to help guide states in understanding the types of information that they should include in their Five-year Action Plan Table. States can use a different tabular form for presenting similar information in the Five-year State Action Plan Table that they prepare.

The Five-year State Action Plan Table is intended to serve as a working tool for states in developing an Action Plan that addresses the state and national MCH priorities identified through the Five-year Needs Assessment process. While there is no required format for the Five-year State Action Plan Table, the information contained must be clearly presented, organized by population health domain, link the state priority needs to the defined priority needs/strategies and serve to inform the selection/development of the NOMs, NPMs, SPMs and ESMs.

As the organizational framework, states will utilize the Five-year State Action Plan Table in developing a five-year State Action Plan. States should review the Table annually and provide updates, as needed, in preparing each year's Application/Annual Report. In the narrative State Action Plan (i.e., Application/Annual Report), states will report annually on their planned activities for the coming year and on the activities they implemented in the reporting year; their planned efforts for improving performance and analyses of current performance trends relative to the NOMs, NPMs, SPMs and ESMs; and their progress/achievements in addressing their identified priority needs through the implementation of strategies defined in their Five-year State Action Plan Table.

Five-Year State Action Plan Table – SAMPLE

Domains	***State Priority Needs***	***Objectives***	***Strategies***	***National Outcome Measures****	***National Performance Measures****	***Evidence-Based or –Informed Strategy Measures***	***State Performance Measures***
Women's/ Maternal Health							
Perinatal/ Infant's Health							
Child Health							
CSHCN							
Adolescent Health							
Cross-Cutting or Life Course							
Other							

* Data to be provided by MCHB

APPENDIX C: ASSURARANCES AND CERTIFICATIONS

View Burden Statement

OMB Number: 4040-0007
Expiration Date: 06130/2014

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, U) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 etseq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Actof1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
APPLICANT ORGANIZATION	DATE SUBMITTED

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CERTIFICATIONS

OMB Approval No. 0990-0317

1. CERTIF1CATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIF1CATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The authorized official signing for the applicant organization certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The official signing agrees that the applicant organization will comply with the HHS terms and conditions of award **if** a grant is awarded as a result of this application.

3. CERTIF1CATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, **if** the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defmed by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

HHS strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the HHS mission to protect and advance the physical and mental health of the American people.

APPENDIX D: NEEDS ASSESSMENT – BACKGROUND AND CONCEPTUAL FRAMEWORK

Needs Assessment is a systematic process to acquire an accurate, thorough picture of the strengths and weaknesses of a state's public health system that can be used in response to the preventive and primary care services needs for ALL pregnant women, mothers, infants (up to age one), children including children with special health care needs [Section 505 (a)(1)]. The Needs Assessment process includes the collection and examination of information about the state's capacity and infrastructure, needs and desired outcomes for the MCH population, and legislative mandates, etc. This information is utilized to determine priority goals, develop a plan of action, and to allocate funds and resources. The Needs Assessment is a collaborative process that should include the HRSA/MCHB, the state Department of Health, families, practitioners, the community, and other agencies and organizations within each state and jurisdiction that have an interest in the wellbeing of the MCH population.

Title V of the Social Security Act requires states to conduct a statewide Needs Assessment every five years. States will report on the next Five-year Needs Assessment in calendar year 2015 as part of the FY 2016 MCH Block Grant Application process. Rather than submitting a comprehensive "stand-alone document, as in previous years, states will submit a Five-year Needs Assessment Summary that concisely describes the process and findings. As the Needs Assessment document may serve multiple purposes, a state may wish to develop a more comprehensive document to meets its broader needs. This document cannot be submitted in place of the required Five-year Needs Assessment Summary, but states may include a URL, if the document is posted online, in the Five-year Needs Assessment Summary or they may submit the document as an attachment to the Application/Annual Report in the electronic application system. Over the five-year reporting period, states are encouraged to continuously revisit the Five-Year Needs Assessment Summary and to provide updates, as needed, in the interim year Applications/Annual Reports. Furthermore, it is expected that states will have ongoing communication with stakeholders and partners throughout the Needs Assessment process and continue to engage with such partners during the interim reporting years.

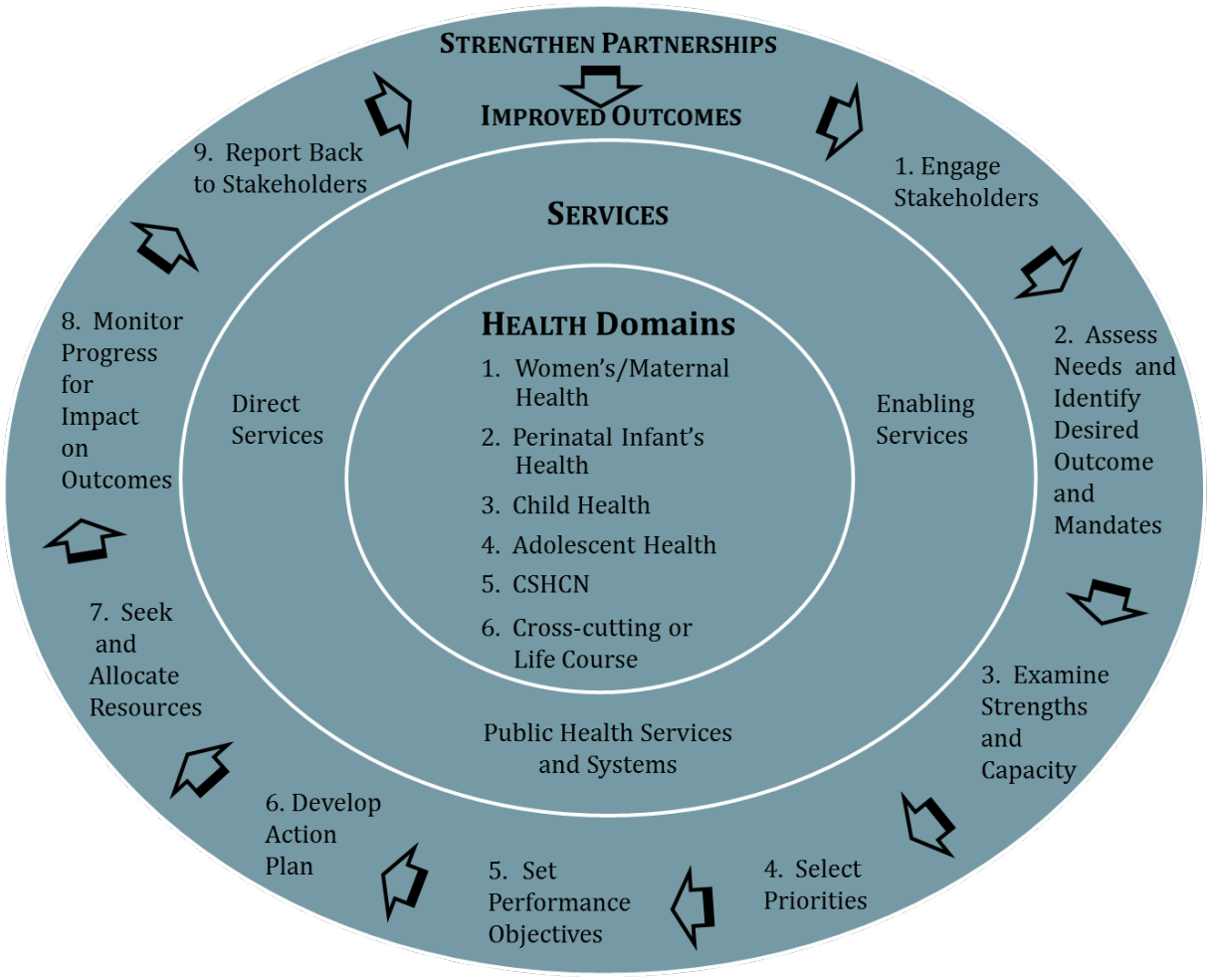
The following figure illustrates the continuity of the Needs Assessment process and its relationship to the planning and monitoring functions of Title V and the population that it serves. The primary goal of the statewide Needs Assessment is to improve MCH outcomes and to strengthen its state, local and community partnerships for addressing the needs of its MCH population. A brief description of the steps involved in the Needs Assessment process is presented in the following sections.

1. Engage Stakeholders

As depicted, the starting point for the Needs Assessment process 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 to 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 targeted outcomes.

State Title V MCH Program Needs Assessment, Planning, Implementation and Monitoring Process



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 the Title V National Outcome Measures (NOMs), national, state and structural/process performance measures and other available state-level quantitative and qualitative data. States should

assess MCH population needs based on the following six population health domains: 1) Women's/Maternal Health; 2) Perinatal/Infant's Health; 3) Child Health; 4) Adolescent Health; 5) Children with Special Health Care Needs (CSHCN); and 6) Cross-cutting or Life Course. These population health domains fall with the three MCH population groups that are defined in Section 505(a)(1) of the Title V legislation. The anticipated outcome of this assessment is to identify community/system needs and **desired outcomes** by specific MCH population groups. In addition, the state will need to **identify** legislative, political, community-driven, financial, and/or other internal and external **mandates** which may go beyond the findings identified through the Needs Assessment process but are priorities for implementation within the state.

3. Examine Strengths and Capacity

The third stage in the Needs Assessment process is **examining strengths and capacity**. This stage involves examining the State's capacity to engage in various activities, including conducting the statewide Five-year Needs Assessment and collecting/reporting annual performance data based on the six identified MCH population health domains and the types of MCH services provided. The working framework for MCH services is presented in Figure 1 of Part One, Section II of the Title V MCH Block Grant to States Application/Annual Report Guidance.

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 three MCH service levels. These levels include 1) Direct Services; 2) Enabling Services; and 3) Public Health Services and Systems. The anticipated outcome is a better understanding of the relationship of the state's existing program/system capacity to its identified strengths and needs. This examination may reveal strengths and weaknesses in capacity not previously identified.

4. Select Priorities

In the **select priorities** stage, each state examines the identified needs and matches them to the desired outcomes, required mandates and level of existing capacity. As a result, states will select seven to ten priority areas for targeted focus in promoting continued improvement and progress. Examples of inputs include: the Needs Assessment process, the opinions of stakeholders, the examination of program capacity and the political priorities within the State. The anticipated outcome is the development of a set of priority needs (between seven and ten), which are unique to the individual state based on its Needs Assessment findings. Priorities identified should address areas in which the state believes there

is reasonable opportunity for a focused programmatic effort (e.g., new or enhanced interventions, initiatives, or systems of care) to lead to an improved outcome.

5. Set Performance Objectives

Setting performance objectives consists of two phases. In the first phase, each state will develop action strategies to address their identified priority needs. Based on the priority needs and program strategies developed, the state will select eight National Performance Measures (NPMs) as part of its interim Five-year Action Plan. States will also give consideration to the potential Evidence-based or –informed Strategy Measures (ESMs) for addressing the selected NPMs and the three to five State Performance Measures (SPMs) that will be developed in Application Year 02. The SPMs should be based on the state's identified MCH priorities and target those priority needs that are not fully addressed by the selected NPMs and their related ESMs.

Secondly, the state will set five-year targets (i.e., performance objectives) for the eight selected NPMs in Application Year 01. In Application Year 02, the state will develop five-year performance targets for the ESMs and the SPMs. The anticipated results of this stage are the identification of NOMs, NPMs, SPMs and, ultimately, ESMs that directly relate to the State priorities and establish a level of accountability for achieving measureable progress.

6. Develop an Action Plan

The next stage is to **develop an action plan**, which involves the planning and identification of specific activities for implementing the program strategies which were developed in Stage 5 to address the identified priority needs and selected national/state measures. In developing an Action Plan, states will create the Five-year State Action Plan Table described in Appendix B. As a planning tool, states will have flexibility in how they format the Table provided that the information is organized around the six identified population health domains. At a minimum, the Five-year State Action Plan Table should include the relevant priority needs, key strategies and measures (i.e., NOMs, NPMs, SPMs and ESMs) for each of the population health domains. Based on the identified priorities, measures and strategies, the state will develop a five-year program plan that includes specific activities for achieving the targeted outcomes and performance specific to each population health domain.

In developing the Action Plan, the state shall complete an interim Five-year State Action Plan Table (see sample in Appendix B) as part of the first year Application/ Annual Report (i.e., FY 2016/FY 2014). This Table

is a tool to assist states in aligning their program strategies, NPMs, SPMs and ESMs with the priority needs that were identified in the Five-year Needs Assessment. States will refine the objectives and strategies and add the ESMs for the selected NPMs and the SPMs to the Five-year Action Plan Table in the second year Application/Annual Report (i.e., FY 2017/FY 2015). Updates to the strategies and activities will be provided by the state, as needed, in subsequent interim year Applications/Annual Reports. Figure 3 in Part Two, Section II.F of the Application/Annual Report Guidance depicts the steps involved in the development of, and the annual reporting on, the implementation of the Five-year State Action Plan.

7. Seek and Allocate Resources

Following the identification of program activities is the allocation of resources stage. In this stage, the focus is on the funding of planned activities to address state priorities. Inputs include the five-year State Action Plan, current budgets, political priorities, and partnerships. The anticipated outcome is the development of a program budget and plan that directs available resources towards the activities identified in Stage Six as the most important for addressing the state's priorities.

8. 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. Inputs include NOMs, NPMs, SPMs and ESMs, 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 availability of resources. Feedback loops between various stages of the process allow for continuous input and re-evaluation of the outputs.

9. 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 processes.

APPENDIX E: PERFORMANCE MEASURE FRAMEWORK

Overview of the Framework

The performance measure framework is based on a three-tiered performance measure system: National Outcome Measures (NOMs), National Performance Measures (NPMs), and Evidence-based or -informed Strategy Measures (ESMs).

Measures were considered as NOMs, which are reflective of population health status, if they met one or more of the following criteria: it was mandated by the Title V legislation that the data be collected; it was considered a sentinel health marker for women, infants, or children; it was a major focus of either the Title V legislation or Title V activities; it was considered an important health condition to monitor because the prevalence was increasing, but the reasons for the increase were unclear; or there was a recognized need to move the MCH field forward in this area, even if there was not yet a consensus on how to measure the construct. The latter were considered developmental outcome measures.

Measures were considered as NPMs if they met one or more of the following criteria: there was a large investment of resources as determined by the State narratives; it was considered modifiable through Title V activities; a state could delineate measurable activities to address the performance measures; significant disparities existed among population groups; research had indicated that the condition or activity had large societal costs; or research had indicated that the promotion of certain behaviors, practices or policies had improved outcomes. There also had to be evidence that an NPM was associated with at least one of the NOMs (see Table 1). Fifteen NPMs were identified for the Title V MCH Services Block Grant. Data for NOMs and NPMs will be populated by MCHB from national data sources, as available. NPMs will be stratified by different risk factors, when available. See Table 2 for planned stratifiers.

The ESMs are the key to understanding how a State Title V program tracks programmatic investments designed to impact the NPMs. In the framework, States create ESMs designed to impact the NPMs. These measures would assess the impact of State Title V strategies and activities contained in the State Action Plan. The development of ESMs is guided through an examination of the evidenced-based or evidence-informed practices on what strategies and activities are both practical and measurable. The main criteria for ESMs would be that the activities had to measurable, and there had to be evidence that the activity was related to the NPM chosen. States Can determine the number of ESMs that they will use for addressing the selected NPMs but there is a required minimum of one ESM for each NPM. States may also retire an ESM during the five-year reporting cycle, if it has successfully achieved its objective toward the NPM or new ESMs are introduced measuring new, promising practices.

Fifteen NPMs were identified for the Title V MCH Services Block Grant, covering six population domains: Women's/Maternal Health, Perinatal/Infant's Health, Child Health, Adolescent Health, Children with Special Health Care Needs, and Cross-cutting or Life

Course. In the table below are the 15 national priority areas addressed by the NPMs and the corresponding MCH Population domain(s).

