Celebrating the Legacy, Shaping the Future

75 Years of State and Federal Partnership to Improve Maternal and Child Health
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Member of the Family & Youth Leadership Committee
There are many ways we can celebrate our nation’s commitment to its women, children and families. But if any event is a landmark in the history of the United States’ care for its women and children, certainly the passage of the Social Security Act of 1935 is a major milestone. Through Title V of the Social Security Act, the federal government provided a means for states and territories to care for the health and welfare of all of the mothers and children they serve by establishing the Maternal and Child Health (MCH) Services Block Grant. Seventy-five years later, the Title V MCH Block Grant continues to support combined federal and state efforts to improve the health, safety and well-being of mothers and children nationwide.

As an individual invested in the improved health of our nation’s women and children, you are the future of the Title V MCH Block Grant — whether you work in a state health agency, a local health department, the federal government, a university, a clinic, a hospital, are part of a national organization dedicated to the health of women and children, or a family who has benefited from MCH services. This publication aims to not only celebrate the tremendous accomplishments seen through the state and federal partnership that is Title V, but also to explore what the future may hold. For that, we need you — your energy, your creativity, your passion and caring — and your commitment to moving the partnership forward. You know how to Make Change Happen (MCH!) for the people you serve.

For example:

- The Alabama Department of Public Health noted that in 2009, their infant mortality rate was the lowest ever recorded. The Alabama rate of 8.2 deaths per 1,000 live births represented 513 infant deaths, the fewest ever and 99 fewer than in 2008 when the rate was 9.5. Declines were seen in the percent of pregnant women who smoked and the percent of births to teens. Infants of mothers who smoked were 41 percent more likely to die. Infants of teen mothers are 68 percent more likely to die. A decrease was seen in the number of babies born at low birth weight (less than 5 pounds, 8 ounces) and these babies are 20 times more likely to die than infants of normal weight. The Title V MCH Block Grant supported activities to increase the percent of women who receive adequate prenatal care and decrease the number of low birth weight babies.1

- In Oregon, more than 89 percent of women start out breastfeeding — one of the highest rates in the nation. The majority of them are unable to continue for the recommended six months due to barriers such as lack of accommodations for breastfeeding mothers upon returning to the workplace. Unfortunately less than 27 percent of Oregon infants are exclusively breastfed for the six months recommended by the American Academy of Pediatrics. To address this issue, a public-private coalition supported by Oregon’s state MCH program worked through two legislative sessions to achieve the passage of landmark legislation on employer requirements for accommodation.2

- Maine used data obtained from the Youth Risk Behavior Survey (YRBS), which indicated Maine adolescents had very high smoking rates, to pass tobacco legislation. Using data to influence policy change is a key feature of how the Title V MCH Block Grant supports systems change at the state level. The legislation led to increasing Maine’s tobacco tax to one of the highest in the nation. The money earned from the tax allowed Maine program staff to implement an anti-tobacco campaign with a significant focus toward teenagers. As a result of the campaign, Maine’s adolescent smoking rates decreased. Consequently, declines were noted in adults.3

The Title V MCH Block Grant has supported improvements in health outcomes for women, children and families in so many ways. These are but a few examples of the crucial work states are engaged in, with the support of the Title V MCH Block Grant and with the partnership of many, many others. Join the Association of Maternal & Child Health Programs (AMCHP) as we celebrate these efforts and envision even greater accomplishments through strong state-federal partnerships in the future.

Phyllis Sloyer, RN, PhD, FAAP
President, AMCHP

Michael R. Fraser, PhD, CAE
Chief Executive Officer, AMCHP
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Since its beginning, the Title V MCH Block Grant has provided a foundation for ensuring the health of our nation’s mothers and children. With the passage of the Social Security Act on August 23, 1935, the federal government pledged its support of state efforts to extend health and welfare services, including the welfare of women and children. The Social Security Act resulted in the establishment of state departments of health or public welfare in some states, and assisted the efforts of existing agencies in others.

Title V of the Social Security Act is the longest-standing public health legislation in American history. Over the past 75 years, projects supported by the Title V MCH Block Grant have been integrated into local, state and national systems of care and support for all of America’s women, children and families. Landmark projects have produced guidelines for child health supervision from infancy through adolescence; influenced the nature of nutrition care during pregnancy and lactation; recommended standards for prenatal care; identified successful strategies for the prevention of childhood injuries; and developed health safety standards for out-of-home childcare facilities. Passage of health reform in 2010 will greatly expand health insurance coverage and new sections of Title V provide home visitation to thousands more needy families, in addition to other vital services to women, children and families. There is a great deal to be proud of and many accomplishments to celebrate!

