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)
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 (DHHS). 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 maternal and child health 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.

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, health indicator data, 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.
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 it as part of the first year Title V MCH Block Grant Application/Annual Report. (Note: States will add the S&PMs to the Five-year State Action Plan Table in the Year 02 Application/Annual Report.) The following sample table is provided to help guide states in understanding the types of information that they should include. States can use a different tabular form for presenting similar information in their Five-year State Action Plan Table.

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 NHS/OMs, NPMs, SPMs and S&PMs.

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 NHS/OMs, NPMs, SPMs and S&PMs; and their progress/achievements in addressing their identified priority needs through the implementation of strategies defined in their Five-year State Action Plan Table.
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<td>Other</td>
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* Data to be provided by MCHB
**APPENDIX C: ASSURARANCES AND CERTIFICATIONS**

**View Burden Statement**

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<th>OMB Number: 4040-0007</th>
<th>Expiration Date: 06/30/2014</th>
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**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 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, (j) 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. |

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 178(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (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).


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.
1. CERTIFICATION 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. CERTIFICATION 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. CERTIFICATION 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 defined 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 Health Status/Outcome Measures (NHS/OMs), 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) Maternal/Women’s Health; 2) Perinatal/Infant Health; 3) Children; 4) Adolescents/Young Adults; 5) Children with
Special Health Care Needs (CSHCN); and 6) Crosscutting 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.B. 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 Reimbursable MCH Health Care Services, 2) Non-Reimbursable Primary and Preventive Health Care Services for MCH Populations and 3) Public Health Services and Systems for MCH Populations. 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) and identify five State Performance Measures (SPMs) as part of its five-year Action Plan. States will also give consideration to the potential Structural/Process Measures (S&PMs) that will be developed in Application Year 02 for addressing the selected NPMs.

Secondly, the State will set targets for the NHS/OMs, NPMs and SPMs that it selects. In Application Year 02, the state will develop performance targets for the S&PMs. The anticipated results of this stage are the identification of NHS/OMs, NPMs, SPMs and, ultimately, S&PMs that directly relate to the State priorities and establish a level of accountability for achieving measurable 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., NHS/OMs, NPMs, SPMs and S&PMs) 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.

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 NHS/OMs, NPMs, SPMs and S&PMs, 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

Below are the 15 national priority areas addressed by the NPMs and the corresponding focal MCH Population(s).

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<th>NPM #</th>
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<td>Low risk cesarean deliveries</td>
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<td>4</td>
<td>Safe sleep</td>
<td>Perinatal</td>
</tr>
<tr>
<td>5</td>
<td>Developmental screening</td>
<td>Children</td>
</tr>
<tr>
<td>6</td>
<td>Child safety/Injury</td>
<td>Children</td>
</tr>
<tr>
<td>7</td>
<td>Adolescent well-visit</td>
<td>Adolescents</td>
</tr>
<tr>
<td>8</td>
<td>Bullying</td>
<td>Adolescents</td>
</tr>
<tr>
<td>9</td>
<td>Adequate insurance coverage</td>
<td>Cross Cutting: Children, Adolescents, Families</td>
</tr>
<tr>
<td>10</td>
<td>Breastfeeding</td>
<td>Infants</td>
</tr>
<tr>
<td>11</td>
<td>Physical activity</td>
<td>Cross Cutting: Children, Adolescents</td>
</tr>
<tr>
<td>12</td>
<td>Oral health</td>
<td>Children</td>
</tr>
<tr>
<td>13</td>
<td>Medical home</td>
<td>Children with Special Health Care Needs, Children</td>
</tr>
<tr>
<td>14</td>
<td>Transition</td>
<td>Children with Special Health Care Needs, Children</td>
</tr>
<tr>
<td>15</td>
<td>Household Smoking</td>
<td>Cross Cutting: Pregnant Women, MCH Populations, Families</td>
</tr>
</tbody>
</table>

In implementing this framework while maintaining their flexibility, 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 one NPM from each of the six MCH Populations is selected and that the selected NPMs are based on the findings of the Five-year Needs Assessment process. There are no mandatory NPMs.

Once 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 NHS/OMs 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.

A State will determine performance objectives for FY 2016-2020 for the NPMs that it selects. Performance objectives for future years can be changed for individual NPMs based on ongoing needs assessment efforts and performance monitoring.