Table 3. NPMs and MCH Population Domains

NPM #	National Performance Priority Areas	MCH Population Domains
1	Well woman care	Women/Maternal Health
2	Low risk cesarean deliveries	Women/Maternal Health
3	Perinatal regionalization	Perinatal/Infant Health
4	Breastfeeding	Perinatal/Infant Health
5	Safe sleep	Perinatal/Infant Health
6	Developmental screening	Child Health
7	Injury	Child Health and/or Adolescent Health
8	Physical activity	Child Health and/or Adolescent Health
9	Bullying	Adolescent Health
10	Adolescent well-visit	Adolescent Health
11	Medical home	Children with Special Health Care Needs
12	Transition	Children with Special Health Care Needs
13	Oral health	Cross-cutting/Life course
14	Smoking	Cross-cutting/Life course
15	Adequate insurance coverage	Cross-cutting/Life course

In implementing this framework, states will choose eight (8) out of 15 NPMS for its Title V program to address during the five-year needs assessment cycle. States shall ensure that at least one NPM from each of the six MCH Population domains is selected and that the selected NPMs are based on the findings of the Five-Year Needs Assessment process. There are no mandatory NPMs. For the NPMs on injury and physical activity, they can be selected for either the children's or the adolescent domains or both because the age ranges span both domains, but the interventions to either reduce injuries or increase physical activity are different, depending on the children's ages.

Implementation of Measurement

National Outcome Measures

NOMs are for population health assessment which is an important core function of public health. They should be tracked to understand the MCH population's health, and are important for the development of the needs assessment. Changes in NOM indicators can be discussed in the appropriate population domain section of the narrative but there is not a reporting requirement for this discussion. Data for NOMs will be prepopulated, where possible. States do not provide performance objectives for NOMs.

National Performance Measures

Once NPMs are selected, a state will track the eight NPMs throughout the five-year reporting cycle. States are encouraged not to change the selected NPMs during the five-year reporting cycle. If a state determines that a NPM needs to be changed, clear justification must be provided. In an effort to reduce state burden, annual performance data (indicator/numerator/denominator) for the NOMs and the NPMs will be pre-populated by MCHB from national data sources, as available, and provided to the states for their use in preparing the yearly Title V MCH Block Grant Applications/Annual Reports. If a state selects a NPM for which it is not part of the national data source, the state can develop its own detail sheet and report its data for the measure. However, the definition and data that are collected must match the definition and measure of the national data source.

In the first reporting year of this guidance, a State selects its NPMs and determines performance objectives for FY 2016-2020 for the NPMs. Performance objectives for future years can be changed for individual NPMs based on ongoing needs assessment efforts and performance monitoring.

Other Guidelines for NPMs

Use of Provisional Data: States may, but are not required to, include more timely provisional data if they choose. This will not replace the prepopulated final data provided for the measures.

Lacking a National Data Source: States can choose a measure if they do not have the data source noted on the detail sheet, as long as they provide the indicator, numerator and denominator data as defined on the detail sheet. As for PRAMS, States will be able to submit their PRAMS or PRAMS-like data to TVIS following the same definition for a given measure if CDC cannot furnish it. The same situation may apply to other data sources; for example, all states with hospital discharge data provided to AHRQ. If a state provides its own data from a different source, this should be annotated in a field note.

Integrated Measures: For integrated measures, states can choose a NPM even if they do not have the data from both data sources. Both measures will be reported for these types of measures. Where there are data for both sources, data will be displayed and would need to be discussed for both populations. If only one data source is available, that population will need to be addressed. States will develop an ESM to address each of the strategies developed for the measure.

Evidence-based or -informed Strategy Measures

Developed by the State, Evidence-based or -informed Strategy Measures would assess the impact of State Title V strategies and activities contained in the State Action Plan. It is envisioned that the development of the ESMs will be guided through an examination

of the evidenced-based or evidence-informed practices on what strategies and activities are both practical and measurable. The main criteria for the state ESMs would be that the strategies and activities have to be measurable, and there has to be evidence that the activity is related to the performance measure chosen. Most issues in MCH are multifactorial, therefore, while states are strongly encouraged to develop multiple strategies with a related ESM for each strategy to impact a selected NPM, states are required to submit at least one ESM for each of the NPMs selected.

In the second reporting year (FY 2017 Application/FY 2015 Annual Report), states will develop a detail sheet for each ESM, which they will submit as part of the FY 2017 Application/FY 2015 Annual Report. On the detail sheet, states will define the: (1) measures; (2) goal; (3) indicator, numerator, and denominator; (4) data source; and (5) significance. Beginning with the third reporting year (FY 2018 Application/FY 2016 Annual Report), states will track performance for the ESMs that were established for this five-year needs assessment cycle. States will determine performance objectives for each of the ESMs for application years FY 2018-FY 2020. These objectives can be revised, as needed, for future reporting years. Data for the ESMs (i.e., numerator/denominator) will be entered annually by the state. During the five-year reporting cycle, the ESMs may be modified, replaced, or retired, based on analysis of the effectiveness of the strategy or the validity of the measure.

State Performance and Outcome Measures

To address state priorities not addressed by the National Performance Measures, the State Performance Measures (SPMs) will be developed as part of the second reporting year Application/Annual Report (i.e., FY 2017 Application/FY 2015 Annual Report), and states will establish performance objectives for five years FY 2018-FY 2022) for each of the measures. States may revise their SPM objectives in future years' Applications/Annual Reports. The development of the SPMs coincides with the development of the state ESMs.

States will also develop detail sheets on these measures, which will define the: (1) measure; (2) goal; (3) indicator, numerator, and denominator; (4) data source; and (5) significance. States will track their three to five SPMs throughout the five-year reporting cycle. Data for the SPMs (i.e., indicator/numerator/denominator) will be entered annually by the state. A state can retire a SPM during the five-year reporting cycle and replace it with another SPM based on its MCH priority needs. States are not required to develop ESMs for SPMs.

A state <u>may</u> also develop (but is not required to develop) one or more State Outcome Measures (SOMs) based on its MCH priorities, as determined by the findings of the Five-Year Needs Assessment, provided that none of the NOMs address the same priority area for the state. A SOM should be linked with a performance measure to show the impact of performance on the intended outcome. States will track the SOMs during the five-year reporting cycle and the SOM can be retired if the state chooses.

Data for the SOMs (i.e., indicator/numerator/ denominator) will be entered annually by the state.

Table 1. National Outcome Measures - National Performance Measures Linkage

NPM #	National Performance Measure (NPM)	National Outcome Measures Associated with National Performance Measure
1	Well woman care (Percent of women with a past year preventive visit)	Severe maternal morbidity per 10,000 delivery hospitalizations Low birth weight rate (%) Preterm birth rate (%) Infant mortality per 1,000 live births Perinatal mortality per 1,000 live births plus fetal deaths Neonatal mortality per 1,000 live births Preterm-related mortality per 1,000 live births
2	Low risk cesarean deliveries (Percent of cesarean deliveries among low-risk first births)	Severe maternal morbidity per 10,000 delivery hospitalizations Maternal death rate per 100,000 live births
3	Perinatal regionalization (Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU))	Infant mortality per 1,000 live births Perinatal mortality per 1,000 live births plus fetal deaths Neonatal mortality per 1,000 live births Preterm-related mortality per 1,000 live births
4	Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)	Sleep-related SUID mortality per 1,000 live births
5	Safe sleep (Percent of infants placed to sleep on their backs)	Infant mortality per 1,000 live births Post neonatal mortality per 1,000 live births Sleep-related SUID mortality per 1,000 live births
6	Developmental screening (Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool)	Percent of children in excellent or very good health Percent of children meeting the criteria developed for school readiness

NPM #	National Performance Measure (NPM)	National Outcome Measures Associated with National Performance Measure
7	Child Injury (Rate of injury-related hospital admissions per population aged 0 through 19 years	The child death rate per 100,000 children aged 1 through 9 Rate of death in adolescents age 10-19 per 100,000
8	Physical activity (Percent of children ages 6 through 11 and adolescents ages 12 through 17 who are physically active at least 60 minutes per day)	Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)
9	Bullying (Percent of adolescents, 12 through 17, who are bullied)	Rate of death in adolescents age 10-19 per 100,000 Rate of suicide deaths among youths aged 15 through 19 per 100
10	Adolescent well-visit (Percent of adolescents with a preventive services visit in the last year)	Percent of children and adolescents in very good health Immunization (Percent of children and adolescents who have completed recommended vaccines) Rate of death in adolescents 12-20 per 100,000 Rate of suicide deaths among youths aged 15 through 19 per 100,000 Percent of adolescents in grades 9-12 who used tobacco products in the past month Percent of adolescents with mental health problems who receive treatment
11	Medical home (Percent of children with and without special health care needs having a medical home)	Systems of care for children with special health care needs (Percent of children and youth with special health care needs (CYSHCN) receiving care in a well-functioning system)
12	Transition (Percent of children with and without special health care needs who received services necessary to make transitions to adult health care)	Systems of care for children with special health care needs (Percent of children and youth with special health care needs (CYSHCN) receiving care in a well-functioning system)
13	Oral health (A. Percent of women who had a dental visit during pregnancy and B. Percent of infants and children, ages 1 to 17 years, who had a preventive dental visit in the last year)	Percent of children and adolescents in very good health Percent of children ages 1-6 who have decayed teeth or cavities in the past 12 months

NPM #	National Performance Measure (NPM)	National Outcome Measures Associated with National Performance Measure
14	Smoking during Pregnancy and Household Smoking (A. Percent of women who smoke during pregnancy and B. Percent of children who live in households where someone smokes)	Low birth weight rate (%) Preterm birth rate (%) Infant mortality per 1,000 live births Perinatal mortality per 1,000 live births plus fetal deaths Neonatal mortality per 1,000 live births Preterm-related mortality per 1,000 live births Post neonatal mortality per 1,000 live births Sleep-related SUID mortality per 1,000 live births Severe maternal morbidity per 10,000 delivery hospitalizations Percent of children in excellent or very good health
15	Adequate insurance coverage (Percent of children 0 through 17 who are adequately insured)	Percent of children without health insurance Systems of care for children with special health care needs (Percent of children and youth with special health care needs (CYSHCN) receiving care in a well-functioning system)

Table 2. Stratifiers for National Performance Measures

No.	Title	Planned Stratifiers
1	Percent of women with a past year preventive visit	Age Race/ethnicity Nativity Education Income Insurance Metro/non-metro
2	Percent of cesarean deliveries among low-risk first births	Age Race/ethnicity Nativity Education Insurance Marital status Quarter of the year Metro/non-metro
3	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	Age Race/ethnicity Nativity Education Insurance Marital status Metro/non-metro
4	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months	Sex Birth order Maternal race/ethnicity Maternal age Maternal education Poverty Marital status WIC Metro status
5	Percent of infants placed to sleep on their backs	Age Race/ethnicity Education Insurance Marital status
6	Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool	Age Sex Race/ethnicity Nativity Language CSHCN status Household structure Parental education Poverty Insurance Metro/non-metro
7	Rate of injury-related hospital admissions per population ages 0 through 19 years	Age Sex Race/ethnicity Insurance Metro/non-metro

No.	Title	Planned Stratifiers
8	Percent of children ages 6 through 11 years and adolescents ages 12 through 17 years who are physically active at least 60 minutes per day	YRBSS: Sex Grade Race/ethnicity NSCH: Age Sex Race/ethnicity Nativity Language CSHCN status Household structure Parental education Poverty Insurance Metro/non-metro
9	Percent of adolescents, ages 12 through 17 years, who are bullied	YRBSS: Sex Grade Race/ethnicity NSCH: Age Sex Race/ethnicity Nativity Language CSHCN status Household structure Parental education Poverty Insurance Metro/non-metro
10	Percent of adolescents with a preventive services visit in the last year	Age Sex Race/ethnicity Nativity Language CSHCN status Household structure Parental education Poverty Insurance Metro/non-metro
11	Percent of children with and without special health care needs having a medical home	Age Sex Race/ethnicity Nativity Language CSHCN status Household structure Parental education Poverty Insurance Metro/non-metro

No.	Title	Planned Stratifiers
12	Percent of children with and without special health care needs who received services necessary to make transitions to adult health care	Age Sex Race/ethnicity Nativity Language CSHCN status Household structure Parental education Poverty Insurance Metro/non-metro
13	A) Percent of women who had a dental visit during pregnancy and B) Percent of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year	PRAMS: Age Race/ethnicity Education Insurance Marital status NSCH: Age Sex Race/ethnicity Nativity Language CSHCN status Household structure Parental education Poverty Insurance Metro/non-metro
14	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes	Vitals: Age Race/ethnicity Nativity Education Insurance Marital status Quarter of the year Metro/non-metro NSCH: Age Sex Race/ethnicity Nativity Language CSHCN status Household structure Parental education Poverty Insurance Metro/non-metro

No.	Title	Planned Stratifiers
15	Percent of children 0 through 17 years who are adequately insured	Age Sex Race/ethnicity Nativity Language CSHCN status Household structure Parental education Poverty Insurance Metro/non-metro

APPENDIX F: DETAIL SHEETS FOR THE NATIONAL OUTCOME MEASURES AND NATIONAL PERFORMANCE MEASURES

A. National Outcome Measures

B. National Performance Measures

A.

NOM #	National Outcome Measure
1	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
2	Percent of delivery or postpartum hospitalizations with an indication of severe maternal morbidity
3	Maternal mortality rate per 100,000 live births
4.1	Percent of low birth weight deliveries (<2,500 grams)
4.2	Percent of very low birth weight deliveries (<1,500 grams)
4.3	Percent of moderately low birth weight deliveries (1,500-2,499 grams)
5.1	Percent of preterm births (<37 weeks gestation)
5.2	Percent of early preterm births (<34 weeks gestation)
5.3	Percent of late preterm births (34-36 weeks gestation)
6	Percent of early term births (37,38 weeks gestation
7	Percent of non-medically indicated delivery at 37, 38 weeks' gestation among singleton deliveries without pre-existing conditions
8	Perinatal mortality rate per 1,000 live births plus fetal deaths
9.1	Infant mortality rate per 1,000 live births
9.2	Neonatal mortality rate per 1,000 live births
9.3	Postneonatal mortality rate per 1,000 live births
9.4	Preterm-related mortality rate per 1,000 live births
9.5	Sudden Unexpected Infant Deaths (SUID) mortality rate per 1,000 live births
10	The rate of infants born with fetal alcohol syndrome per 10,000 delivery hospitalizations
11	The rate of infants born with neonatal abstinence syndrome per 10,000 delivery hospitalizations
12	Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)
13	Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
14	Percent of children ages 1-6 who have decayed teeth or cavities in the past 12 months
15	Rate of death in children aged 1 through 9 per 100,000
16.1	Rate of death in adolescents age 10-19 per 100,000
16.2	Rate of deaths to children aged 15-19 years caused by motor vehicle crashes per 100,000
16.3	Rate of suicide deaths among youths aged 15 through 19 per 100,000
17.1	Percent of children with special health care needs
17.2	Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
17.3	Percent of children diagnosed with an autism spectrum disorder
17.4	Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)
18	Percent of children with a mental/behavioral condition who receive treatment
19	Percent of children in excellent or very good health
20	Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)
21	Percent of children without health insurance
22.1	Percent of children ages 19-35 months, with the 4:3:1:3(4):3:1 :4 combined series of vaccines
22.2	Percent of children 6 months to 17 years who are vaccinated annually against seasonal influenza

NOM #	National Outcome Measure
22.3	Percent of adolescents, ages 13-17, who have received at least one dose of the HPV vaccine
22.4	Percent of adolescents, ages 13-17, who have received at least one dose of the Tdap vaccine
22.5	Percent of adolescents, ages 13-17, who have received at least one dose of the meningococcal conjugate vaccine

OUTCOME MEASURE 1	**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 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) 10.1. Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester. (Baseline: 70.8 % of females delivering a live birth received prenatal care beginning in the first trimester in 2007, Target: 77.9%)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
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.