Yet recognition of and support for the needs of women, children and families is not always as forthcoming as we would hope. With the economic downturn of recent years creating a host of challenges, a robust future for the funding of state and territorial maternal and child health (MCH) programs is anything but certain. While authorized at $850 million, the Title V MCH Block Grant in 2010 stands at $662 million — almost $60 million less than the 2002 funding level of $730 million. Needs are great; resources are tight.

Although Title V legislation and the services in enables have changed over 75 years, the principles of partnership and performance and a single focus on improving the health, safety and well-being of all mothers and children remains. The legacy of our state and federal partnership to improve maternal and child health is cause for great celebration — and continued commitment.
Overview

The legislation authorizing the Title V MCH Block Grant is broad, encompassing a wide array of direct services to individuals and population-based programs that serve everyone in a community. As a “block grant,” states and territories program their MCH investments to meet their specific needs. Through a thorough process that identifies all potential MCH priorities, states and territories conduct surveys and analyze data to determine where they can have the most impact and need the most resources to address MCH problems and challenges. Every year states and territories submit an application to the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) for MCH funding, and these are made public to all stakeholders and partners. A formula is used to determine funding allocations based on population size and need.

Applications for funding must include:
1) Needs assessment and priorities
2) Measurable objectives
3) Budget accountability
4) Documentation of matching funds
5) Maintenance of efforts
6) Public input

To ensure accountability for the funds appropriated, the MCHB requires states and territories to report on a number of performance and outcome measures. These measures, part of the Title V Information System (or TVIS, available at: https://perfdata.hrsa.gov/MCHB/TVISReports/default.aspx), provide a foundation for assessing progress over time and improving MCH outcomes.

By law, 85 percent of the Title V MCH Block Grant appropriation, up to $600 million, is allocated to the states and territories and 15 percent goes to Special Projects of Regional and National Significance (SPRANS). Appropriated funds in excess of $600 million are distributed as follows: 12.75 percent to Community Integrated Service Systems (CISS) and, of the amount remaining, 85 percent to states and territories and 15 percent to SPRANS. There are more than 475 SPRANS grantees working on a variety of projects to improve MCH outcomes. SPRANS grantee reports can be reviewed via the Discretionary Grant Information System (DGIS), maintained by the MCHB online at https://perfdata.hrsa.gov/MCHB/DGISReports.

Federal investment is matched by the state or territory. For every four dollars in federal funding appropriated by Congress, states and territories are required to match three dollars with state revenue. That means that for a four dollar federal investment, seven dollars is leveraged within the state or territory to address urgent MCH needs. Combined, the total federal and state funding for the Title V MCH Block Grant at the state level is estimated to be more than two billion dollars a year.5

The needs met by state and territorial MCH programs are vast—more than 2.5 million pregnant women, 4 million infants and nearly 30 million children are directly served by a program that touches the lives of all our nation’s women and children.
The Title V MCH Block Grant

The Title V MCH Block Grant includes a wide range of maternal and child health programs that meet national, state and territorial needs. Although specific initiatives vary among states and territories, all programs attempt to:

- Reduce infant mortality and incidence of handicapping conditions among children
- Increase the number of children appropriately immunized against disease
- Increase the number of children in low-income households who receive assessments and follow-up diagnostic and treatment services
- Provide and ensure access to comprehensive perinatal care for women; preventative and child care services; comprehensive care, including long-term care services, for children with special health care needs; and rehabilitation services for blind and disabled children under 16 years of age who are eligible for Supplemental Security Income
- Facilitate the development of comprehensive, family-centered, community-based, culturally competent, coordinated systems of care for children and youth with special health care needs (CYSHCN)

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Health Insurance Programs For Women, Children And Families

Private Insurance Programs include all forms of health insurance that are not funded by the government. Private health insurance plans may be purchased on an individual or group basis. Most group plans are offered by large employers, although some are available through voluntary associations. Individual policies are usually more expensive than group policies. Furthermore, they may have additional coverage restrictions.