In the second reporting year (FY 2017 Application/FY 2015 Annual Report), states will develop one or more S&PMs for each of the NPMs they selected. The S&PMs will serve to assess the impact of the strategies and programming implemented by the state for each of the selected NPMs. States will be required to develop a detail sheet for each established S&PM, 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 S&PMs that were established for this Five-year Needs Assessment cycle. States will determine performance objectives for each of the S&PMs for Application years FY 2018-FY 2020. These objectives can be revised, as needed, for future reporting years. Data for the S&PMs (i.e., indicator/numerator/denominator) will be entered annually by the state. During the five-year reporting cycle, the S&PMs may be modified, replaced, or retired, based on analysis of the effectiveness of the strategy or the validity of the measure.

The SPMs will be developed as part of the first year Application/Annual Report (i.e., FY 2016 Application/FY 2014 Annual Report), and states will determine performance objectives for each of the five reporting years (FY 2016-FY 2020) for each of the measures. States may revise their SPM objectives in future years’ Applications/Annual Reports.

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. While the SPMs will be developed as part of the first year Application/Annual Report (i.e., FY 2016 Application/FY 2014 Annual Report), the detail sheets will be developed and submitted as part of the second year Application/Annual Report (i.e., FY 2017 Application/FY 2015 Annual Report.) States will track their 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.

A state may 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 NHS/OMs 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, performance objectives should be established for each of the five reporting years (FY 2016-FY 2020.)

In the second reporting year (i.e., FY 2017 Application/FY 2015 Annual Report), the state will develop a detail sheet for any SOMs that it has identified. On the detail sheet, states will define the: (1) measure; (2) goal; (3) indicator, numerator, and denominator; (4) data source; and (5) significance. States will track the SOMs during the five-year reporting cycle (FY 2016-FY 2020), 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.
APPENDIX F: DETAIL SHEETS FOR THE NATIONAL HEALTH STATUS/OUTCOME MEASURES AND NATIONAL PERFORMANCE MEASURES

A. National Health Status/Outcome Measures

B. National Performance Measures
<table>
<thead>
<tr>
<th>HEALTH STATUS/OUTCOME MEASURE 1</th>
<th>Infant mortality rate per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL</td>
<td>To reduce the rate of infant death.</td>
</tr>
<tr>
<td>DEFINITION</td>
<td><strong>Numerator:</strong> Number of deaths to infants from birth through 364 days of age</td>
</tr>
<tr>
<td></td>
<td><strong>Denominator:</strong> Number of live resident births</td>
</tr>
<tr>
<td>HEALTHY PEOPLE 2020 OBJECTIVE</td>
<td>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)</td>
</tr>
<tr>
<td>DATA SOURCES and DATA ISSUES</td>
<td>National Vital Statistics System (NVSS)</td>
</tr>
<tr>
<td>SIGNIFICANCE</td>
<td>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.</td>
</tr>
<tr>
<td>HEALTH STATUS/OUTCOME MEASURE</td>
<td>Rate of deaths due to preterm-related causes</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>GOAL</td>
<td>To reduce the number of preterm-related deaths.</td>
</tr>
<tr>
<td>DEFINITION</td>
<td>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 (&lt;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</td>
</tr>
<tr>
<td>HEALTHY PEOPLE 2020 OBJECTIVE</td>
<td>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)</td>
</tr>
<tr>
<td>DATA SOURCES and DATA ISSUES</td>
<td>National Vital Statistics System (NVSS)</td>
</tr>
<tr>
<td>SIGNIFICANCE</td>
<td>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.</td>
</tr>
</tbody>
</table>
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.
<table>
<thead>
<tr>
<th>HEALTH STATUS/OUTCOME MEASURE 3</th>
<th>Neonatal mortality rate per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL</td>
<td>To reduce the rate of neonatal deaths.</td>
</tr>
<tr>
<td>DEFINITION</td>
<td>Numerator: Number of deaths to infants under 28 days</td>
</tr>
<tr>
<td></td>
<td>Denominator: Number of live resident births</td>
</tr>
<tr>
<td>Units:</td>
<td>1,000</td>
</tr>
<tr>
<td>Text:</td>
<td>Rate</td>
</tr>
<tr>
<td>HEALTHY PEOPLE 2020 OBJECTIVE</td>
<td>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)</td>
</tr>
<tr>
<td>DATA SOURCES and DATA ISSUES</td>
<td>National Vital Statistics System (NVSS)</td>
</tr>
<tr>
<td>SIGNIFICANCE</td>
<td>The 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.</td>
</tr>
</tbody>
</table>
### HEALTH STATUS/ OUTCOME MEASURE 4