OUTCOME MEASURE 2	**Percent of deliveries or postpartum hospitalizations with an indication of severe maternal morbidity**
GOAL	To reduce life-threatening maternal illness and complications.
DEFINITION	**Numerator:** Deliveries or postpartum hospitalizations with an indication of severe morbidity from ICD-10 diagnosis or procedure codes (e.g. heart or kidney failure, stroke, embolism, hemorrhage). Exact codes TBD **Denominator:** Delivery hospitalizations **Units:** 10,000 **Text:** Rate
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) 5. Reduce the rate of maternal mortality. (Baseline:12.7 maternal deaths per 100,000 live births in 2007, Target: 11.4 maternal deaths per 100,000 live births) Related to Maternal, Infant, and Child Health (MICH) 6. Reduce maternal illness and complications due to pregnancy (complications during hospitalized labor and delivery) . (Baseline: 31.1%, Target: 28%)
DATA SOURCES and DATA ISSUES	HCUP – State inpatient database
SIGNIFICANCE	Severe maternal morbidity is more than 100 times as common as pregnancy-related mortality—translating to about 52,000 women affected annually—and it is estimated to have increased by 75 percent over the past decade. Rises in chronic conditions, including obesity, diabetes, hypertension, and cardiovascular disease, are likely to have contributed to this increase (Callaghan et al, 2012). Minority women and particularly non-Hispanic black women have higher rates of severe maternal morbidity. Non-Hispanic Black, Hispanic, Asian/Pacific Islander, and American Indian/Alaska Native women had 2.1, 1.3, 1.2, and 1.7 times, respectively, higher rates of severe morbidity compared with non-Hispanic white women (Creanga et al, 2014).

OUTCOME MEASURE 3 The maternal death rate per 100,000 live births

GOAL	To reduce the maternal death rate.
DEFINITION	**Numerator:** Deaths related to or aggravated by pregnancy and occurring within 42 days of the end of a pregnancy **Denominator:** Number of resident live births **Units:** 100,000 **Text:** Rate
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to Maternal, Infant, and Child Health (MICH) 5. Reduce the rate of maternal mortality. (Baseline:12.7 maternal deaths per 100,000 live births in 2007, Target: 11.4 maternal deaths per 100,000 live births) Related to Maternal, Infant, and Child Health (MICH) 6. Reduce maternal illness and complications due to pregnancy (complications during hospitalized labor and delivery) . (Baseline: 31.1%, Target: 28%)
DATA SOURCES and DATA ISSUES	National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS; National Vital Statistics System-Natality (NVSS-N), CDC/NCHS
SIGNIFICANCE	Maternal deaths related to childbirth in the U.S. are nearly at the highest rate in a quarter century, and the U.S. has seen a rise in maternal mortality over the past decade. The rate of death for mothers for every 100,000 live births was18.5 in the U.S. in 2013, a total of almost 800 deaths, showing a rise in pregnancy-related deaths in the U.S. since at least 1987, when the mortality rate was 7.2 per 100,000 births. There are also significant racial disparities with Black women being three times as likely White women to experience maternal death.

OUTCOME MEASURE 4.1 Percent of low birth weight deliveries (<2,500 grams)

GOAL	To reduce the proportion of low birth weight deliveries
DEFINITION	**Numerator:** Number of resident live births weighing less than 2,500 grams **Denominator:** Number of live resident births **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to Maternal, Infant, and Child Health (MICH) Objective 8.1: Reduce low birth weight (LBW). (Baseline: 8.2% in 2007, Target 7.8%)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
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. Advanced maternal age and *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. In 2010, 68% of all infant deaths occurred to the 8.2% of low birth weight infants and over half (53%) of all infant deaths occurred to the 1.5% of very low birth weight infants. Infants born to non-Hispanic Black women have the highest rates of low birth weight, particularly very low birth weight. In 2012, 13.2 percent of non-Hispanic Black infants were born low birthweight and 2.9 percent were born at very low birth weight--these rates are 1.9 and 2.6 times the rates for infants born to non-Hispanic Whites women (7.0 and 1.1 percent, respectively). Infants born to Puerto Rican women also have elevated rates of low and very low birth weight (9.4 and 1.8, respectively).

OUTCOME MEASURE 4.2 — Percent of very low birth weight deliveries (<1,500 grams)

GOAL	To reduce the proportion of low birth weight deliveries
DEFINITION	**Numerator:** Number of resident live births weighing less than 1,500 grams **Denominator:** Number of live resident births **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to MICH Objective 8.2: Reduce very low birth weight (VLBW). (Baseline: 1.5% in 2007, Target 1.4%)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
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. Advanced maternal age and *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. In 2010, 68% of all infant deaths occurred to the 8.2% of low birth weight infants and over half (53%) of all infant deaths occurred to the 1.5% of very low birth weight infants. Infants born to non-Hispanic Black women have the highest rates of low birth weight, particularly very low birth weight. In 2012, 13.2 percent of non-Hispanic Black infants were born low birthweight and 2.9 percent were born at very low birth weight--these rates are 1.9 and 2.6 times the rates for infants born to non-Hispanic Whites women (7.0 and 1.1 percent, respectively). Infants born to Puerto Rican women also have elevated rates of low and very low birth weight (9.4 and 1.8, respectively).

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

GOAL	To reduce the proportion of low birth weight deliveries
DEFINITION	**Numerator:** Number of resident live births weighing between 1,500-2,499 grams **Denominator:** Number of live resident births **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) Objective 8.1: Reduce low birth weight (LBW). (Baseline: 8.2% in 2007, Target 7.8%)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
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. Advanced maternal age and *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. In 2010, 68% of all infant deaths occurred to the 8.2% of low birth weight infants and over half (53%) of all infant deaths occurred to the 1.5% of very low birth weight infants. Infants born to non-Hispanic Black women have the highest rates of low birth weight, particularly very low birth weight. In 2012, 13.2 percent of non-Hispanic Black infants were born low birthweight and 2.9 percent were born at very low birth weight--these rates are 1.9 and 2.6 times the rates for infants born to non-Hispanic Whites women (7.0 and 1.1 percent, respectively). Infants born to Puerto Rican women also have elevated rates of low and very low birth weight (9.4 and 1.8, respectively).

OUTCOME MEASURE 5.1 Percent of preterm births (<37 weeks)

GOAL	To reduce the proportion of all preterm, early term, and early elective deliveries.
DEFINITION	**Numerator:** Number of resident live births before 37 weeks of complete gestation **Denominator:** Number of live resident births **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to Maternal, Infant, and Child Health (MICH) Objective 9.1: Reduce total preterm births (PTB). (Baseline:12.7% in 2007, Target 11.4%)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
SIGNIFICANCE	Babies born preterm, before 37 completed weeks of gestation, are at increased risk of immediate life-threatening health problems, as well as long-term complications and developmental delays. Among preterm infants, complications that can occur during the newborn period include respiratory distress, jaundice, anemia, and infection, while long-term complications can include learning and behavioral problems, cerebral palsy, lung problems, and vision and hearing loss. As a result of these risks, preterm birth is a leading cause of infant death and childhood disability. Although the risk of complications is greatest among those babies who are born the earliest, even those babies born “late preterm” (34 to 36 weeks’ gestation) and "early term" (37, 38 weeks' gestation) are more likely than full-term babies to experience morbidity and mortality. Infants born to non-Hispanic Black women have the highest rates of preterm birth, particularly early preterm birth. In 2012, 16.5 percent of non-Hispanic Black infants were born preterm and 5.9 percent were born early preterm--these rates are 1.6 and 2.0 times the rates for infants born to non-Hispanic Whites women (10.3 and 2.9 percent, respectively). Infants born to Puerto Rican, Cuban, and American Indian/Alaska Native mothers also had elevated rates of preterm and early preterm birth. Non-medically indicated early term births (37,38 weeks) present avoidable risks of neonatal morbidity and costly NICU admission (Clark et al, 2009; Tita et al, 2009). Early elective delivery prior to 39 weeks is an endorsed perinatal quality measure by the Joint Commission, National Quality Forum, ACOG/NCQA, Leapfrog Group, and CMS/CHIPRA.

OUTCOME MEASURE 5.2 Percent of early preterm births (<34 weeks)

GOAL	To reduce the proportion of all preterm, early term, and early elective deliveries.
DEFINITION	**Numerator:** Number of resident live births before 34 weeks of completed gestation. **Denominator:** Number of live resident births **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) Objective 9.3: Reduce live births at 32-33 weeks. (Baseline: 1.6% in 2007, Target 1.4%) Related to MICH Objective 9.4: Reduce early preterm or births at less than 32 weeks' gestation. (Baseline: 2.0% in 2007, Target 1.8%)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
SIGNIFICANCE	Babies born preterm, before 37 completed weeks of gestation, are at increased risk of immediate life-threatening health problems, as well as long-term complications and developmental delays. Among preterm infants, complications that can occur during the newborn period include respiratory distress, jaundice, anemia, and infection, while long-term complications can include learning and behavioral problems, cerebral palsy, lung problems, and vision and hearing loss. As a result of these risks, preterm birth is a leading cause of infant death and childhood disability. Although the risk of complications is greatest among those babies who are born the earliest, even those babies born “late preterm” (34 to 36 weeks’ gestation) and "early term" (37, 38 weeks' gestation) are more likely than full-term babies to experience morbidity and mortality. Infants born to non-Hispanic Black women have the highest rates of preterm birth, particularly early preterm birth. In 2012, 16.5 percent of non-Hispanic Black infants were born preterm and 5.9 percent were born early preterm--these rates are 1.6 and 2.0 times the rates for infants born to non-Hispanic Whites women (10.3 and 2.9 percent, respectively). Infants born to Puerto Rican, Cuban, and American Indian/Alaska Native mothers also had elevated rates of preterm and early preterm birth. Non-medically indicated early term births (37,38 weeks) present avoidable risks of neonatal morbidity and costly NICU admission (Clark et al, 2009; Tita et al, 2009). Early elective delivery prior to 39 weeks is an endorsed perinatal quality measure by the

Joint Commission, National Quality Forum, ACOG/NCQA, Leapfrog Group, and CMS/CHIPRA.

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

GOAL	To reduce the proportion of all preterm, early term, and early elective deliveries.
DEFINITION	**Numerator:** Number of resident live births between 34 and 36 weeks of completed gestation **Denominator:** Number of live resident births **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to MICH Objective 9.2: Reduce late preterm or births at 34-36 weeks' gestation. (Baseline: 9.0% in 2007, Target 8.1%)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
SIGNIFICANCE	Babies born preterm, before 37 completed weeks of gestation, are at increased risk of immediate life-threatening health problems, as well as long-term complications and developmental delays. Among preterm infants, complications that can occur during the newborn period include respiratory distress, jaundice, anemia, and infection, while long-term complications can include learning and behavioral problems, cerebral palsy, lung problems, and vision and hearing loss. As a result of these risks, preterm birth is a leading cause of infant death and childhood disability. Although the risk of complications is greatest among those babies who are born the earliest, even those babies born “late preterm” (34 to 36 weeks’ gestation) and "early term" (37, 38 weeks' gestation) are more likely than full-term babies to experience morbidity and mortality. Infants born to non-Hispanic Black women have the highest rates of preterm birth, particularly early preterm birth. In 2012, 16.5 percent of non-Hispanic Black infants were born preterm and 5.9 percent were born early preterm--these rates are 1.6 and 2.0 times the rates for infants born to non-Hispanic Whites women (10.3 and 2.9 percent, respectively). Infants born to Puerto Rican, Cuban, and American Indian/Alaska Native mothers also had elevated rates of preterm and early preterm birth. Non-medically indicated early term births (37,38 weeks) present avoidable risks of neonatal morbidity and costly NICU admission (Clark et al, 2009; Tita et al, 2009). Early elective delivery prior to 39 weeks is an endorsed perinatal quality measure by the Joint Commission, National Quality Forum, ACOG/NCQA, Leapfrog Group, and CMS/CHIPRA.

OUTCOME MEASURE 6 — Percent of early term births (37,38 weeks)

GOAL

To reduce the proportion of all preterm, early term, and early elective deliveries.

DEFINITION

Numerator:
Number of live resident births born at 37,38 weeks of completed gestation

Denominator:
Number of live resident births

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

DATA SOURCES and DATA ISSUES

National Vital Statistics System (NVSS)

SIGNIFICANCE

Babies born preterm, before 37 completed weeks of gestation, are at increased risk of immediate life-threatening health problems, as well as long-term complications and developmental delays. Among preterm infants, complications that can occur during the newborn period include respiratory distress, jaundice, anemia, and infection, while long-term complications can include learning and behavioral problems, cerebral palsy, lung problems, and vision and hearing loss. As a result of these risks, preterm birth is a leading cause of infant death and childhood disability. Although the risk of complications is greatest among those babies who are born the earliest, even those babies born “late preterm” (34 to 36 weeks’ gestation) and "early term" (37, 38 weeks' gestation) are more likely than full-term babies to experience morbidity and mortality.

Infants born to non-Hispanic Black women have the highest rates of preterm birth, particularly early preterm birth. In 2012, 16.5 percent of non-Hispanic Black infants were born preterm and 5.9 percent were born early preterm--these rates are 1.6 and 2.0 times the rates for infants born to non-Hispanic Whites women (10.3 and 2.9 percent, respectively). Infants born to Puerto Rican, Cuban, and American Indian/Alaska Native mothers also had elevated rates of preterm and early preterm birth.

Non-medically indicated early term births (37,38 weeks) present avoidable risks of neonatal morbidity and costly NICU admission (Clark et al, 2009; Tita et al, 2009). Early elective delivery prior to 39 weeks is an endorsed perinatal quality measure by the Joint Commission, National Quality Forum, ACOG/NCQA, Leapfrog Group, and CMS/CHIPRA.

OUTCOME MEASURE 7 — Percent of non-medically indicated early term deliveries (37,38 weeks) among singleton term deliveries

GOAL

To reduce the proportion of all preterm, early term, and early elective deliveries.

DEFINITION

Numerator:
Inductions or cesareans without trial of labor and without indication (fetal distress, prolonged labor, PROMS) at 37, 38 weeks' gestation among singleton deliveries without pre-existing conditions, following The Joint Commission list of conditions possibly justifying delivery <39 weeks

Denominator:
Number of singleton live births at 37-41 weeks' gestation without pre-existing conditions, following the Joint Commission list of conditions possibly justifying delivery <39 weeks

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

DATA SOURCES and DATA ISSUES

CMS HospitalCompare data

SIGNIFICANCE

Babies born preterm, before 37 completed weeks of gestation, are at increased risk of immediate life-threatening health problems, as well as long-term complications and developmental delays. Among preterm infants, complications that can occur during the newborn period include respiratory distress, jaundice, anemia, and infection, while long-term complications can include learning and behavioral problems, cerebral palsy, lung problems, and vision and hearing loss. As a result of these risks, preterm birth is a leading cause of infant death and childhood disability. Although the risk of complications is greatest among those babies who are born the earliest, even those babies born “late preterm” (34 to 36 weeks’ gestation) and "early term" (37, 38 weeks' gestation) are more likely than full-term babies to experience morbidity and mortality.

Infants born to non-Hispanic Black women have the highest rates of preterm birth, particularly early preterm birth. In 2012, 16.5 percent of non-Hispanic Black infants were born preterm and 5.9 percent were born early preterm--these rates are 1.6 and 2.0 times the rates for infants born to non-Hispanic Whites women (10.3 and 2.9 percent, respectively). Infants born to Puerto Rican, Cuban, and American Indian/Alaska Native mothers also had elevated rates of preterm and early preterm birth.

Non-medically indicated early term births (37,38 weeks) present avoidable risks of neonatal morbidity and costly NICU admission

(Clark et al, 2009; Tita et al, 2009). Early elective delivery prior to 39 weeks is an endorsed perinatal quality measure by the Joint Commission, National Quality Forum, ACOG/NCQA, Leapfrog Group, and CMS/CHIPRA.

OUTCOME MEASURE 8	Perinatal mortality rate per 1,000 live births plus fetal deaths
GOAL	To reduce the rate of perinatal deaths.
DEFINITION	**Numerator:** Number of fetal deaths 28 weeks or more gestation plus early neonatal deaths occurring under 7 days **Denominator:** The number of live resident births plus fetal deaths **Units:** 1,000 **Text:** Rate
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) Objective 1.2: Reduce the rate of fetal and infant deaths during the perinatal period (28 weeks of gestation to 7 days after birth). (Baseline: 6.6 fetal and infant deaths per 1,000 live births and fetal deaths occurred during the perinatal period, 28 weeks gestation to 7 days after birth, in 2005; Target: 5.9 perinatal deaths per 1,000 live births and fetal deaths)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
SIGNIFICANCE	Perinatal mortality is a reflection of the health of the pregnant woman and newborn and reflects the pregnancy environment and early newborn care. Perinatal mortality is particularly high for non-Hispanic Black women. In 2006, the rate for non-Hispanic black women (11.76) was the highest among the racial and ethnic groups, and was more than twice the rate for non-Hispanic white women.