Public Insurance Programs include the following:

Medicaid is the largest source of funding for medical and health-related services for people with limited income in the United States. Each state operates a Medicaid program that provides health coverage for lower-income individuals, families and children, the elderly, and people with disabilities. The eligibility rules for Medicaid are different for each state, but most states offer coverage for adults with children at some income level. In addition, beginning in 2014, most adults under age 65 with individual incomes up to about $15,000 per year will qualify for Medicaid in every state.

Medicare is a social insurance program funded entirely at the federal level that focuses primarily on people age 65 or older, people under age 65 with certain disabilities, and people of all ages with end stage renal disease. The Medicare Program provides a Medicare part A which covers hospital bills, Medicare Part B which covers medical insurance coverage, and Medicare Part D which covers prescription drugs.

The State Children’s Health Insurance Program (SCHIP) – or the Children’s Health Insurance Program (CHIP) is a program administered by the U.S. Department of Health and Human Services (HHS) that provides matching funds to states for health insurance to families with children. The program was designed to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid.
The flexibility of the Title V MCH Block Grant is a strength. It allows states and territories to determine the best use of resources to meet the needs of their communities. It is also a challenge — every MCH program is different, making it difficult to identify a set of specific services or programs provided by every state or territorial health agency. States and territories are accountable for core national performance and outcome measures that unite all programs and guide their efforts. But what truly unites all state and territorial MCH programs is passion, dedication and commitment to improve the health of women, children and families within a state, and across the country.

What Do State and Territorial MCH Programs Do?

Within the broad and flexible scope of Title V legislation, the mix of agency functions and community services varies considerably. Each agency has a unique history in the context of the state or territory’s political, cultural and socioeconomic characteristics. The states’ health care delivery and financing systems, including the roles of private and public sectors, add to the variety. Diversity in geography, race, ethnicity, income level and immigrant status are other key factors affecting family health. States are different, needs are different, and how states implement their MCH programs is different. All, however, have at their core the mission of improving the health of women, children and families.

The MCHB created a graphic depiction of the many ways that the Title V MCH Block Grant works to improve maternal and child health. The MCH Services Pyramid on the following page shows the four levels at which state and territorial MCH programs have an impact. At the top of the pyramid are “direct services.” These include, for example, prenatal care and family planning. The second level of the pyramid features “enabling services,” those services that bolster and support direct care. Population-based services are classic features of state and territorial health departments and include activities such as education, newborn screening and injury prevention that address maternal and child health needs of populations, not just individual patients. At the foundation of the pyramid are systems-building and infrastructure services such as data collection and analysis and needs assessment. This foundation provides the basis upon which all other MCH work is accomplished.

In AMCHP’s 2009 review of state and territorial programs, those in the Southern United States, often with highly diverse populations and high rates of poverty, historically play active roles in delivering health services through the public sector, often through local health departments. States in the Northeast and the West Coast tend to have high concentrations of academic and medical institutions and play a lesser role in public delivery of care. These states tend to assist more in the financing and regulating of health care. States in the middle of the country tend to have a mix of these roles.

In any given jurisdiction, the scope of program activities are configured to best address the population needs and resources in that territory or state. Most MCH programs administer adolescent health, early childhood, epidemiology, reproductive health (including family planning) and women’s health programs (Appendix B, Figure 1). The most frequently cited activity areas within CYSHCN programs are direct care, care coordination and financial assistance, medical home programs and transition programs (Appendix B, Figure 2).

MCH programs play a significant role in delivering clinical preventive and primary care services to women, children and youth with state or local health agency staff. Many states and territories
provide specialty and therapeutic services for children and youth with special health care needs in medical centers and mobile units. Others rely on contracting with providers such as community health centers. State and territorial needs, contexts, and the population densities and diversity in states or territories determine how MCH programs provide services. Historically, state and territorial MCH programs were involved where services were not available or not accessible due to barriers such as lack of coverage. With the expansion of health care services and new resources for access to clinical care available through the passage of the Affordable Care Act in March 2010, the role of state and territorial MCH programs will continue to change in the future.

As more children, youth and women gain access to private medical care, state and territorial MCH programs are working to ensure that they receive comprehensive, multidisciplinary services, often in new ways. Some have developed reimbursable bundles of services to “wrap around” basic medical care provided in office settings. These packages include services such as nutrition counseling, social work, health and parent education, and therapies for special needs children and youth.