**Post neonatal mortality rate per 1,000 live births**

<table>
<thead>
<tr>
<th>GOAL</th>
<th>To reduce the rate of post-neonatal deaths.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITION</td>
<td><strong>Numerator:</strong> Number of deaths to infants 28 through 364 days of age  &lt;br&gt; <strong>Denominator:</strong> Number of live births  &lt;br&gt; <strong>Units:</strong> 1,000  &lt;br&gt; <strong>Text:</strong> Rate</td>
</tr>
<tr>
<td>HEALTHY PEOPLE 2020 OBJECTIVE</td>
<td>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)</td>
</tr>
<tr>
<td>DATA SOURCES and DATA ISSUES</td>
<td>National Vital Statistics System (NVSS)</td>
</tr>
<tr>
<td>SIGNIFICANCE</td>
<td>Postneonatal mortality is generally related to Sudden Unexpected Infant Death (SUID)/Sudden Infant Death Syndrome (SIDS), unintentional injuries and congenital malformations. In 2011, the U.S. postneonatal mortality rate was 2.01 deaths per 1,000 live births.  &lt;br&gt; 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.</td>
</tr>
</tbody>
</table>
HEALTH STATUS/OUTCOME MEASURE 5  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.
<table>
<thead>
<tr>
<th>HEALTH STATUS/ OUTCOME MEASURE 6</th>
<th>Rate of sleep-related Sudden Unexpected Infant Deaths (SUID) deaths to infants</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL</td>
<td>To reduce the number of sleep-related SUID deaths.</td>
</tr>
<tr>
<td>DEFINITION</td>
<td><strong>Numerator:</strong> Number of sleep-related SUID deaths to infants</td>
</tr>
<tr>
<td></td>
<td><strong>Denominator:</strong> Number of live resident births</td>
</tr>
<tr>
<td></td>
<td><strong>Units:</strong> 1,000 <strong>Text:</strong> Rate</td>
</tr>
<tr>
<td>HEALTHY PEOPLE 2020 OBJECTIVE</td>
<td>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)</td>
</tr>
<tr>
<td>DATA SOURCES and DATA ISSUES</td>
<td>National Vital Statistics System (NVSS)</td>
</tr>
<tr>
<td>SIGNIFICANCE</td>
<td>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).</td>
</tr>
</tbody>
</table>
### HEALTH STATUS/OUTCOME MEASURE 7.1

**Percent of low birth weight deliveries (<2,500 grams)**

<table>
<thead>
<tr>
<th>GOAL</th>
<th>To reduce the proportion of low birth weight deliveries</th>
</tr>
</thead>
</table>
| 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). |
**HEALTH STATUS/OUTCOME MEASURE 7.2**

**Percent of moderately low birth weight deliveries**

(1,500-2,499 grams)

<table>
<thead>
<tr>
<th>GOAL</th>
<th>To reduce the proportion of low birth weight deliveries</th>
</tr>
</thead>
</table>
| DEFINITION | **Numerator:** Number of resident live births weighing between 1,500-2,499 grams  
**Denominator:** Number of live resident births |
| 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). |
**HEALTH STATUS/OUTCOME MEASURE 7.3**

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

<table>
<thead>
<tr>
<th>GOAL</th>
<th>To reduce the proportion of low birth weight deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITION</td>
<td><strong>Numerator:</strong> Number of resident live births weighing less than 1,500 grams &lt;br&gt;<strong>Denominator:</strong> Number of live resident births</td>
</tr>
<tr>
<td>HEATHY PEOPLE 2020 OBJECTIVE</td>
<td>Identical to MICH Objective 8.2: Reduce very low birth weight (VLBW). (Baseline: 1.5% in 2007, Target 1.4%)</td>
</tr>
<tr>
<td>DATA SOURCES and DATA ISSUES</td>
<td>National Vital Statistics System (NVSS)</td>
</tr>
<tr>
<td>SIGNIFICANCE</td>
<td>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 <em>in vitro</em> 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. &lt;br&gt;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).</td>
</tr>
</tbody>
</table>
HEALTH STATUS/OUTCOME MEASURE 8.1

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.
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