OUTCOME MEASURE 9.1 Infant mortality rate per 1,000 live births

GOAL	To reduce the rate of infant death.
DEFINITION	**Numerator:** Number of deaths to infants from birth through 364 days of age **Denominator:** Number of live resident births **Units:** 1,000 **Text:** Rate
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to Maternal, Infant, and Child Health (MICH) Objective 1.3: Reduce the rate of all infant deaths (within 1 year). (Baseline: 6.7 infant deaths per 1,000 live births within the first year of life in 2006, Target: 6.0 infant deaths per 1,000 live births)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
SIGNIFICANCE	The U.S. infant mortality rate has substantially declined over the last century. Based on preliminary data for 2011, 23,910 infants died before age one year, representing an infant mortality rate of 6.05 deaths per 1,000 live births, which is the lowest infant mortality rate recorded in the U.S. However, significant disparities continue to persist in U.S. infant deaths between racial groups, especially for Blacks and American Indians and Alaskan Natives. The non-Hispanic Black infant mortality rate (12.2 deaths per 1,000 live births in 2010) is nearly two and half times the rate among non-Hispanic Whites and Hispanics. (Child Health USA 2013: Department of Health and Human Services, HRSA). The infant mortality rate in American Indians and Alaskan Natives is more than one and a half times the rate of non-Hispanic Whites. Infant mortality continues to be an extremely complex health issue with many medical, social, and economic determinants, including race/ethnicity, maternal age, education, smoking and health status.

OUTCOME MEASURE 9.2 Neonatal mortality rate per 1,000 live births

GOAL	To reduce the rate of neonatal deaths.
DEFINITION	**Numerator:** Number of deaths to infants under 28 days **Denominator:** Number of live resident births **Units:** 1,000 **Text:** Rate
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to Maternal, Infant, and Child Health (MICH) Objective 1.4: Reduce the rate of neonatal deaths (within the first 28 days of life). (Baseline: 4.5 neonatal deaths per 1,000 live births occurred within the first 28 days of life in 2006, Target: 4.1 neonatal deaths per 1,000 live births)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
SIGNIFICANCE	The preliminary U.S. neonatal infant mortality rate was 4.06 deaths per 1,000 live births in 2011, accounting for two-thirds of all infant deaths. Neonatal mortality is related to gestational age, low birth weight, congenital malformations and health problems originating in the perinatal period, such as infections or birth trauma. A significant disparity exists in neonatal deaths between racial groups, especially for infants born to Black women. Non-Hispanic black women had the highest neonatal mortality rate in 2010 at 7.45, 2.2 times that for non-Hispanic white women (3.35). Neonatal mortality rates were also higher for Puerto Rican (4.82), AIAN (4.28), and Mexican women (3.53) than for non-Hispanic white women.

OUTCOME MEASURE 9.3 Post neonatal mortality rate per 1,000 live births

GOAL	To reduce the rate 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
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to Maternal, Infant, and Child Health (MICH) Objective 1.5: Reduce the rate of post-neonatal deaths (between 28 days and 1 year). (Baseline: 2.2 post-neonatal deaths per 1,000 live births occurred between 28 days and 1 year of life in 2006, Target: 2.0 post-neonatal deaths per 1,000 live births)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
SIGNIFICANCE	Postneonatal mortality is generally related to Sudden Unexpected Infant Death (SUID)/Sudden Infant Death Syndrome (SIDS), unintentional injuries and congenital malformations. In 2011, the preliminary U.S. postneonatal mortality rate was 2.01 deaths per 1,000 live births. Similar to overall infant mortality, infants of non-Hispanic black (4.01) and AIAN (4.00) women had the highest postneonatal mortality rates of any group—more than twice those for non-Hispanic white women (1.82) in 2010. The postneonatal mortality rate was also higher for Puerto Rican women (2.28) than for non-Hispanic white women.

OUTCOME MEASURE 9.4 Rate of deaths due to preterm-related causes

GOAL	To reduce the number of preterm-related deaths.
DEFINITION	**Numerator:** Number of deaths due to preterm-related causes. Causes are defined as preterm-related if 75% or more of infants whose deaths were attributed to that cause were born at at less than 37 weeks of gestation, and the cause of death was a direct consequence of preterm birth based on a clinical evaluation and review of the literature. This includes low birth weight, several maternal complications, respiratory distress, bacterial sepsis, etc. To be included as a preterm-related death, the infant must have been born preterm (<37 completed weeks of gestation) with the underlying cause of death assigned to one of the following ICD-10 categories: K550, P000, P010, P011, P015, P020, P021, P027, P070–P073, P102, P220–229, P250–279, P280, P281, P360–369, P520–523, and P77. **Denominator:** Number of live resident births **Units:** 1,000 **Text:** Rate
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) Objective 1.4: Reduce the rate of neonatal deaths (within the first 28 days of life). (Baseline: 4.5 neonatal deaths per 1,000 live births occurred within the first 28 days of life in 2006, Target: 4.1 neonatal deaths per 1,000 live births) Related to Maternal, Infant, and Child Health (MICH) Objective 1.3: Reduce the rate of all infant deaths (within 1 year). (Baseline: 6.7 infant deaths per 1,000 live births within the first year of life in 2006, Target: 6.0 infant deaths per 1,000 live births) Related to Maternal, Infant, and Child Health (MICH) Objective 9.1: Reduce total preterm births (PTB). (Baseline:12.7% in 2007, Target 11.4%) Related to Maternal, Infant, and Child Health (MICH) 33: Increase the proportion of very low birth weight (VLBW) infants born at Level III hospitals or subspecialty perinatal centers (Baseline: 75% in 2003-2006, Target: 83.7)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
SIGNIFICANCE	Preterm birth is a leading cause of infant mortality. In 2010, 35% of infant deaths were preterm-related or considered to be a direct consequence of prematurity. There are significant racial/ethnic disparities in preterm-related deaths. The preterm-related infant mortality rate for non-Hispanic black women (4.87 per 1,000) is three times that for non-Hispanic white women. The preterm-related infant mortality rate is 86% higher for

Puerto Rican women (2.95 per 1,000), and 10% higher for Mexican women (1.74 per 100,000), than for non-Hispanic white women.

OUTCOME MEASURE 9.5 — Rate of sleep-related Sudden Unexpected Infant Deaths (SUID) deaths to infants

GOAL	To reduce the number of sleep-related SUID deaths.
DEFINITION	**Numerator:** Number of sleep-related SUID deaths to infants **Denominator:** Number of live resident births **Units:** 1,000 **Text:** Rate
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to Maternal, Infant, and Child Health (MICH) Objective 1.9: Reduce the rate of infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed). (Baseline: .93 per 1,000 live births in 2006, Target: .84 infant deaths per 1,000 live births)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
SIGNIFICANCE	Sleep-related SUIDs are the leading cause of death in infants from one month up to one year (postneonatal deaths) and the third leading cause of all infant deaths. In 2010, there were a total of 3,610 or 0.9 sudden unexpected infant deaths (SUID) per 1,000 live births, accounting for 43 percent of postneonatal deaths and 15 percent of all infant deaths. SUID rates vary greatly by race and ethnicity. In 2010, SUID rates were highest for infants born to American Indian/Alaska Native and non-Hispanic Black mothers (1.82 and 1.77 per 1,000, respectively); these rates were more than twice the rate among infants born to non-Hispanic Whites (0.87 per 1,000).

OUTCOME MEASURE 10 — The rate of infants born with fetal alcohol syndrome per 10,000 delivery hospitalizations

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GOAL

To reduce the number of infants born with fetal alcohol syndrome (FAS)

DEFINITION

Numerator:
Number of infants born with fetal alcohol syndrome (FAS)

Denominator:
Number of delivery hospitalizations

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

HEALTHY PEOPLE 2020 OBJECTIVE

Related to Maternal, Infant, and Child Health (MICH) 2.11. Increase abstinence from alcohol among pregnant women. (Baseline: 89.4 percent of pregnant females aged 15 to 44 years reported abstaining from alcohol in the past 30 days in 2007–08, Target: 98.3%)

Related to Maternal, Infant, and Child Health (MICH) 25. Reduce the occurrence of fetal alcohol syndrome. (Baseline: 3.6 cases of fetal alcohol syndrome per 10,000 live births in 2006 were suspected or confirmed among children born in 2001–04, Target: Not Applicable)

DATA SOURCES and DATA ISSUES

HCUP – State Inpatient Database

SIGNIFICANCE

Fetal alcohol syndrome (FAS) represents the severe end of fetal alcohol spectrum disorders, and is characterized by abnormal facial features (e.g., smooth ridge between nose and upper lip), lower than average height or weight, and central nervous system problems that create deficits in learning, memory, attention, communication, vision, and/or hearing. FAS is completely preventable through abstinence from alcohol among pregnant women. Early diagnosis and intervention programs are critical to improve developmental outcomes for children with FAS.

OUTCOME MEASURE 11 — The rate of infants born with neonatal abstinence syndrome per 10,000 delivery hospitalizations

GOAL	To reduce the number of infants born with drug dependency.
DEFINITION	**Numerator:** Number of infants born with neonatal abstinence syndrome **Denominator:** Number of delivery hospitalizations **Units:** 10,000 **Text:** Rate
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health Objective 11.4. Increase abstinence from illicit drugs among pregnant women. (Baseline: 94.8 percent of pregnant females aged 15 to 44 years reported abstaining from illicit drugs in the past 30 days in 2007–08; Target 100%)
DATA SOURCES and DATA ISSUES	HCUP – State Inpatient Database
SIGNIFICANCE	Neonatal drug dependency or withdrawal symptoms, known as neonatal abstinence syndrome (NAS), occur from maternal use of opiates such as heroin, methadone, and prescription pain medications. Symptoms of NAS include fever, diarrhea, irritability, trembling, and increased muscle tone. Along with a rise in prescription drug abuse, the incidence of NAS nearly tripled over the past decade with substantial increases in health care costs (Patrick et al, 2012). Prevention strategies exist along the continuum from preconception, prenatal, postpartum, and infant/childhood stages to help avert substance-exposed pregnancies and improve outcomes for infants born with NAS (ASTHO, 2014; SAMHSA, 2009).

OUTCOME MEASURE 12	**Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)**
GOAL	To increase the percent of eligible newborns screened for heritable disorders with on-time physician notification for out of range screens and timely follow up.
DEFINITION	**Numerator:** Number of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. UNDER DEVELOPMENT. **Denominator:** Number of live eligible resident births **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to Maternal, Infant, and Child Health (MICH) Objective 32: Increase appropriate newborn blood-spot screening and follow-up testing (Baseline: 98.3% of screen-positive children received follow-up testing within the recommended time period in 2003–06, Target: 100%).
DATA SOURCES and DATA ISSUES	The American Public Health Laboratories data set
SIGNIFICANCE	Newborn screening detects thousands of babies each year with potentially devastating, but treatable disorders. The benefits of newborn screening depend upon timely collection of the newborn blood-spots or administration of a point-of-care test (pulse oximeter for critical congenital heart disease), receipt of the newborn blood spot at the laboratory, testing of the newborn blood spot, and reporting out of all results. Timely detection prevents death, mental retardation, and other significant health complications. 1) The number of eligible infants for screening differs by state so the denominator should reflect the individual state protocol. This will typically be the number of live births minus those who die before screening can occur, or transferred and screened elsewhere, or or whom screening may not be appropriate. 2) The American Public Health Laboratories is a voluntary database so not all states will be represented. 3) The Health People Objective was written before point-of-care testing for CCHD was added to the Recommended Uniform Screening Panel.

OUTCOME MEASURE 13 — Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

GOAL	To increase the number of children ready for school.
DEFINITION	**Numerator:** Under development **Denominator:** Under development **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Early and Middle Childhood (EMC) 1. (Developmental) Increase the proportion of children who are ready for school in all five domains of healthy development: physical development, social-emotional development, approaches to learning, language, and cognitive development.
DATA SOURCES and DATA ISSUES	National Survey of Children's Health (NSCH)
SIGNIFICANCE	The early years are a critical period where the pathways to a child's lifetime social, emotional and educational outcomes begin. Although early experiences do not determine children's ongoing development, the patterns laid down early tend to be very persistent and some have lifelong consequences. Studies have shown that children's literacy and numeracy skills at age 4–5 are a good predictor of academic achievement in primary school. Social gradients in language and literacy, communication and socioemotional functioning emerge early for children across socioeconomic backgrounds, and these differences persist into the school years. There are also disparities in the US as to who participates in an early childhood program. Further, it is known that children at risk of poor developmental and educational outcomes benefit from attending high-quality education and care programs in the years before school.

OUTCOME MEASURE 14	Percent of children ages 1-6 who have decayed teeth or cavities in the past 12 months
GOAL	To reduce the proportion of children and adolescents who have dental caries or decayed teeth.
DEFINITION	**Numerator:** Number of children ages 1-6 who have decayed teeth or cavities in the past 12 months **Denominator:** All children, ages 1-6 **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Oral Health of Children and Adolescents (OH) Objectives 1.1 : Reduce the proportion of children aged 3-5 who have dental caries experience in their primary or permanent teeth, (Baseline: 33.3%, Target: 30.0%) and 1.2: Reduce the proportion of children aged 6-9 who have dental caries experience in their primary or permanent teeth (Baseline: 54.4%, Target: 49.0%)
DATA SOURCES and DATA ISSUES	National Survey of Children's Health (NSCH)
SIGNIFICANCE	Early childhood caries (ECC), despite being preventable, remains extremely consequential and prevalent (NHANES reports 11% of 2 year olds and 21% of 3 year olds, 34% of 4 year olds, and 44% of 5 year olds are affected). Early childhood is the only life period for which CDC reports increasing prevalence and ECC is the best predictor of future caries risk. ECC is marked by profound income and racial disparities as evidenced by federal NHANES, NHIS, and NSCH data.

OUTCOME MEASURE 15 — The child death rate per 100,000 children aged 1 through 9

GOAL	To reduce the death rate of children aged 1 through 9.
DEFINITION	**Numerator:** Number of deaths among children aged 1 through 9 years **Denominator:** Number of children aged 1 through 9 **Units:** 100,000 **Text:** Rate
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) Objective 3.1: Reduce the rate of child deaths aged 1 to 4 years. (Baseline: 28.6 deaths among children aged 1 to 4 years per 100,000 population occurred in 2007, Target: 25.7 deaths per 100,000 population) Related to Objective Maternal, Infant, and Child Health (MICH) 3.2: Reduce the rate of child deaths aged 5 to 9 years. (Baseline: 13.7 deaths among children aged 5 to 9 years per 100,000 population occurred in 2007, Target: 12.3 deaths per 100,000 population)
DATA SOURCES and DATA ISSUES	Child death certificates are collected by State vital records/NVSS. Data on total number of children comes from the U.S. Census Bureau.
SIGNIFICANCE	The overall mortality rate for children 1 to 4 years was 26.5 per 100,000 children in 2010 and 12.9 per 100,000 for children aged 5 to 14 years. Unintentional injury continues to be the leading cause of death in children 1 to 14 years. Mortality rates were higher among males than females in each age group. Also, child death rates reflect racial/ethnic disparities, with non-Hispanic Black children having considerably higher rates of mortality than children of other racial/ethnic groups. (Child Health USA 2012, Department of Health and Human Services, HRSA)

OUTCOME MEASURE 16.1 Rate of death in adolescents age 10-19 per 100,000

GOAL	To reduce the death rate of adolescents age 10-19.
DEFINITION	**Numerator:** Number of deaths among adolescents aged 10 through 19 years **Denominator:** Number of adolescents aged 10 through 19 **Units:** 100,000 **Text:** Rate
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective Maternal, Infant, and Child Health (MICH) 4.1: Reduce the rate of adolescent deaths aged 10 to 14 years. (Baseline: 16.9 deaths among adolescents aged 10 to 14 years per 100,000 population occurred in 2007, Target: 15.2 deaths per 100,000) Related to Objective Maternal, Infant, and Child Health (MICH) 4.2: Reduce the rate of adolescent deaths aged 15 to 19 years. (Baseline: 60.3 deaths among adolescents aged 15 to 19 years per 100,000 population occurred in 2007, Target: 54.3 deaths per 100,000)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
SIGNIFICANCE	The leading causes of illness and death among adolescents and young adults are largely preventable. Health outcomes for adolescents and young adults are grounded in their social environments and are frequently mediated by their behaviors. Behaviors of young people are influenced at the individual, peer, family, school, community, and societal levels.