Additionally, state and territorial MCH programs are revisiting needs assessments and reviewing evidence-based research to identify unmet needs and opportunities for prevention and intervention. Areas receiving increased attention in the early part of the 21st century include:

- Adolescent health
- Care coordination, especially for children and youth with special health care needs
- Early childhood development and linking education, social services, and health for young children
- Home visiting
- Mental health
- Newborn screening
- Oral health
- School health
- Transition services to bridge child and adult health systems

State and territorial MCH programs are addressing these areas by applying core functions and building the infrastructure for population-based health services. Optimally
starting with a needs assessment and planning that includes stakeholder input and review of evidence-based practice and progress on performance measures, state and territorial MCH programs determine strategies to meet identified goals and objectives. Providing data, expertise and assistance to other agencies may help shape a policy or program in another agency’s jurisdiction. Funding and evaluating limited demonstration models both at the national and state levels results in new interventions and opportunities to leverage additional local, state and federal funding sources. Using data and turning it into action, state and territorial MCH programs are leaders and catalysts for systems change.11

What Works In Improving Maternal And Child Health

Preterm birth is the leading cause of death in the first month of life in the United States.12 In 2005, preterm birth cost the United States at least 26.2 billion or $51,600 for every preterm infant born.13 Risk factors for having a preterm birth include lack of prenatal care, smoking, substance abuse, and low socio-economic status.14 State and territorial MCH programs link uninsured women to available prenatal services, coordinate closely with state Medicaid programs to improve outreach and enrollment services to eligible women, and assure capacity to meet the needs of women in their state. State and territorial MCH programs also develop regionalized systems to care for low birthweight and medically fragile newborns.

Total medical costs are lower for fully breastfed infants than never-breastfed infants, since breastfed infants typically need fewer sick care visits, prescriptions, and hospitalizations.15 State and territorial MCH programs promote breastfeeding by developing educational materials for new mothers on breastfeeding practices and providing information on breastfeeding to all residents of their states through websites, toll-free telephone information lines, and coordinating with other programs such as WIC (The Special Supplemental Nutrition Program for Women, Infants, and Children). State and territorial MCH programs also provide lactation consultants and work with policy makers, employers, hospitals and other partners to adopt breastfeeding friendly policies in the workplace.

Home visiting programs result in fewer incidences of child injury and neglect, reduced child mortality, fewer subsequent pregnancies, and mothers’ greater stability of relationships with partners.16,17 Federal Title V legislation has a new section supporting home visiting programs in all states. For pregnant women and mothers with new babies, these programs deliver educational visits, provide parent education, and link new mothers and families to needed health and social services.

Vaccines are one of the most cost effective tools for preventing disease. Every $1 spent on vaccines saves up to $27 in future medical and social costs.18 State and territorial MCH programs work to promote routine health screenings for children that include assessment of immunization status, and establish systems and referral networks that link low-income children to immunization programs.

The injuries incurred by children and adolescents in one year create total lifetime economic costs estimated at more than $50 billion in medical expenses and lost productivity.16 State and territorial MCH programs invest in injury prevention, including initiatives to promote the proper use of child safety seats and helmets. State and territorial MCH programs also promote safe sleeping practices including Sudden Infant Death Syndrome (SIDS) education programs like the “Back to Sleep” campaign to prevent infant mortality. Intentional injury, child abuse and neglect, and shaken baby syndrome are also addressed in education campaigns to encourage proper child supervision.
A Family Delegate is a parent, relative or adult consumer of a state or territorial MCH program system who has been designated by the state MCH director to serve as a voting member of the program’s delegation to AMCHP. Each state and territory can select up to four individuals to serve as delegates to AMCHP with the option of adding a fifth delegate that must be a family member. The Family Delegate is selected primarily for his/her specific perspective as a family member.

The Family Delegate is an active advocate for all families in his or her state or territory, including families with special health care needs, and works within state, territorial, and/or community systems of care to advise, promote, and educate families and program/policy leaders on new and existing policies and programs.

The naming of a Family Delegate is an important step toward meaningful family involvement and in connecting families to their counterparts across the country. As of September 30, 2010, 39 states had named Family Delegates.
**State Spotlight**

**Parent Consultants to the State MCH Program in New Hampshire**

The New Hampshire (NH) CYSHCN program contracts with Family Voices of New Hampshire to fund three full-time employees as parent consultants to the state MCH program. Following are the key family involvement and leadership activities in NH:

- **Block Grant:** The state conducted a survey to gather input on Block Grant Priorities and Family Voices participated in distribution of the electronic survey; 400 individuals responded.