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.
<table>
<thead>
<tr>
<th>HEALTH STATUS/OUTCOME MEASURE 8.3</th>
<th>Percent of late preterm births (34-36 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOAL</strong></td>
<td>To reduce the proportion of all preterm, early term, and early elective deliveries.</td>
</tr>
</tbody>
</table>
| **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. |
<table>
<thead>
<tr>
<th>GOAL</th>
<th>To reduce the proportion of all preterm, early term, and early elective deliveries.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEFINITION</td>
<td><strong>Numerator:</strong> Number of live resident births born at 37,38 weeks of completed gestation</td>
</tr>
<tr>
<td></td>
<td><strong>Denominator:</strong> Number of live resident births</td>
</tr>
<tr>
<td>Units:</td>
<td>100</td>
</tr>
<tr>
<td>Text:</td>
<td>Percent</td>
</tr>
</tbody>
</table>

**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.
HEALTH STATUS/OUTCOME MEASURE 8.5 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 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.
<table>
<thead>
<tr>
<th>HEALTH STATUS/OUTCOME MEASURE 9</th>
<th>Percent of children in excellent or very good health</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL</td>
<td>To increase the health status of children.</td>
</tr>
</tbody>
</table>
| 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  | National Survey of Children’s Health (NSCH) |
| DATA SOURCES and DATA ISSUES   | 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. |
| HEALTH STATUS/OUTCOME MEASURE 10.1 | 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)
HEALTH STATUS/OUTCOME MEASURE 10.2
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)
HEALTH STATUS/OUTCOME MEASURE 10.3  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)
<table>
<thead>
<tr>
<th>HEALTH STATUS/OUTCOME MEASURE 10.4</th>
<th>Percent of adolescents, ages 13-17, who have received at least one dose of the Tdap vaccine</th>
</tr>
</thead>
</table>

**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)
### HEALTH STATUS/OUTCOME MEASURE 10.5

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

<table>
<thead>
<tr>
<th><strong>GOAL</strong></th>
<th>To increase the number of children and adolescents who have completed recommended vaccines.</th>
</tr>
</thead>
</table>
| **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) |
<table>
<thead>
<tr>
<th>HEALTH STATUS/OUTCOME MEASURE 11</th>
<th>Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL</td>
<td>To reduce the proportion of children and adolescents who are considered overweight or obese.</td>
</tr>
</tbody>
</table>
| 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. |
<p>| 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. |</p>
<table>
<thead>
<tr>
<th>HEALTH STATUS/OUTCOME MEASURE 12</th>
<th>The child death rate per 100,000 children aged 1 through 9</th>
</tr>
</thead>
</table>

### 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 28.6 per 100,000 children in 2007 and 15.3 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 2010, Department of Health and Human Services, HRSA)
HEALTH STATUS/OUTCOME MEASURE 13

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 in March)

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)
### HEALTH STATUS/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.
<table>
<thead>
<tr>
<th>HEALTH STATUS/OUTCOME MEASURE 15</th>
<th>Rate of death in adolescents age 10-19 per 100,000</th>
</tr>
</thead>
</table>

**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**

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)

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.
**HEALTH STATUS/OUTCOME MEASURE 16**  
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.
<table>
<thead>
<tr>
<th>HEALTH STATUS/OUTCOME MEASURE 17</th>
<th>Rate of suicide deaths among youths aged 15 through 19 per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL</td>
<td>To eliminate self-induced, preventable morbidity and mortality.</td>
</tr>
</tbody>
</table>
| 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, an average of more than 5,400 suicide attempts by young people grades 7-12.
HEALTH STATUS/OUTCOME MEASURE 18  Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

GOAL  To ensure access to needed and continuous system 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 CYSHCN 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".
### 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.
<table>
<thead>
<tr>
<th>HEALTH STATUS/OUTCOME MEASURE 19.2</th>
<th>Percent of children diagnosed with an autism spectrum disorder</th>
</tr>
</thead>
</table>

**GOAL**
To track the percent of children and youth with special health care needs, autism spectrum disorder (ASD), and attention deficit disorder/attention 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.
**HEALTH STATUS/OUTCOME MEASURE 19.3**  
Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

<table>
<thead>
<tr>
<th>GOAL</th>
<th>To track the percent of children and youth with special health care needs, autism spectrum disorder (ASD), and attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD).</th>
</tr>
</thead>
</table>
| 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. 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. |
HEALTH STATUS/OUTCOME MEASURE 20
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

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.
HEALTH STATUS/OUTCOME MEASURE 21

Percent of deliveries or postpartum hospitalizations with an indication of severe 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).
### HEALTH STATUS/OUTCOME MEASURE 22

<table>
<thead>
<tr>
<th>GOAL</th>
<th>To reduce the maternal death rate.</th>
</tr>
</thead>
</table>

**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

**Goal:**
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


### 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. 18.5 of mothers died for every 100,000 births 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.
HEALTH STATUS/ OUTCOME MEASURE 23

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.