OUTCOME MEASURE 16.2 The rate of deaths to children aged 15-19 years caused by motor vehicle crashes per 100,000 children

GOAL	To reduce the death rate of adolescents age 15-19 from motor vehicle crashes
DEFINITION	**Numerator:** Number of deaths to children aged 15-19 years 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 15-19 years **Units:** 100,000 **Text:** Rate
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective IVP-13: Reduce motor vehicle crash-related deaths. (Baseline: 13.8 motor vehicle traffic-related deaths per 100,000 population occurred in 2007 , Target: 12.4 deaths per 100,000 population)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
SIGNIFICANCE	Unintentional injuries are the leading cause of mortality among adolescents, with motor vehicle crashes accounting for 64% of those deaths.

OUTCOME MEASURE 16.3 Rate of suicide deaths among youths aged 15 through 19 per 100,000

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
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Mental Health and Mental Disorders (MHMD) Objective 1: Reduce the suicide rate. (Baseline: 11.3 suicides per 100,000 in 2007, Target: 10.2 suicides per 100,000) Related to Mental Health and Mental Disorders (MHMD) Objective 2: Reduce suicide attempts by adolescents. (Baseline: 1.9 suicide attempts per 100 occurred in 2009, Target: 1.7 suicide attempts per 100)
DATA SOURCES and DATA ISSUES	National Vital Statistics System (NVSS)
SIGNIFICANCE	Suicide is the second leading cause of death for ages 10-24, and the third leading cause of death for college age youths and ages 12-18. In the U.S. each day, there are an average of more than 5,400 suicide attempts by young people grades 7-12.

OUTCOME MEASURE 17.1 Percent of children with special health care needs

GOAL	To track the percent of children and youth with special health care needs, autism spectrum disorder (ASD), and attention deficit disorder/attent deficit hyperactivity disorder (ADD/ADHD).
DEFINITION	**Numerator:** Parent report on number of children, ages 0-17, who met the criteria for having a special health care need based on the CSHCN screener **Denominator:** All children, ages 0-17 **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	
DATA SOURCES and DATA ISSUES	The revised National Survey of Children's Health (NSCH). States can use the 2009-2010 National Survey of Children with Special Health Care Needs as a baseline.
SIGNIFICANCE	The percent of children with special health care needs has been increasing since 2001. About 12-18% of all US children are considered to have special health care needs. However, they account for almost half of all health care expenditures for children.

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

GOAL	To ensure access to needed and continuous systems of care for children and youth with special health care needs.
DEFINITION	**Numerator:** Parent report on number of CSHCN that received all components of a well-functioning system (family partnership, medical home, early screening, adequate insurance, easy access to services, and preparation for adult transition) **Denominator:** All CSHCN **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) Objectives 30.1 : Increase the proportion of children who have access to a medical home, (Baseline: 57.5%, Target: 63.3%) and 30.2: Increase the proportion of children with special health care needs who have access to a medical home. (Baseline: 49.8%, Target: 54.8%) Related to Objective Maternal, Infant, and Child Health (MICH) 31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems. (Baseline: 20.4% for children aged 0-11 Target: 22.4% Baseline: 13.8%, for children aged 12 through 17, Target: 15.2%)
DATA SOURCES and DATA ISSUES	The revised National Survey of Children's Health (NSCH). States can use the 2009-2010 National Survey of Children with Special Health Care Needs as a baseline.
SIGNIFICANCE	According to the 2009-10 NS-CSHCN, only 17.6% of CSHCN receive services in a well-functioning system of services. The Omnibus Budget Reconciliation Act of 1989 requires Title V to provide and promote family-centered, community-based, coordinated care and facilitate the development of community-based systems of services for children with special health care needs and their families. To address this requirement a minimum of 30 percent of the Title V Block Grant funding is allocated for this purpose, and HP 2020 Objective MICH-31 establishes the goal to increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems.

OUTCOME MEASURE 17.3 Percent of children diagnosed with an autism spectrum disorder

GOAL	To track the percent of children and youth with special health care needs, autism spectrum disorder (ASD), and attention deficit disorder/attent deficit hyperactivity disorder (ADD/ADHD).
DEFINITION	**Numerator:** Number of children, ages 3-17, reported by their parents to have been diagnosed by a health care provider with ASD **Denominator:** Number of children, ages 3-17 **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	
DATA SOURCES and DATA ISSUES	National Survey of Children's Health (NSCH)
SIGNIFICANCE	The prevalence of autism spectrum disorders has risen sharply over the last two decades. However, the average age at diagnosis for ASD is 4 years old, while the American Academy of Pediatrics recommends screening beginning at nine months. Interventions for ASD are more effective when they're started earlier.

OUTCOME MEASURE 17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

GOAL	To track the percent of children and youth with special health care needs, autism spectrum disorder (ASD), and attention deficit disorder/attent deficit hyperactivity disorder (ADD/ADHD).
DEFINITION	**Numerator:** Number of children, ages 3-17, reported by their parents to have been diagnosed by a health care provider with ADD/ADHD **Denominator:** Number of children, ages 3-17 **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	
DATA SOURCES and DATA ISSUES	National Survey of Children's Health (NSCH)
SIGNIFICANCE	Attention-deficit/hyperactivity disorder (ADHD) is one of the most common neurobehavioral disorders of childhood. The prevalence has been increasing over the last decade for reasons that are not yet clear. It is sometimes referred to as Attention Deficit Disorder (ADD). It is usually first diagnosed in childhood and often lasts into adulthood. Children with ADHD may have trouble paying attention, controlling impulsive behaviors, or be overly active.

OUTCOME MEASURE 18 — Percent of children with a mental/behavioral condition who receive treatment

GOAL	To increase the percent of children with a mental/behavioral condition who receive treatment.
DEFINITION	**Numerator:** Number of children, ages 3-17, reported by their parents to have been diagnosed by a health care provider with a mental/behavioral condition (depression, anxiety problems, or behavioral or conduct problems) who received treatment **Denominator:** Number of children, aged 3-17, reported by their parents to have been diagnosed by a health care provider with a mental/behavioral condition (depression, anxiety problems, or behavioral or conduct problems **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Mental Health and Mental Disorders Objective 6: Increase the proportion of children with mental health problems who receive treatment (Baseline: 68.9% in 2008, Target: 75.0%)
DATA SOURCES and DATA ISSUES	National Survey of Children's Health (NSCH)
SIGNIFICANCE	The prevalence of mental/behavioral health conditions has been increasing among children and has been found to vary by geographic and sociodemographic factors. However, a significant portion of children diagnosed with a mental health condition do not receive treatment. Further, the receipt of treatment is generally dependent on sociodemographic and health-related factors.

OUTCOME MEASURE 19 — Percent of children in excellent or very good health

GOAL	To improve the health status of children.
DEFINITION	**Numerator:** Number of children ages 0-17 years reported by their parents to be in excellent or very good health **Denominator:** Number of children aged 0-17 **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	
DATA SOURCES and DATA ISSUES	National Survey of Children's Health (NSCH)
SIGNIFICANCE	Overall health status for children provides a global, summary measure of children's health and well-being. Children reported to be in excellent or very good health are more likely to thrive in a variety of health dimensions, including physical and mental health.

OUTCOME MEASURE 20	Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)
GOAL	To reduce the proportion of children and adolescents who are considered overweight or obese.
DEFINITION	**Numerator:** Number of children and adolescents aged 2-17 years were considered overweight or obese **Denominator:** Number of children and adolescents aged 2-17 **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Nutrition and Weigh Status (NWS) 10.4. Reduce the proportion of children and adolescents aged 2 to 19 years who are considered obese. (Baseline: 16.1% in 2005-2008, Target: 14.5%). Related to NWS 11. (Developmental) Prevent inappropriate weight gain in youth and adults.
DATA SOURCES and DATA ISSUES	WIC for children 2-5 years; NSCH for children 10-17 years (parent-report); YRBSS for adolescents grades 9-12
SIGNIFICANCE	Childhood overweight/obesity 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.

OUTCOME MEASURE 21 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 Bureau) **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Access to Health Services Objective 1: Increase the proportion of persons with health insurance. (Baseline: 83.2% persons had medical insurance in 2008, Target: 100%)
DATA SOURCES and DATA ISSUES	The U.S. Census Bureau (American Community Survey, 2009) and the National Survey of Children's Health provides data on health insurance coverage for children
SIGNIFICANCE	There is a well documented benefit for children in having health insurance. Research has shown that children who acquire health insurance are more likely to have access to a usual source of care, receive well child care and immunizations, to have developmental milestones monitored, and receive prescriptions drugs, appropriate care for asthma and basic dental services. Serious childhood problems are more likely to be identified early in children with insurance, and insured children with special health care needs are more likely to have access to specialists. Insured children not only receive more timely diagnosis of serious health care conditions but experience fewer avoidable hospitalizations, improved asthma outcomes and fewer missed school days. (Institute of Medicine's report, America's Uninsured Crisis: Consequences for Health and Health Care, 2009)

OUTCOME MEASURE 22.1 Percent of children ages 19-35 months, with the 4:3:1:3(4):3:1:4 combined series of vaccines

GOAL	To increase the number of children and adolescents who have completed recommended vaccines.
DEFINITION	**Numerator:** Children, ages 19-35 months, with the 4:3:1:3(4):3:1:4 combined series of vaccines **Denominator:** All children, ages 19-35 months **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to Immunization and Infectious Disease (IID) 8.0: Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV) (Baseline in 2009 of 44.3%, Target of 80.0%)
DATA SOURCES and DATA ISSUES	National Immunization Survey (NIS)
SIGNIFICANCE	Vaccination is one of the greatest public health achievements of the 20th century, resulting in dramatic declines in morbidity and mortality for many infectious diseases. Childhood vaccination in particular is considered among the most cost-effective preventive services available, as it averts a potential lifetime lost to death and disability. Currently, there are 12 different vaccines recommended by the Centers for Disease Control and Prevention from birth through age 18, many of which require multiple doses for effectiveness as well as boosters to sustain immunity. (CDC National Immunization Program; Child Health USA 2012)

OUTCOME MEASURE 22.2 Percent of children 6 months to 17 years who are vaccinated annually against seasonal influenza

GOAL	To increase the number of children and adolescents who have completed recommended vaccines.
DEFINITION	**Numerator:** Children 6 months to 17 years who are vaccinated annually against seasonal influenza **Denominator:** All children, ages 6 months through 17 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to Immunization and Infectious Disease (IID) 12.11. Increase the percentage of children aged 6 months through 17 years who are vaccinated annually against seasonal influenza (Baseline of 46.9% in 2010-11 flu season, Target of 70%)
DATA SOURCES and DATA ISSUES	National Health Interview Survey (NHIS)
SIGNIFICANCE	Vaccination is one of the greatest public health achievements of the 20th century, resulting in dramatic declines in morbidity and mortality for many infectious diseases. Childhood vaccination in particular is considered among the most cost-effective preventive services available, as it averts a potential lifetime lost to death and disability. Currently, there are 12 different vaccines recommended by the Centers for Disease Control and Prevention from birth through age 18, many of which require multiple doses for effectiveness as well as boosters to sustain immunity. (CDC National Immunization Program; Child Health USA 2012)

OUTCOME MEASURE 22.3 Percent of adolescents, ages 13-17, who have received at least one dose of the HPV vaccine

GOAL	To increase the number of children and adolescents who have completed recommended vaccines.
DEFINITION	**Numerator:** Adolescents, ages 13-17, who have received at least one dose of the HPV vaccine **Denominator:** All adolescents, ages 13-17 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Immunization and Infectious Disease (IID) 11.4 Increase the vaccination coverage level of 3 doses of human papillomavirus (HPV) vaccine for females by age 13 to 15 years (Baseline in 2008 of 16.6%, Target of 80%)
DATA SOURCES and DATA ISSUES	National Immunization Survey (NIS)
SIGNIFICANCE	Vaccination is one of the greatest public health achievements of the 20th century, resulting in dramatic declines in morbidity and mortality for many infectious diseases. Childhood vaccination in particular is considered among the most cost-effective preventive services available, as it averts a potential lifetime lost to death and disability. Currently, there are 12 different vaccines recommended by the Centers for Disease Control and Prevention from birth through age 18, many of which require multiple doses for effectiveness as well as boosters to sustain immunity. (CDC National Immunization Program; Child Health USA 2012)

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

GOAL	To increase the number of children and adolescents who have completed recommended vaccines.
DEFINITION	**Numerator:** Adolescents, ages 13-17, who have received at least one dose of the Tdap vaccine **Denominator:** All adolescents, ages 13-17 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Immunization and Infectious Disease (IID) 11.1. Increase the vaccination coverage level of 1 dose of tetanus-diphtheria-acellular pertussis (Tdap) booster vaccine for adolescents by age 13 to 15 years (Baseline 46.7% in 2008; Target of 80%)
DATA SOURCES and DATA ISSUES	National Immunization Survey (NIS)
SIGNIFICANCE	Vaccination is one of the greatest public health achievements of the 20th century, resulting in dramatic declines in morbidity and mortality for many infectious diseases. Childhood vaccination in particular is considered among the most cost-effective preventive services available, as it averts a potential lifetime lost to death and disability. Currently, there are 12 different vaccines recommended by the Centers for Disease Control and Prevention from birth through age 18, many of which require multiple doses for effectiveness as well as boosters to sustain immunity. (CDC National Immunization Program; Child Health USA 2012)

OUTCOME MEASURE 22.5 Percent of adolescents, ages 13-17, who have received at least one dose of the meningococcal conjugate vaccine

GOAL	To increase the number of children and adolescents who have completed recommended vaccines.
DEFINITION	**Numerator:** Adolescents, ages 13-17, who have received at least one dose of the meningococcal conjugate vaccine **Denominator:** All adolescents, ages 13-17 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Immunization and Infectious Disease (IID) 11.3.Increase the vaccination coverage level of 1 dose meningococcal conjugate vaccine for adolescents by age 13 to 15 years (Baseline 43.9% in 2008; Target 80%)
DATA SOURCES and DATA ISSUES	National Immunization Survey (NIS)
SIGNIFICANCE	Vaccination is one of the greatest public health achievements of the 20th century, resulting in dramatic declines in morbidity and mortality for many infectious diseases. Childhood vaccination in particular is considered among the most cost-effective preventive services available, as it averts a potential lifetime lost to death and disability. Currently, there are 12 different vaccines recommended by the Centers for Disease Control and Prevention from birth through age 18, many of which require multiple doses for effectiveness as well as boosters to sustain immunity. (CDC National Immunization Program; Child Health USA 2012)

B.