- **Rule Making:** The state MCH program always seeks input from the Family Voices parent consultants when making any kind of Administrative Rule or policy change. The parent consultants also participate in MCH, Medicaid, and Child Protective Services rule changes discussions.

- **Newborn Screening Panel:** Because of the passionate presence of families of children with cystic fibrosis (CF) on the Newborn Screening Panel, the Screening Panel agreed to an expanded panel of screening conditions, which included CF.

**AMCHP Family Scholars Program**

For the past 15 years, AMCHP has supported family scholars to participate in its annual conference. Families contribute invaluable insight and experience to AMCHP programs and policies concerning maternal and child health and children and youth with special health care needs. Within AMCHP, families advise on the development of publications and programs and also serve on AMCHP committees and the Board of Directors. Families who have attended the annual conference consistently praise it as a valuable way to network with other families and state and territorial MCH programs, and to understand more clearly how the Title V MCH Block Grant makes a difference in the lives of children, youth, families and communities.

FAMILY VOICES

Family Voices offers an online Title V Toolbox for Family Participation. To encourage the active participation of families within Title V programs, Family Voices has collected materials developed by states that support family involvement in MCH and CYSHCN programs. By building upon existing materials and models, states and territories can strengthen family involvement in their own programs.

Visit [www.familyvoices.org/toolbox](http://www.familyvoices.org/toolbox/).
Looking Back: Celebrating the Legacy

At the beginning of the 1900s, America faced many maternal and child health challenges. Poverty. Malnutrition and food insecurity. The average life expectancy in the United States from 1900-1902 was 49.2 years. **One in five children would die before reaching their fifth birthday.** In some U.S. cities, up to 30 percent of infants died before reaching their first birthday. The maternal death rate in the early 20th century was one mother’s death per every 150 living births. So, “if women delivered ... five live babies during their child-bearing years ... then one of every 30 women might have expected to die of childbirth over the course of her fertile years.”

Children that did survive worked early, and worked hard. A recommendation from the first White House Conference on Children in 1909 led to the creation of the Federal Children’s Bureau, initially located in the Department of Labor.

The mission of the Children’s Bureau was to “... investigate and report upon matters pertaining to the welfare of children and child life among all classes of people.” Although federal involvement in such issues was controversial at the time, the Children’s Bureau was created through active support of President Taft and key individuals such as Julia C. Lathrop, who became the chief of the new bureau (for nine years) and the first woman to be selected by a president to head a federal statutory agency.

The Children’s Bureau continued to hold a leadership role in various areas of maternal and child health, including education. By 1920, child hygiene bureaus had been established in 28 states, 16 of them in 1919 alone, as a result of the Children’s Bureau leadership.

Julia Lathrop and The Children’s Bureau

Social worker and reformer Julia Lathrop has been called “America’s First Official Mother,” reflecting her devotion toward bettering conditions for children, the mentally challenged and the disabled. Her philanthropic soul, however, was backed by a sharp mind. Lathrop declared, “The era of rule by thumb and a kind heart must give way to trained individuals, whose kindness of heart is rendered more effective because [it is] governed by intelligence.”

The Maternity and Infancy Care Act, better known as the Sheppard-Towner Act, was adopted by Congress in 1921 and remained in effect until 1929. The passage of this Act resulted in federal grants-in-aid to states for child and adult health programs. Another major result of this Act was the development of full-time units of MCH services in state health departments and the first MCH training program.

The Sheppard-Towner Act was the first federal aid program to states for health, establishing the principle of public responsibility for child health. The Act was criticized by some as being “socialistic” and radical; The American Medical Association (AMA), the Catholic Church, and the Public Health Service were instrumental in having it repealed in 1929. However, the Act set the pattern for state and federal cooperation that would re-emerge in Title V of the Social Security Act in 1935.

In 1921, Grace Abbott replaced Julia Lathrop as Chief of Children’s Bureau, taking over administration of the Sheppard-Towner Act. Priorities for Abbott in the Children’s Bureau included a seminal study on childhood rickets, neglected children, “crippled children” and juvenile delinquency.
The Sheppard-Towner Act

The purpose of the Sheppard-Towner Act of 1921 was “to reduce maternal and infant mortality.” The legislation was supported by progressives, social reformers, and feminists including Grace Abbott and Julia Lathrop.