**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.
HEALTH STATUS/OUTCOME MEASURE 24

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.
B. 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)

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.
<table>
<thead>
<tr>
<th>PERFORMANCE MEASURE 2</th>
<th>Percent of cesarean deliveries among low-risk first births</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL</td>
<td>To reduce the number of cesarean deliveries among low-risk first births.</td>
</tr>
</tbody>
</table>
| 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   | 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 |
| 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)

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  Percent of infants placed to sleep on their backs

<table>
<thead>
<tr>
<th>GOAL</th>
<th>To increase the number of infants placed to sleep on their backs</th>
</tr>
</thead>
</table>
| 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) |
| 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 5  Percent of children, ages 9-71 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 9-71 months

**Denominator:**  All children ages 9-71 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.

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 6**  
Rate of injury-related hospital admissions per population ages 0-19 years

**GOAL**
To decrease the number of injury-related hospital admissions among children ages 0-19 years.

**DEFINITION**
**Numerator:**
Number of hospital admissions among children ages 0-19 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 ages 0-19 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)

**SIGNIFICANCE**
Injury is the leading cause of child mortality. For those who suffer non-fatal severely injured, 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 7  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 12-17, with a preventive services visit in the past year from the survey

Denominator: Number of adolescents, ages 12-17 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.

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 8  Percent of adolescents, ages 12-17 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 12-17 years, who were bullied  

Denominator:  
Number of adolescents, ages 12-17 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/or 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).  

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 9  Percent of children 0 through age 17 years who are adequately insured

<table>
<thead>
<tr>
<th>GOAL</th>
<th>To increase the number of children who are adequately insured</th>
</tr>
</thead>
</table>
| 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 ages 17 years |

<table>
<thead>
<tr>
<th>Units: 100</th>
<th>Text: Percent</th>
</tr>
</thead>
</table>

### 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.

### 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.
<table>
<thead>
<tr>
<th>PERFORMANCE MEASURE</th>
<th>Percent of infants who are ever breastfed</th>
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<table>
<thead>
<tr>
<th>GOAL</th>
<th>To increase the proportion of infants who are breastfed</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>DEFINITION</th>
<th>Numerator: Infants who were ever breastfed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Denominator: All infants born in a calendar year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTHY PEOPLE 2020 OBJECTIVE</th>
<th>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%)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DATA SOURCES and DATA ISSUES</th>
<th>CDC’s National Immunization Survey (NIS)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SIGNIFICANCE</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERFORMANCE MEASURE 11</td>
<td>Percent of children ages 6-11 years and adolescents ages 12-17 years who are physically active at least 60 minutes per day</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>GOAL</strong></td>
<td>To increase the number of children and adolescents who are physically active.</td>
</tr>
</tbody>
</table>
| **DEFINITION**         | **Numerator:** Parent report of children (in NSCH), ages 6-11 years, and adolescents (in NSCH), ages 12-17 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 6-11 years and adolescents ages 12-17 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. States can use the Youth Risk Behavior Surveillance System for adolescents until 2017.

**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 12

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

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 to 6 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 to 6 years, who had a preventive dental visit in the last year

Denominator:
A) All live births
B) All infants and children, ages 1 to 6 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.

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.
<table>
<thead>
<tr>
<th>PERFORMANCE MEASURE 13</th>
<th>Percent of children with and without special health care needs having a medical home</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOAL</strong></td>
<td>To increase the number of children with and without special health care needs who have a medical home</td>
</tr>
</tbody>
</table>
| **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. |
| **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 14

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 12-17, 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 12-17 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.

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 15

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.