Title V MCH Services Block Grant
National Performance Measures

No.	National Performance Measure
1	Percent of women with a past year preventive visit
2	Percent of cesarean deliveries among low-risk first births
3	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
4	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
5	Percent of infants placed to sleep on their backs
6	Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool
7	Rate of injury-related hospital admissions per population ages 0 through 19 years
8	Percent of children ages 6 through 11 years and adolescents ages 12 through 17 years who are physically active at least 60 minutes per day
9	Percent of adolescents, ages 12 through 17 years, who are bullied
10	Percent of adolescents with a preventive services visit in the last year
11	Percent of children with and without special health care needs having a medical home
12	Percent of children with and without special health care needs who received services necessary to make transitions to adult health care
13	A) Percent of women who had a dental visit during pregnancy and B) Percent of infants and children, ages 1 to 6 years, who had a preventive dental visit in the last year
14	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
15	Percent of children 0 through 17 years who are adequately insured

PERFORMANCE MEASURE 1 Percent of women with a past year preventive visit

GOAL	To increase the number of women who have a preventive visit.
DEFINITION	**Numerator:** Women who reported having a routine check-up in the last year **Denominator:** Women, ages 18-44 **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) Developmental Objective 16.1: Increase the percentage of women delivering a live birth who discussed preconception health with a health care worker prior to pregnancy Related to Access to Health Services (AHS) Developmental Objective 7.0: Increase the proportion of persons who receive appropriate clinical preventive services
DATA SOURCES and DATA ISSUES	Behavioral Risk Factor Surveillance System (BRFSS)
MCH POPULATION DOMAIN	Women/Maternal Health
SIGNIFICANCE	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.

PERFORMANCE MEASURE 2 Percent of cesarean deliveries among low-risk first births

GOAL	To reduce the number of cesarean deliveries among low-risk first births.
DEFINITION	**Numerator:** Cesarean delivery among term (37+ weeks), singleton, vertex births to nulliparous women **Denominator:** All term (37+ weeks), singleton, vertex births to nulliparous women **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) Objective 7.1. Reduce cesarean births among low-risk women with no prior cesarean (Baseline: 26.5%, Target: 23.9%)
DATA SOURCES and DATA ISSUES	Birth certificates
MCH POPULATION DOMAIN	Women/Maternal Health
SIGNIFICANCE	Cesarean delivery can be a life-saving procedure for certain medical indications. However, for most low-risk pregnancies, cesarean delivery poses avoidable maternal risks of morbidity and mortality, including hemorrhage, infection, and blood clots—risks that compound with subsequent cesarean deliveries. Much of the temporal increase in cesarean delivery (over 50% in the past decade), and wide variation across states, hospitals, and practitioners, can be attributed to first-birth cesareans. Moreover, cesarean delivery in low-risk first births may be most amenable to intervention through quality improvement efforts. This low-risk cesarean measure, also known as nulliparous term singleton vertex (NTSV) cesarean, is endorsed by the ACOG, The Joint Commission (PC-02), National Quality Forum (#0471), Center for Medicaid and Medicare Services (CMS) – CHIPRA Child Core Set of Maternity Measures, and the American Medical Association-Physician Consortium for Patient Improvement.

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

GOAL	To ensure that higher risk mothers and newborns deliver at appropriate level hospitals.
DEFINITION	**Numerator:** VLBW infants born in a hospital with a level III or higher NICU **Denominator:** VLBW infants (< 1500 grams) **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) Objective 33: Increase the proportion of VLBW infants born at level III hospitals or subspecialty perinatal centers (Baseline: 75%, Target: 83.7%)
DATA SOURCES and DATA ISSUES	Linked birth certificate and hospital data on NICU levels from American Academy of Pediatrics (AAP)
MCH POPULATION DOMAIN	Perinatal/Infant Health
SIGNIFICANCE	Very low birth weight infants (<1,500 grams or 3.25 pounds) are the most fragile newborns. Although they represented less than 2% of all births in 2010, VLBW infants accounted for 53% of all infant deaths, with a risk of death over 100 times higher than that of normal birth weight infants (≥2,500 grams or 5.5 pounds). VLBW infants are significantly more likely to survive and thrive when born in a facility with a level-III Neonatal Intensive Care Unit (NICU), a subspecialty facility equipped to handle high-risk neonates. In 2012, the AAP provided updated guidelines on the definitions of neonatal levels of care to include Level I (basic care), Level II (specialty care), and Levels III and IV (subspecialty intensive care) based on the availability of appropriate personnel, physical space, equipment, and organization. Given overwhelming evidence of improved outcomes, the AAP recommends that VLBW and/or very preterm infants (<32 weeks' gestation) be born in only level III or IV facilities. This measure is endorsed by the National Quality Forum (#0477).

PERFORMANCE MEASURE 4

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

GOAL

To increase the proportion of infants who are breastfed and who are breastfed at six months

DEFINITION

Numerator:
A) Number of infants who were ever breastfed
B) Number of infants breastfed exclusively through 6 months

Denominator:
A) All infants born in a calendar year
B) All infants born in a calendar year

Units: 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE

Related to Maternal, Infant, and Child Health (MICH) Objective 21.1: Increase the proportion of children who are ever breastfed (Baseline: 74% in 2006, Target: 81.9%)

Related to Maternal, Infant, and Child Health (MICH) Objective 21.5: Increase the proportion of children who are breastfed exclusively at (Baseline: 14.1% in 2006, Target: 25.5%)

DATA SOURCES and DATA ISSUES

CDC's National Immunization Survey (NIS)

MCH POPULATION DOMAIN

Perinatal/Infant Health

SIGNIFICANCE

Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity, and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and post natal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time, mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.

PERFORMANCE MEASURE 5 Percent of infants placed to sleep on their backs

GOAL	To increase the number of infants placed to sleep on their backs
DEFINITION	**Numerator:** Mothers reporting that they most often place their baby to sleep on their back (Excludes multiple responses of back and combination with side or stomach sleep positions) **Denominator:** Live births **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Identical to Maternal, Infant, and Child Health (MICH) Objective 20: Increase the proportion of infants placed to sleep on their backs (Baseline: 69.0%, Target: 75.9%)
DATA SOURCES and DATA ISSUES	Pregnancy Risk Assessment Monitoring System (PRAMS)
MCH POPULATION DOMAIN	Perinatal/Infant Health
SIGNIFICANCE	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the AAP has long recommended the back (supine) sleep position. However, in 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. Among others, additional higher-level recommendations include breastfeeding and avoiding smoke exposure during pregnancy and after birth. These expanded recommendations have formed the basis of the National Institute of Child Health and Development (NICHD) Safe to Sleep Campaign.

PERFORMANCE MEASURE 6 Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool

GOAL	To increase the number of children who receive a developmental screening.
DEFINITION	**Numerator:** Parent reporting they have filled out a questionnaire provided by a health care provider concerning child's development, communication or social behaviors for a child ages 9 through 71 months **Denominator:** All children ages 9 through 71 months **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) Objective 29-1: Increase the proportion of children (aged 10-35 months) who have been screened for an Autism Spectrum Disorder and other developmental delays. (Baseline: 22.6%, Target: 24.9%)
DATA SOURCES and DATA ISSUES	The revised National Survey of Children's Health (NSCH) in 2017. States can use the 2011-2012 NSCH as a baseline until that time.
MCH POPULATION DOMAIN	Child Health
SIGNIFICANCE	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.

PERFORMANCE MEASURE 7 Rate of injury-related hospital admissions per population ages 0 through 19 years

GOAL	To decrease the number of injury-related hospital admissions among children ages 0 through 19 years.
DEFINITION	**Numerator:** Number of hospital admissions among children ages 0 through 19 years with a diagnosis of unintentional or intentional injury. (first admission for an injury event, excludes readmissions for same event) **Denominator:** Number of children and adolescents 0 through 19 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Injury and Violence Prevention (IVP) Objective 1.2: Reduce hospitalizations for nonfatal injuries. (Baseline: 617.6 per 100,000. Target: 555.8 per 100,000.)
DATA SOURCES and DATA ISSUES	State Hospital Discharge data in the State Inpatient Databases (SID)
MCH POPULATION DOMAIN	Child Health and/or Adolescent Health
SIGNIFICANCE	Injury is the leading cause of child mortality. For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.

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

GOAL	To increase the number of children and adolescents who are physically active.
DEFINITION	**Numerator:** Parent report of children (in NSCH), ages 6 through 11 years, and adolescents (in NSCH), ages 12 through 17 years, who are physically active at least 60 minutes per day. (YRBSS is also available and provides self-report by adolescents) **Denominator:** All children ages 6 through 11 years and adolescents ages 12 through 17 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Physical Activity (PA) Objective 4.1: Increase the proportion of the Nation's public and private elementary schools that require daily physical education for all students. (Baseline: 3.8%, Target: 4.2%) Related to Physical Activity (PA) Objective 3: Increase the proportion of adolescents who meet current Federal physical activity guidelines for aerobic physical activity and for muscle-strengthening activity. (Baseline: 18.4%, Target: 20.2% for adolescents to meet current physical activity guidelines for aerobic physical activity)
DATA SOURCES and DATA ISSUES	The revised National Survey of Children's Health (NSCH), beginning in 2017 and the Youth Risk Behavior Surveillance System.
MCH POPULATION DOMAIN	Child Health and/or Adolescent Health
SIGNIFICANCE	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

PERFORMANCE MEASURE 9 Percent of adolescents, ages 12 through 17 years, who are bullied

GOAL	To reduce the number of adolescents who are bullied.
DEFINITION	**Numerator:** Parent report on adolescents (in NSCH), and adolescent report (in YRBSS), for adolescents ages 12 through 17 years, who were bullied **Denominator:** Number of adolescents, ages 12 through 17 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Injury and Violence Prevention (IVP) Objective 35: Reduce bullying among adolescents. (Baseline: 19.9%, Target: 17.9%)
DATA SOURCES and DATA ISSUES	Youth Risk Behavior Surveillance System (YRBSS), and the National Survey of Children's Health (NSCH). States can use data from the 2013 YRBSS and from the 2011-2012 NSCH as a baseline. (The state will be able to use both data sources as the YRBSS is reported by the adolescents and the NSCH is reported by the parents. The YRBSS is available every other year, and the NSCH will be available annually).
MCH POPULATION DOMAIN	Adolescent Health
SIGNIFICANCE	Bullying, particularly among school-age children, is a major public health problem. Current estimates suggest nearly 30% of American adolescents reported at least moderate bullying experiences as the bully, the victim, or both. Specifically, of a nationally representative sample of adolescents, 13% reported being a bully, 11% reported being a victim of bullying, and 6% reported being both a bully and a victim. Studies indicate bullying experiences are associated with a number of behavioral, emotional, and physical adjustment problems. Adolescents who bully others tend to exhibit other defiant and delinquent behaviors, have poor school performance, be more likely to drop-out of school, and are more likely to bring weapons to school. Victims of bullying tend to report feelings of depression, anxiety, low self-esteem, and isolation; poor school performance; suicidal ideation; and suicide attempts. Evidence further suggests that people who are the victims of bullying and who also perpetrate bullying (i.e., bully-victims) may exhibit the poorest functioning, in comparison with either victims or bullies. Emotional and behavioral problems experienced by victims, bullies, and bully-victims may continue into adulthood and produce long-term negative outcomes, including low self-esteem and self-worth, depression, antisocial behavior, vandalism, drug use and abuse, criminal behavior, gang membership, and suicidal ideation.

PERFORMANCE MEASURE 10	Percent of adolescents with a preventive services visit in the last year
GOAL	To increase the number of adolescents who have a preventive services visit.
DEFINITION	**Numerator:** Parent report of adolescents, ages 12 through 17, with a preventive services visit in the past year from the survey **Denominator:** Number of adolescents, ages 12 through 17 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Adolescent Health (AH) Objective 1: Increase the proportion of adolescents who have had a wellness checkup in the past 12 months. (Baseline: 68.7%, Target: 75.6%)
DATA SOURCES and DATA ISSUES	The revised National Survey of Children's Health (NSCH) beginning in 2017. States can use data from the 2011-2012 NSCH as a baseline.
MCH POPULATION DOMAIN	Adolescent Health
SIGNIFICANCE	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. The Bright Futures guidelines recommends that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health-related behaviors, and immunizations. It recommends that the annual checkup include discussion of several health-related topics, including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.

PERFORMANCE MEASURE 11	Percent of children with and without special health care needs having a medical home
GOAL	To increase the number of children with and without special health care needs who have a medical home
DEFINITION	**Numerator:** Parent report for all children with and without special health care needs, ages 0 to 18 years, who meet the criteria for having a medical home, with subset analyses for children with special health care needs **Denominator:** All children and adolescents, ages 0 to 18 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Maternal, Infant, and Child Health (MICH) Objectives 30.1: Increase the proportion of children who have access to a medical home, (Baseline: 57.5%, Target: 63.3%) and 30.2: Increase the proportion of children with special health care needs who have access to a medical home. (Baseline: 49.8%, Target: 54.8%) Related to Objective Maternal, Infant, and Child Health (MICH) Objective 31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems. (Baseline: 20.4% for children aged 0-11, Target: 22.4%; Baseline: 13.8% for children aged 12 through 17, Target 15.2%)
DATA SOURCES and DATA ISSUES	The revised National Survey of Children's Health (NSCH) beginning in 2017. States can use data from the 2011-2012 NSCH as a baseline.
MCH POPULATION DOMAIN	Children with Special Health Care Needs
SIGNIFICANCE	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric 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 Maternal and Child Health Bureau uses the AAP definition of medical home.

PERFORMANCE MEASURE 12	**Percent of children with and without special health care needs who received services necessary to make transitions to adult health care**
GOAL	To increase the percent of youth with and without 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:** Parent report of youth with and without special health care needs, ages 12 through 17, whose families report that they received the services necessary to transition to adult health care, with subset analyses for children with special health care needs **Denominator:** All adolescents, ages 12 through 17 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Disability and Health (DH) Objective 5: Increase the proportion of youth with special health care needs whose health care provider has discussed transition planning from pediatric to adult health care. (Baseline: 41.2%, Target: 45.3%)
DATA SOURCES and DATA ISSUES	The revised National Survey of Children's Health (NSCH) beginning in 2017. States can use data from the 2011-2012 NSCH as a baseline.
MCH POPULATION DOMAIN	Children with Special Health Care Needs
SIGNIFICANCE	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. 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.

PERFORMANCE MEASURE 13	**A) Percent of women who had a dental visit during pregnancy and B) Percent of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year**
GOAL	A) To increase the number of pregnant women who have a dental visit and B) To increase the number of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year.
DEFINITION	**Numerator:** A) Report of a dental visit during pregnancy B) Parent report of infant or child, ages 1 through 17 years, who had a preventive dental visit in the last year **Denominator:** A) All live births B) All infants and children, ages 1 through 17 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Oral Health (OH) Objective 7. Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year. (Baseline: 44.5%, Target: 49.0%) Related to Oral Health (OH) Objective 8. Increase the proportion of low-income children and adolescents who receive any preventive dental service during the past year. (Baseline: 30.2%, Target: 33.2%)
DATA SOURCES and DATA ISSUES	This is an integrated measure with two data sources: A) CDC's Pregnancy Risk Assessment Monitoring System (PRAMS); B) the revised National Survey of Children's Health (NSCH) beginning in 2017. States can use data from the 2011-2012 NSCH as a baseline. If a state has access to both PRAMS and the NSCH, the state needs to address both parts (A & B) of the measure. If a state does not have access to PRAMS, the state will need to address part B of the measure.
MCH POPULATION DOMAIN	Cross-cutting/Life course
SIGNIFICANCE	Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.

Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care.

State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.