At the time the legislation was introduced, childbirth remained the second leading cause of death for women. About 20 percent of children in the United States died in their first five years. Family income was an important factor in these mortality rates, and the Sheppard-Towner Act was designed to encourage states to develop programs to serve women at lower income levels.

The Sheppard-Towner Act provided for federal matching funds for such programs as:

- Health clinics for women and children, hiring physicians and nurses to educate and care for pregnant women and mothers and their children
- Visiting nurses to educate and care for pregnant and new mothers
- Midwife training
- Distribution of nutrition and hygiene information

With the passing of the Social Security Act, Title V provided resources for state programs for maternity, infant and child care; as well as a full range of medical services for children. Funds were allocated to states to pay for maternal and child health and “crippled children” services, including physicians, dentists, public health nurses, medical social workers and nutritionists. Title V did not establish an entitlement program like other sections of the Social Security legislation, meaning that funds for the Title V MCH Block Grant need to be appropriated annually by Congress.

Shortly before she left the Children’s Bureau, Grace Abbott delivered the commencement address at the New Jersey College of Women in which she stated,

“Without apology, then, I ask you to use courageously your intelligence, your strength, and your good will toward the removal of economic barriers which have retarded the full development of children in the past. The important thing is that we should be ‘on our way’ toward adequately meeting their needs. Perhaps you may ask, ‘Does the road lead uphill all the way?’ and I must answer, ‘Yes, to the very end.’ But if I offer you a long hard struggle, I can also promise you great rewards. Justice for all children is the high ideal in a democracy... We have hardly, as yet, made more than a beginning in the realization of that great objective.”

As a result of the Great Depression, cutbacks in federal health programs, and the declining health of mothers and babies, the Social Security Act was signed into law in August 1935 by President Franklin Roosevelt. Secretary of Labor Frances Perkins enrolled Katharine Lenroot, then Children’s Bureau Chief, to work with her to assure that children were considered by the Committee on Economic Security, which drafted the legislation.
“We can never insure one hundred percent of the population against one hundred percent of the hazards and vicissitudes of life, but we have tried to frame a law which will give some measure of protection to the average citizen and to his family against the loss of a job and against poverty-ridden old age.”

President Roosevelt upon signing the Social Security Act, August 14, 1935

### Social Security Act – Titles

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Decades of MCH: A Timeline of Leadership

Adapted from the MCH timeline. Full version available online at: [http://mchb.hrsa.gov/timeline/](http://mchb.hrsa.gov/timeline/)

**1900s**

President Theodore Roosevelt convened the First White House Conference on the care of dependent children.

The Act of 1912 (Public Law 62-116) established the Children’s Bureau to “investigate and report on the status of children and on their common as well as special needs.”

Birth Registration Areas established in 10 states and the District of Columbia.

Child Labor Act passed.

**20s**

The Maternity and Infancy (Sheppard-Towner) Act passed.

The American Medical Association (AMA), the Catholic Church, and the Public Health Service instrumental in having the Sheppard-Towner Act repealed in 1929.

**30s**


White House Conference on Children produced a “Children’s Charter,” which outlined the specific rights of children.

Birth Registration Areas included in all states.

Title V authorized as part of the Social Security Act and administered by the Children’s Bureau.

Scientific advances in maternity care and pediatrics.

March of Dimes founded.

Original food stamp program enacted by President Roosevelt in response to the Great Depression.

Grace Abbott stated, “Child labor and poverty are inevitably bound together and if you continue to use the labor of children as the treatment for the social disease of poverty, you will have both poverty and child labor to the end of time.”

After much debate, Congress finally passed the first child labor law, the Owen-Keating Bill, in 1916.
40s

In 1944 state MCH leaders created an association of directors of maternal and child health programs (AMCHP) to provide both a framework and a focal point for state and national efforts centered on mothers, children and families. AMCHP has since provided a forum for state directors of programs for MCH and CYSHCN to work with a wide range of partners to improve the health of families nationwide.

National School Lunch Act passed in 1946.30

Hill Burton Act passed to modernize hospitals.