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.
As described in the seventh edition of the *Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report*, the revised Application and reporting requirements for state MCH programs are intended to yield Applications/Annual Reports that are streamlined, Title V-focused and reflect a results-driven approach. Specific changes to this edition include the development of enhanced vision and mission statements which build on the legislatively-defined goals and purpose of Title V; a new performance measure framework that enables states to better assess their Title V program efforts while reducing their annual reporting burden; and revised Application/Annual Report instructions that clearly describe the narrative and data reporting requirements yet retain state flexibility in how they tell their Title V story. The organizational structure, content and key changes to the state Title V MCH Block Grant Needs Assessment and Application/Annual Report process for this five-year reporting cycle are summarized below.

First Year Application/Annual Report (FY2016/FY 2014):

**Part Two, Section I**

- Few changes were made to the general requirements (e.g., letter of transmittal, face sheet and assurances) section of the state application/annual report. Reporting on a state’s public input process on the state’s programmatic efforts and its development of a yearly application and annual report were incorporated into Section IIF and Section IIG. For the first time, states will be required to include an Executive Summary. As described in Part Two, Section I.E, the Executive Summary shall present a brief description (no more than three pages in length) 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 around the NHS/OMs, NPMs, SPMs, SPMs and S&PMS. This discussion should address each of the six identified population health domains.

**Part Two, Section II**

- This section addresses the components of the state’s Application/Annual Report.
  
  o This section begins with the State Overview (Part Two, Section II A), which describes the Title V program in the context of the state’s larger health care delivery environment and highlights the principal characteristics that are key to understanding the health status and needs of the state’s MCH population. Roles/responsibilities of the Title V program relative to the state health agency’s current priorities
and initiatives, along with the state’s efforts related to health care reform and ACA implementation, should be discussed. Impacts of such efforts on the health status of the MCH and CSHCN populations and the delivery of Title V-supported services should be noted.

- The State Overview is followed by the five-year Needs Assessment Summary (Part Two, Section IIB).

- While states discuss their broader state priority needs and link them to the identified national MCH priority areas as part of the analysis they provide on their five-year needs assessment findings in Sections IIB, states will list the seven to ten priority needs they determined to be their highest ranked in Part Two, Section IIC. In addition to listing them, states will provide a rationale for their selection as the highest ranked priority needs. States should describe the methodologies they used to rank the broader set of identified needs and the process used to select the final 7-10 state MCH priority needs. Factors that contributed to changes in identified priority needs since the previous five-year reporting cycle should also be discussed. Specifically, states should note if a priority need: (1) continues from the previous five-year reporting cycle; (2) replaces a prior priority need; or (3) is an added priority need. For each priority need, the state should discuss why a priority need was continued, replaced, or added.

- Following the discussion of their identified MCH priority needs, states shall link the development of their five SPMs (Part Two, Section IID) and the selection of eight out of a possible fifteen NPMs (Part Two, Section IIE) with their state-specific priority needs and national MCH priority areas. States shall establish performance objectives for both the state and national measures.

- In Part Two, Section IIF, states shall summarize their efforts to engage family consumer partners and other stakeholders in their Five-year Needs Assessment process and programming. States should describe the mechanisms in place to obtain input and feedback on their programs. Such methods may include advisory groups and task forces addressing specific programs or issues.

- As described in Part Two, Section IIG, the organization of the narrative Application and Annual Report has been reformatted from previous reporting cycles. For this five-year reporting cycle, states shall develop a five-year “Action Plan” and identify strategies for addressing their state-specific priority needs and the national MCH priority areas. The purpose of the State Action Plan is to enable a state to more clearly and concisely report on its progress report relative to its state-specific priority needs and national MCH priority areas, by population domain, and to present an effective and quality-driven plan for the coming year.
Using the priorities identified through the Five-year Needs Assessment process and in consideration of the national MCH priority areas, states will develop a five-year Action Plan which incorporates both the legislatively required Application (Section 505) for the coming year and Annual Report (Section 506.) The action plan will be organized by the following population health domains: 1) maternal/women’s health; 2) perinatal/infant health; 3) child health; 4) adolescent/young adult health; 5) CYSHCN; and 6) crosscutting or life course.