PERFORMANCE MEASURE 14	A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes
GOAL	A) To decrease the number of women who smoke during pregnancy and B) To decrease the number of households where someone smokes.
DEFINITION	**Numerator:** A) Women who report smoking during pregnancy B) Parent report of cigar, cigarette, or pipe tobacco use by household members **Denominator:** A) All women who delivered a live birth in a calendar year B) All children, ages 0 to 18 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Tobacco Use (TU) Objective 6: Increase smoking cessation during pregnancy (Target: 30.0%) and related to Tobacco Use (TU) Objective 11.1: Reduce the proportion of children aged 3 to 11 years exposed to secondhand smoke. (Baseline: 52.2% , Target 47%) Related to Respiratory Diseases (RD) Objective 7.5: Increase the proportion of persons with current asthma who have been advised by a health professional to change things in their home, school, and work environments to reduce exposure to irritants or allergens to which they are sensitive according to National Asthma Education and prevention Program guidelines. (Baseline: 50.8%, Target: 54.5%)
DATA SOURCES and DATA ISSUES	This is an integrated measure with two data sources: A) National Vital Statistics System (NVSS) for smoking during pregnancy and B) the revised National Survey of Children's Health (NSCH) beginning in 2017. States can use data from the 2011-2012 NSCH as a baseline. If selected, the state needs to address both parts (A & B) of the measure.
MCH POPULATION DOMAIN	Cross-cutting/Life course
SIGNIFICANCE	Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Further, secondhand smoke (SHS) is a mixture of mainstream smoke (exhaled by smoker) and the more toxic side stream smoke (from lit end of nicotine product) which is classified as a “known human carcinogen” by the US Environmental Protection Agency, the US National Toxicology Program, and the

International Agency for Research on Cancer. Adverse effects of parental smoking on children have been a clinical and public health concern for decades and were documented in the 1986 U.S. Surgeon General Report. The only way to fully protect non-smokers from indoor exposure to SHS is to prevent all smoking in the space; separating smokers from non-smokers, cleaning the air, and ventilating buildings do not eliminate exposure. Unfortunately, millions (more than 60%) of children are exposed to SHS in their homes. These children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections leading to 7,500 to 15,000 hospitalizations annually in children under 18 months; and sudden infant death syndrome (SIDS). Higher intensity medical services are also required by children of parents who smoke including an increased need for intensive care unit services when admitted for flu, longer hospital stays; and more frequent use of breathing tubes during admissions.

PERFORMANCE MEASURE 15	Percent of children 0 through 17 years who are adequately insured
GOAL	To increase the number of children who are adequately insured
DEFINITION	**Numerator:** Parent report of children, ages 0 through 17 years, who were reported to be adequately insured, based on 3 criteria: whether their children's insurance covers needed services and providers, and reasonably covers costs. If a parent answered "always" or "usually" to all three dimensions of adequacy, then the child was considered to have adequate insurance coverage. (No out-of-pocket costs were considered to be "always" reasonable.) **Denominator:** All children, 0 through 17 years **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Access to Health Services (AHS) Objective 1: Increase the proportion of persons with health insurance Related to Access to Health Services (AHS) Objective 6: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines
DATA SOURCES and DATA ISSUES	The National Survey of Children's Health (NSCH). States can use data from the 2011-2012 NSCH as a baseline.
MCH POPULATION DOMAIN	Cross-cutting/Life course
SIGNIFICANCE	Almost one-quarter of American children with continuous insurance coverage are not adequately insured. Inadequately insured children are more likely to have delayed or forgone care, lack a medical home, be less likely to receive needed referrals and care coordination, and receive family-centered care. The American Academy of Pediatrics highlighted the importance of this issue with a policy statement. The major problems cited were cost-sharing requirements that are too high, benefit limitations, and inadequate coverage of needed services.

APPENDIX G: REQUIRED APPLICATION/ANNUAL REPORT COMPONENTS AND TIMELINE

Submission Date	Application Year	Annual Report Year
July 15, 2015	**Fiscal Year (FY) 2016** (First Application Year of New Five-year Reporting Cycle.) ☐ Complete Application for Federal Assistance (Standard Form - 424) ☐ Develop Executive Summary for Application ☐ Include Needs Assessment Summary in the Application ☐ Identify 7-10 Priority Needs (Form #9) ☐ Select 8 National Performance Measures (NPMs) and Enter Five-year Performance Objectives on Form #10A ☐ Prepare Interim Five-Year State Action Plan Table ☐ Complete Narrative Sections of Application, including Presentation of the State's Five-year Action Plan by Population Health Domain ☐ Enter Budgeted Data for Application Year on Forms #2, #3a and #3b ☐ List Names of MCH Director, CSHSN Director and Family/Youth Leader on Form #8 ☐ Review Other State Data (OSD) on Form #11 and Form #10A for National Outcome Measures (NOMs)	**FY 2014** (Interim Year 04 of Previous Reporting Cycle) ☐ Enter the FY 2014 Annual Indicator Data (specifically, the Numerator, Denominator, Data Source and Data Note) for the 18 NPMs and State Performance Measures (SPMs) from the Previous Reporting Cycle on Form #10D ☐ Report on FY 2014 Program Activities and Analyze Performance, by Population Health Domain, using New Narrative Format ☐ Enter Expenditure Data on Forms #2, #3a, and #3b ☐ Enter Required Data (i.e., Newborn and Others Screening, Unduplicated Count and Total Encounters of Individuals Served, Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX and State Toll-free Hotline and Other Appropriate Methods Data) on Forms #4, #5a, #5b, #6 and #7 for the Reporting Year.
July 15, 2016	**FY 2017** (Second Year Application, or Interim Year 01, of Five-year Reporting Cycle) ☐ Complete SF-424 ☐ Update Executive Summary ☐ Update Needs Assessment Summary	**FY 2015** (Last Annual Report Year, or Interim Year 05, of Previous Five-year Reporting Cycle) ☐ Enter the FY 2015 Annual Indicator Data (specifically, the Numerator, Denominator, Data Source and Data Note) for the 18 NPMs and SPMs from the Previous Reporting Cycle on Form #10D

Submission Date	Application Year	Annual Report Year
	FY 2017 (Continued) ☐ Incorporate Ongoing Needs Assessment Activities/Findings into Annual Update on State Priority Needs ☐ Add FY 2021 Performance Objective for Each Selected NPMs on Form #10A ☐ Develop Evidence-based or -informed Strategy Measures (ESMs) for Each Selected NPM; Prepare Detail Sheet for each ESM on Form #10C; and Enter Five-year Performance Objectives for Each ESM on Form #10A ☐ Develop 3-5 SPMs to Address Priority Needs Not Addressed Through the NPMs and ESMs; Prepare Detail Sheet for Each SPM on Form #10B; and Enter Five-year Performance Objectives for Each SPM on Form #10A ☐ Add Strategies, ESMs and SPMs to Finalize the Five-Year State Action Plan Table ☐ Complete Narrative Sections of Application, including Presentation of the State's Five-year Action Plan by Population Health Domain ☐ Enter Budgeted Data for Application Year on Forms #2, #3a and #3b ☐ Update Listed Names of MCH Director, CSHSN Director and Family/Youth Leader on Form #8 ☐ Review Other State Data (OSD) on Form #11 and Form #10A for NOMs	**FY 2015 (Continued)** ☐ Report on FY 2015 Program Activities and Analyze Performance, by Population Health Domain, using New Narrative Format ☐ Enter Expenditure Data on Forms #2, #3a, and #3b ☐ Enter Required Data (i.e., Newborn and Others Screening, Unduplicated Count and Total Encounters of Individuals Served, Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX and State Toll-free Hotline and Other Appropriate Methods Data) on Forms #4, #5a, #5b, #6 and #7 for the Reporting Year.
July 15, 2017	**FY 2018** (Interim Year 03 Application) ☐ Complete SF-424 ☐ Update Executive Summary ☐ Update Needs Assessment Summary	**FY 2016** (First Annual Report of New Five-year Reporting Cycle) ☐ Enter the FY 2016 Annual Indicator Data (specifically, the Numerator, Denominator, Data Source and Data Note) for the Selected NPMs, ESMs and SPMs

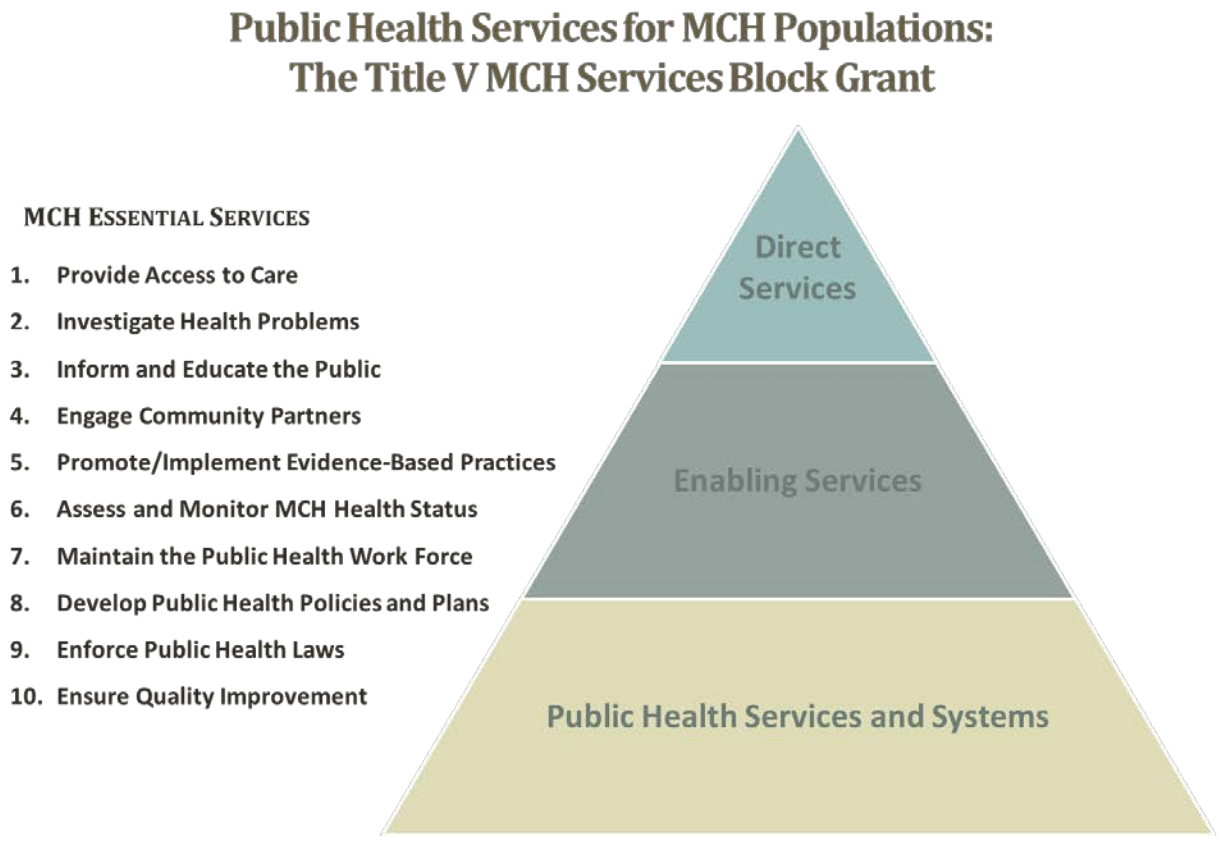
Submission Date	Application Year	Annual Report Year
	FY 2018 (Continued) ☐ Incorporate Ongoing Needs Assessment Activities/Findings into Annual Update on State Priority Needs ☐ Add FY 2022 Performance Objective for Each Selected NPMs, ESMs and SPMs on Form #10A ☐ Update the State Action Plan, as Needed ☐ Complete Narrative Sections of Application, including Presentation of the State's Five-year Action Plan by Population Health Domain ☐ Enter Budgeted Data for Application Year on Forms #2, #3a and #3b ☐ Update Listed Names of MCH Director, CSHSN Director and Family/Youth Leader on Form #8 ☐ Review Other State Data (OSD) on Form 11 and Form #10A for NOMs	**FY 2018 (Continued)** ☐ Report on FY 2016 Program Activities and Analyze Performance, by Population Health Domain, in the State Action Plan ☐ Enter Expenditure Data on Forms #2, #3a, and #3b ☐ Enter Required Data (i.e., Newborn and Others Screening, Unduplicated Count and Total Encounters of Individuals Served, Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX and State Toll-free Hotline and Other Appropriate Methods Data) on Forms #4, #5a, #5b, #6 and #7 for the Reporting Year

APPENDIX H: GLOSSARY

A comprehensive glossary of terms relevant to maternal and child health (MCH) practice, including services for children with special health care needs (CSHCN), is available on the MCH Navigator site. To access the Glossary, click on: http://www.mchnavigator.org. This project is administered by Georgetown University through funding provided by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB.) The MCH Navigator is a learning portal for MCH professionals, students, and others working to improve the health and well-being of women, children, adolescents, and families.

Definitions included in this Glossary are intended to supplement the broader set of terms that are included in the MCH Navigator Glossary. The following list of terms and their definitions have specific relevance to the State Title V MCH Block Grant programs.

MCH Working Framework: MCH Pyramid of Services



As depicted on the Revised MCH Pyramid, the working framework for the Title V MCH Block Grant to States Program aligns with the 10 MCH Essential Services and consists of three levels. Definitions are provided on the next page for each level of service. In developing systems of care, States should assure that they are family centered, community based and culturally competent.

Direct Services – Direct services are preventive, primary, or specialty clinical services to pregnant women and children, including children with special health care needs, where MCH Services Block Grant funds are used to reimburse or fund providers for these services through a formal process similar to paying a medical billing claim or managed care contracts. State reporting on direct services should not include the costs of clinical services which are delivered with Title V dollars but reimbursed by Medicaid, CHIP or other public or private payers. Examples include, but are not limited to, preventive, primary or specialty care visits, emergency department visits, inpatient services, outpatient and inpatient mental and behavioral health services, prescription drugs, occupational and physical therapy, speech therapy, durable medical equipment and medical supplies, medical foods, dental care, and vision care.

Enabling Services – Enabling services are non-clinical services (i.e., not included as direct or public health services) that enable individuals to access health care and improve health outcomes where MCH Services Block Grant funds are used to finance these services. Enabling services include, but are not limited to: case management, care coordination, referrals, translation/interpretation, transportation, eligibility assistance, health education for individuals or families, environmental health risk reduction, health literacy, and outreach. State reporting on enabling services should not include the costs for enabling services that are reimbursed by Medicaid, CHIP, or other public and private payers. This category may include salary and operational support to a clinic or program that enable individuals to access health care or improve health outcomes. Examples include the salary of a public health nurse who provides prenatal care in a local clinic or compensation provided to a specialist pediatrician who provides services for children with special health care needs.

Public Health Services and Systems – Public health services and systems are activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development, and the 10 essential public health services. Examples include the development of standards and guidelines, needs assessment, program planning, implementation, and evaluation, policy development, quality assurance and improvement, workforce development, and population-based disease prevention and health promotion campaigns for services such as newborn screening, immunization, injury prevention, safe-sleep education and anti-smoking. State reporting on public health services and systems should not include costs for direct clinical preventive services, such as immunization, newborn screening tests, or smoking cessation.

Title V Program Administration

Administrative Title V Funds - The amount of funds the State uses for the management of the Title V allocation. This amount is limited by statute to 10 percent of the Federal Title V allotment.

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?"

Children – A child from his/her first birthday through the 21st year, who is not otherwise included in any other class of individuals (e.g., counted as a pregnant woman.)

Data Systems Development – Development of data management systems (electronic or other) or linking of existing databases to support States' ability to collect, tabulate, analyze, and report data accurately. (See Systems Development.)

Early Neonatal Period – The early neonatal period begins at birth and lasts through the 6th day of life.

Federal Allocation – The funding provided to the States under the Federal Title V Block Grant in any given fiscal year; applies specifically to the Application Face Sheet (SF-424) and Form 2.

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.

Infants – Children less than one year of age that are not included in any other class of individuals.

Jurisdictions – The following jurisdictions receive Title V Maternal and Child Health Block Grant Program funding: the District of Columbia, the Republic of the Marshall Islands, the Federated States of Micronesia, the Republic of Palau and the U.S. territories of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

Life Course Theory (LCT) – A conceptual framework that helps explain health and disease patterns – particularly health disparities – across populations and over time. Instead of focusing on differences in health patterns based on one disease or condition at a time, LCT points to broad social, economic and environmental factors as underlying causes of persistent inequalities in health for a wide range of diseases and conditions across population groups. LCT is population focused, and firmly rooted in social determinants and social equity models. Though not often explicitly state, LCT is also community (or "place") focused, since social, economic and environmental patterns are closely linked to community and neighborhood settings.[1]

[1] http://mchb.hrsa.gov/lifecourse/rethinkingmchlifecourse.pdf

Local – Funds derived from local jurisdictions within the State, which are used for MCH program activities and reported on the Application Face Sheet (SF 424) and Form 2.

Low Income – An individual or family with an income that is determined to be below the income official federal poverty line, as 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)]

Needs Assessment – A process to understand the strengths and needs of the health service system within a community or population. For maternal and child health purposes, needs assessment efforts consider the following components: 1) health status, 2) health service utilization, 3) health systems capacity, and 4) population/ community characteristics and contextual characteristics.

Neonatal Period – The neonatal period begins at birth and lasts through the 28th day following birth.

Newborn – A human infant from the time of birth through the 28th day of life.

Other Federal Funds – 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 and reported on the Application Face Sheet (SF 424) and Form 2. These funds may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC, MCH Education funds and Medicaid Federal Medical Assistance Percentage (FMAP).

Others (Class of Individuals) – Women of childbearing age, over age 21, and any others defined by the State who are not otherwise included in any of the other listed classes of individuals. (Form 3a and Form 5a)

Perinatal – The period of gestation between 28 weeks or more to 7 days or less after birth.

Post-neonatal Period – The period between the end of the first month to a year after birth.

Pregnant Woman – A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Prenatal – Occurring or existing before birth, referring to both the care of the woman during pregnancy and the growth and development of the fetus.

Program Income – Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, Medicaid reimbursements, HMO payments, etc., as reported on the Application Face Sheet [SF 424] and Form 2.

State – Terminology used in this Guidance to reference the 50 States and the nine jurisdictions. (See also "Jurisdictions")

State Funds – The State's required matching funds (including overmatch) in any given year, as reported on the Application Face Sheet [SF 424] and Form 2.

Technical Assistance (TA) – The process of providing advice, assistance, and training by an expert with specific technical/content knowledge to address an identified need. Technical Assistance relationships are program-focused, and may use an interactive, on-site/hands-on approach as well as telephone or email assistance. Technical Assistance delivery is short in duration, customized to meet the needs of the client, and offers prescriptive solutions to a specific issue. [Concordia University, 2007www.mnsmart.org]

Title V of the Social Security Act – The authorizing legislation for the Maternal and Child Health Services Block Grant to States Program.

Title V Reporting Form 6, Deliveries to Pregnant Women – 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 Reporting Form 6, Infants Served by Title V – The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Title XIX of the Social Security Act – The authorizing legislation for the Medicaid program.

Title XIX Reporting on Form 6, Pregnant Women Eligible for Title XIX – The number of pregnant women who delivered during the reporting period and were eligible for the State's Title XIX (Medicaid) program.

Title XIX Reporting on Form 6, Infants Eligible for Title XIX – The number of infants eligible for the State's Title XIX (Medicaid) program.

Title XXI – Children's Health Insurance Program (CHIP) financed via the Centers for Medicare and Medicaid Services (CMS). The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.
(Sec. 2101. [42 U.S.C. 1397aa])

Total MCH Funding – All of the MCH funds administered by a State MCH program. Included in this sum total are: 1) the *Federal* Title V Block grant allocation; 2) the *Applicant's* funds, which consists of the unobligated balance from the previous year's MCH Block Grant allocation, the *State*'s total matching funds for the Title V allocation (match and overmatch); 3) the *Local* funds, which are the total amount of MCH

dedicated funds from local government within the State); 4) *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 5) *Program Income* (funds collected by State MCH agencies from insurance payments, Medicaid, HMO's, private grants, etc.)

Unobligated Balance – The amount of unexpended funds from the previous year's Title V MCH Block Grant, as reported as *Applicant* funds on the Application Face Sheet [SF 424] and as *Unobligated Balance* on Form 2.

Performance Measurement

Objectives – The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also Performance Objectives)

Outcome Measure – The ultimate focus and desired result of any set of public health program activities and interventions is an improved health and well-being outcome. Health and well-being outcomes are usually longer term and tied to the ultimate program goal. Morbidity and mortality statistics are indicators of achievement of health outcomes. Other outcomes reflect commonly accepted indicators of a highly functioning system of care for children with special health care needs and their families, positive outcomes, outcomes which are legislatively mandated or are a legislative focus, outcomes where the prevalence is increasing, and developmental outcomes where a fully functioning data system does not exist.

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 20__." 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 comparison to 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 the target populations.

Evidence-based or –Informed Strategy Measure (ESM) –Developed by the State, ESMs would assess the impact of State Title V strategies and activities contained in the State

Action Plan. It is envisioned that the development of the ESMs will be guided through an examination of the evidenced-based or evidence-informed practices on what strategies and activities are both practical and measurable. The main criteria for the ESM would be that the activities had to be measurable, and there had to be evidence that the activity was related to the performance measure chosen.

Evidence-based or –Informed Strategy Measure (ESM) Objectives – The objectives for activities and interventions that drive the achievement of higher-level objectives by the State Title V program.

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 desired 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)?"

Risk Factor Objectives – Objectives that describe an improvement in risk factors (usually behavioral or physiological) that are associated with morbidity and mortality.

Targets – An aspired outcome that is explicitly stated, e.g. achieve 90% of timeliness of reporting, 100% completeness of reporting, etc. In this Guidance, "Targets" is often used interchangeably with "Objectives."

Collaborative Learning, Innovation and Quality Improvement

Aim Statement – A written measureable description of desired outcomes used in a quality improvement initiative. A strong AIM statement outlines what is to be accomplished, quantifies the changes that are to be achieved and sets a date by which the goals will be reached.

Blueprint for Change – A tool to help define action steps for a team's strategic priorities.

CoIIN versus COIN – The Collaborative Improvement and Innovation Network (CoIIN) initiative extends the Collaboration Innovation Network (COIN) model to include the concept of *improvement* in recognition of the need to strengthen existing investments in maternal and infant health as well as to develop innovative, new approaches.

Collaborative Innovation Network (COIN) – A cyberteam of self-motivated people with a collective vision, enabled by the Web to collaborate in achieving a common goal by sharing ideas, information and work.[2]

[2] Gloor, Peter A. "Swarm Creativity." *Competitive Advantage through Collaborative Innovation Network*s. (2006)

Collaborative Learning – Projects using this model enable learners of different abilities and interests to work jointly in small groups to complete a project or solve a problem.

Collective Impact – A concept that provides a framework for bringing diverse people and organizations together in a structured way to achieve social change.[3]

Driver Diagram – A logic chart that organizes the different aspects of an improvement project so key interventions and relationships between these interventions may be clearly understood by all involved.

Infant Mortality CoIIN Framework – A framework that presents a theory of the relationships between (1) key domains of influence (e.g., engaged leadership or innovation), (2) the periods of engagement, and (3) the strategies priorities that will be employed to reduce infant mortality rates in the U.S.

Learning Collaborative – A group of individuals or organizations that come together for a defined period of time to work together to improve process relevant to a specific topic. Members of a learning collaborative generally agree upon a shared set of data to measure and meet regularly to learn from each other and project experts.

Learning Sessions – Members of learning collaboratives generally agree to a regular schedule of multi-day meetings throughout the collaborative. These meetings may be in person or virtual. The learning sessions allow Collaborative faculty and partners to share latest research or important information on the topic of the collaborative, and they allow participants to share their work and to learn from each other.

Perinatal Periods of Risk (PPOR) – Both a community approach and an analytic framework for investigating and addressing high infant mortality rates in urban settings. The overall intent of the PPOR approach is to develop a simple method that can be used by communities to mobilize and prioritize prevention efforts. PPOR brings community stakeholders together to build consensus, support and partnership around infant mortality rates.[4]

Primary Drivers – Found in the CoIIN framework and driver diagrams, drivers are system components, factors or broad improvement areas that contribute directly to achieving the stated outcome. For example, if the outcome is reducing infant mortality, a strategic priority/primary driver might be to improve access to and quality of prenatal care for women. (See Strategic Priorities)

Potential Action/Change Concept – Actionable steps for change targeted at improving specific processes, often originating from brainstorming sessions with the team and evidence-based best practices.

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[3] http://collectiveimpactforum.org/what-collective-impact

[4] http://www.citymatch.org/projects/perinatal-periods-risk-ppor

Quality Improvement in Public Health – The use of a deliberate and defined improvement process, which is focused on activities that are responsive to community needs and improving population health. This effort is continuous and ongoing to achieve measureable improvements in the efficiency, effectiveness, performance, accountability, outcomes and other indicators of quality in services or processes, which achieve equity and improve the health of the community.[5]

Strategic Priorities – Found in the CoIIN framework and driver diagrams, these priorities are system components, factors or broad improvement areas that contribute directly to achieving the stated outcome. For example, if the outcome is reducing infant mortality, a strategic priority/primary driver might be to improve access to and quality of prenatal care for women.

Family/Consumer Engagement

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, cultural competence 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 who 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 which reflects 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 everyone has a culture.[6]

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[5] http://www.apha.org/NR/rdonlyres/6CC21952-4A55-4E3F-BB51-1BA060BF60FE/0/QI_in_PH_IT_Works.pdf

[6] *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*

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.

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 Consumer Partnership – The intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course. Family engagement reflects a belief in the value of the family leadership at all levels from an individual, community and policy level.[7] Examples of family/consumer partnership for Title V organizations can be found on the Family Voices website at: http://www.familyvoices.org/work/title_v?id=0012

Children with Special Health Care Needs

Care Coordination Services – 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)*] This category sometimes overlaps with services identified as case management.

Case Management Services – Services that assure access to quality prenatal, delivery and postpartum care for pregnant women; Services that assure access to quality preventive and primary care services for infants up to age one. [*Title V Sec. 501(b)(4)]*

Children With Special Health Care Needs (CSHCN) – Children who have health problems that require more than routine and basic care, which includes children with or at risk of disabilities; chronic illnesses and conditions; and health-related education and behavioral problems. For budgetary purposes, CSHCN are infants or children from birth through the 21st year who have special health care needs and for whom the State has elected to provide with services that are funded through Title V. For planning and systems development, CSHCN are 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 that goes beyond that which is required by children generally.

2004; and Denboba, "Federal Viewpoint," Special Additions Newsletter for Children with Special Health Care Needs, Spring/Summer 2005.

[7] Definition provided by the Family and Youth Leadership Committee of AMCHP.

Constructs of a Service System for CSHCN:

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 mechanism 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, which includes early intervention and special education, social services and family support services.

Additional MCH Terms

Acquired Brain Injury – Injury to the brain which is not hereditary, congenital, degenerative, or induced by birth trauma. Traumatic brain injury is a type of acquired brain injury.

Bullying – Unwanted, aggressive behavior among school aged children that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Additional guidance on bullying surveillance is available at: http://www.cdc.gov/violenceprevention/pdf/bullying-definitions-final-a.pdf.

Clinical Genetics – Clinical and laboratory services for individuals and families with, or at risk for, health problems with a heritable component. The application of the principles of inheritance and our knowledge of human genes to diagnose, prevent and treat disease and improve health.

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 and other uniting factors.

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 that is developed by a community and based on an assessment of needs.

Genetic Counseling: The process of helping people to understand and adapt to the medical, psychological, and familial implications of genetic contributions to disease. This process integrates: interpretation of family and medical history to assess the chance of disease occurrence or recurrence; education about inheritance, testing, management, prevention, resources and research; counseling to promote informed choices; and adaptation to the risk or condition.

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.

(Human) Genetics: The science of genes, heredity and variation in human organisms

Health Care Transition – The process of changing from a pediatric to an adult model of health care. The goal of health care transition (HCT) is to optimize health and assist youth in reaching their full potential. To reach that goal, there's an active process over time that addresses many aspects of a youth's life, including medical, psychosocial, educational, and vocational needs and ensures continuity of developmental and age appropriate health care services. Successful transition involves the engagement and participation of the pediatric and adult medical home team, the family and other care givers, and the individual youth collaborating in a positive and mutually respectful relationship.

Medical Home – An approach to providing health care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Care occurs in an environment of trust and mutual responsibility between the family, patient, and primary care provider. The principle of family-centered care defines the care to be received in a medical home while a team-based approach is central to delivering care in the medical home. Within the medical home, care coordination addresses interrelated medical, dental, mental and behavioral, social, educational, and financial needs to achieve optimal health and wellness outcomes.

Morbidity – A general term for any health condition that encompasses diseases, injuries, and impairments in a population or group.

Mortality – A general term for the incidence of deaths in a population or group. The number of deaths may be reported by age, sex, race/ethnicity, geographic area, and cause of death.

Mortality Rate **–** The number of deaths occurring in a particular population during a specific time period, as calculated by the number of deaths in that group (numerator) divided by the total population (denominator) and expressed as per 1,000 live births (infant mortality rate only) or per 100,000 population, generally at mid-year.

National Improvement Partnership Network (NIPN) – A network of States who have an Improvement Partnership (IP), which is a durable collaborative of public and private partners that use the science of quality improvement and a systems approach to improve healthcare infrastructure and practice. Established in 2009, NIPN is led by the Vermont Child Health Improvement Program (VCHIP).

National Survey of Children's Health (NSCH) **–** Sponsored by the Maternal and Child Health Bureau of the Health Resources and Services Administration, the NSCH examines the physical and emotional health of children ages 0-17 years of age. Special emphasis is placed on factors that may relate to well-being of children, including medical homes, family interactions, parental health, school and after-school experiences, and safe neighborhoods. The NSCH has been fielded three times, in 2003, 2007 and 2011-2012, yielding both State- and nationally-representative data. The NSCH is currently being redesigned, with the first public release of data scheduled for spring 2017.

National Survey of Children with Special Health Care Needs (NS-CSHCN) – This survey was sponsored by the Maternal and Child Health Bureau of the Health Resources and Services Administration. The NS-CSHCN was conducted three times, in 2001, 2005-2006 and 2009-2010, and yielded State- and nationally-representative data on the health care experiences of CSHCN and their families. The NS-CSHCN is currently being combined with the NSCH to provide one unified survey.

Newborn Screening (NBS) – The process of testing newborn babies for some serious, but treatable, conditions. NBS can include a heel stick, hearing screen, and pulse oximetry. The conditions that newborn babies are screened for varies by state. When a newborn screening result is positive, further diagnostic testing is usually required to confirm or specify the results.

Newborn Screening Long-term Follow-up – Comprises the assurance and provision of quality chronic disease management, condition-specific treatment, and age-appropriate preventive care throughout the lifespan of individuals identified with a condition included in newborn screening. Integral to assuring appropriate long-term follow-up are activities

related to improving care delivery, including engagement of affected individuals and their families as effective partners in care management, continuous quality improvement through the medical home, research into pathophysiology and treatment options, and active surveillance and evaluation of data related to care and outcomes.

Newborn Screening Short-term Follow-up – The process of ensuring that all newborns are screened, that an appropriate follow-up caregiver is informed of results, that confirmatory testing has been completed, and that the infant has received a diagnosis and, if necessary, treatment.

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.

Preventive Oral Health Services – Activities that aim to improve and maintain good oral health and function by reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries. Examples of preventive oral health services include, but are not limited to, oral hygiene instructions, fluoride treatment, and Dental Sealants.

Primary Care/Primary Care Services – 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.

Recommended Uniform Screening Panel (RUSP) – The RUSP is a list of disorders that are screened at birth and recommended by the Secretary of the Department of Health and Human Services (HHS) for States to screen as part of their State universal newborn screening (NBS) programs. Disorders on the RUSP are chosen based on evidence that supports the potential net benefit of screening, the ability of states to screen for the disorder, and the availability of effective treatments. It is recommended that every newborn be screened for all disorders on the RUSP. Most States screen for the majority of disorders on the RUSP; newer conditions are still in process of adoption. Some states also screen for additional disorders. Although States ultimately determine what disorders their NBS program will screen for, the RUSP establishes a standardized list of disorders that have been supported by the Discretionary Advisory Committee on Heritable Disorders in Newborns and Children (DACHDNC) and the Secretary of HHS.

Safe Infant Sleep Environment – Infant is placed to sleep on its back, in its own crib without blankets or soft items or bed-sharing. Reference: http://pediatrics.aappublications.org/content/early/2011/10/12/peds.2011-2284

Sudden Unexpected Infant Deaths (SUID) - Deaths in infants less than one year of age that occur suddenly and unexpectedly, and in whom the cause of death is not immediately obvious prior to investigation.

Sudden Infant Death Syndrome (SIDS) – The sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and review of the clinical history.

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.

Traumatic Brain Injury – An alteration in brain function, or other evidence of brain pathology caused by an external force.