Within the description of each population domain, States will include two sections: 1) Five-Year State Action Plan Table; and 2) State Action Plan Narrative. In the State Action Plan narrative, states will include a plan for the coming year (i.e., Application) and an Annual Report for the reporting year that provides greater detail on the information that they presented in their Five-year State Action Plan Table. For each population domain, states should provide necessary narrative about the plan for the coming year and the previous year’s activities, accomplishments, challenges and revisions to the program goals, objectives, strategies and planned activities. In addition, states should include a description of other programmatic activities which are supported under federal MCH Block Grant funds for a population health domain but do not specifically address the state-specific priority needs or the identified national MCH priority areas. A rationale for such investments, including an explanation of their role in supporting the State’s overall system of care for the MCH population, should be provided. This section should also include a discussion of the status of the MCH workforce in the State, its family/consumer partnerships, the role of the state Title V agency in supporting health reform efforts, other significant, emerging issues not addressed as part of the state action plan narrative and the state’s process for making the Application/Annual Report available to the public for comment during its development and after its transmittal. In addition, states should clearly identify specific activities for engaging families and other stakeholders prior to, during and after the application process. Relative to public input, states should include a description of the state’s process for making the Application/Annual Report available to the public for comment during its development and after its transmittal. The number and nature of the comments received and how they were addressed in the final Application/Annual Report should be noted.

Part Two, Section III

- The reporting of financial, program and performance data is an integral part of the Title V MCH Block Grant to States Program. In this section, states should report on their planned budget for the Application year and their expenditures for the Annual Report year. The reporting forms should coincide and complement the information that states provide in their MCH Block Grant Application/Annual Report narrative discussions.
Unlike previous reporting cycles in which federal-state budget and expenditures were reported, states will report separate budget estimates and expenditures for the federal MCH Block Grant funds they receive and the state matching funds they contribute.

For this reporting cycle, budget/expenditure reporting forms were revised to eliminate unnecessary burden to States and reduce duplication in reporting requirements across forms.

States will continue to report budget/expenditure data for populations served by Title V and by types of services using the new working MCH framework that was discussed in Section XX.


- States should update the Executive Summary to reflect its accomplishments relative to the implementation of the five-year Action Plan and performance around the NHS/OMs, NPMs, SPMs, SPMs and S&PMs for each of the population health domains.
- States provide updates to the State Overview Section, as needed.
- Based on ongoing needs assessment activities, states update the Needs Assessment Summary to include a description of ongoing needs assessment methodologies and any identified changes in the state’s MCH population, the Title V program’s capacity and its partnerships/collaborations.
- States provide updates relative to the selected priority needs.
- States develop and submit S&PMs to address each of the selected NPMS. In addition, states establish performance objectives for the S&PMs.
- States report on program activities in the State Action Plan narrative and update the Five-year State Action Plan Table, as needed. This update includes the addition of the S&PMs that were developed by the state.
- States report separate federal and state budget and expenditure totals for the application year and annual report year.

Third-Year Application/Annual Report (FY 2018/FY 2016):

- States should update the Executive Summary to reflect its accomplishments relative to the implementation of the five-year Action Plan and performance around the NHS/OMs, NPMs, SPMs, SPMs and S&PMs for each of the population health domains.
- States provide updates to the State Overview Section, as needed.
- Based on ongoing needs assessment activities, states update the Needs Assessment Summary to include a description of ongoing needs assessment methodologies and identified changes in the
State’s MCH population, the Title V program’s capacity and its partnerships/collaborations.
  o States provide updates relative to the selected priority needs.
  o States begin reporting annual performance indicators for SPMs and S&PMs as part of their Annual Report and analyze their performance.
  o States report on program activities in the State Action Plan narrative and update the Five-year State Action Plan Table, as needed.
  o States report separate federal and state budget and expenditure totals for the Application year and Annual Report year.

Fourth-Year (FY 2019/FY 2017) and Fifth-Year (FY 2020/FY 2018) Applications/Annual Reports:
  o States should update the Executive Summary to reflect its accomplishments relative to the implementation of the five-year Action Plan and performance around the NHS/OMs, NPMs, SPMs, SPMs and S&PMs for each of the population health domains.
  o States provide updates to the State Overview Section, as needed.
  o Based on ongoing needs assessment activities, states update the Needs Assessment Summary to include a description of ongoing needs assessment methodologies and identified changes in the State’s MCH population, the Title V program’s capacity and its partnerships/collaborations.
  o States provide updates relative to the selected priority needs.
  o States report annual performance indicators for SPMs and S&PMs as part of their Annual Report and analyze performance trends.
  o States report on program activities in the State Action Plan narrative and update the Five-year State Action Plan Table, as needed.
  o States report separate federal and state budget and expenditure totals for the application year and annual report year.