The United Nations Children’s Fund (UNICEF) established in 1946 to provide food, clothing and health care to children facing famine and disease.

Centers for Disease Control and Prevention (CDC) founded to combat malaria.

United Cerebral Palsy founded by parents of children with cerebral palsy.

Linus Pauling makes critical discoveries regarding sickle-cell disease.31

50s

American Congress of Obstetricians and Gynecologists (ACOG) formed.

Dr. Jonas Salk produces a vaccine for polio.

Training of Professional Personnel Act of 1959 (PL 86-158), which helped train leaders to educate children with mental retardation.32

More women in the workforce.

Post-World War II baby boom.

Social Security Disability Insurance (SSDI) passed in 1956 to provide income to people who are unable to work because of a disability.

Watson and Crick reveal the structure of DNA.33

A Technical Advisory Committee to the Children’s Bureau recommends screening for Phenylketonuria (PKU) in 1958. PKU was the first metabolic disorder for which a screening test was developed.34
60s

Birth control and newborn screening.

National Institute on Child Health and Human Development (NICHD) established to investigate the broad aspects of human development as a means of understanding developmental disabilities and the events that occur during pregnancy.35

Title V-supported research program on mental retardation.

Significant amendments to the National School Lunch Act enacted in 1962.36

Head Start launched in 1965, serving more than 560,000 children and families across America.37

Economic Opportunity Act passed.

Neighborhood Health Centers established.

“Migrant Mother” is one of a series of photographs that Dorothea Lange made of Florence Owens Thompson and her children.

In 1960, Lange gave this account of the experience:

“I saw and approached the hungry and desperate mother, as if drawn by a magnet. I do not remember how I explained my presence or my camera to her, but I do remember she asked me no questions. I made five exposures, working closer and closer from the same direction. I did not ask her name or her history. She told me her age, that she was thirty-two. She said that they had been living on frozen vegetables from the surrounding fields, and birds that the children killed. She had just sold the tires from her car to buy food. There she sat in that lean-to tent with her children huddled around her, and seemed to know that my pictures might help her, and so she helped me. There was a sort of equality about it.”


Children and Youth Programs established.

Medicare and Medicaid enacted.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is enacted in 1967.38

Migrant Health program established.

Childhood Nutrition program established.

Title V Maternal and Child Health Services Block Grant administration transferred to the Public Health Service.
In the 1970 reauthorization of the Developmental Disabilities Act, Congress authorized funding for State Developmental Disabilities Councils (DD Councils) in each state and territory. State and Territorial DD Councils work to improve the quality of supports and services for individuals with developmental disabilities and their families.41

President Richard M. Nixon signed the Family Planning Services and Population Research Act (Family Planning Act) of 1970 into law.

“It is noteworthy that this landmark legislation on family planning and population has had strong bipartisan support. I am confident that by working together—at Federal, State, and local levels—we can achieve the goal of providing adequate family planning services within the next 5 years to all those who want them but cannot afford them.”
– President Richard M. Nixon

Sickle Cell Anemia Control Act of 1972 allots government health funds for screening, research and treatment programs.

P.L. 92-433 established the Special Supplemental Food Program for Women, Infants, and Children (WIC) as a 2-year pilot program. By the end of 1974, WIC was operating in 45 States.42

Child Abuse and Prevention Treatment Act (CAPTA) signed into law in 1974.43

The Food Stamp Act of 1977 enacted the program as we know it today, expanding participation and eliminating the process of purchasing food stamps.

The Health Research and Health Services Amendments of 1976 provide for a national program of research, training, testing, counseling and education programs for genetic diseases, including sickle-cell and Cooley’s anemias, Tay-Sachs diseases, cystic fibrosis, dysautonomia, hemophilia, retinitis pigmentosa, Huntington’s chorea and muscular dystrophy.44

Education for All Handicapped Children Act (Public Law 94-142)—later amended as Individuals with Disabilities Education Act (IDEA) in 1997.
Omnibus Budget Reconciliation Act (OBRA) converted Title V-funded programs to a Block Grant in 1981, combining seven categorical programs: MCH/CSHCN, SSI, lead screening, hemophilia treatment centers, Sudden Infant Death Syndrome, genetic diseases, and adolescent programs.

Emergency Medical Services for Children enacted in 1984 to improve the availability of child-appropriate equipment in ambulances and emergency departments; support hundreds of programs to prevent injuries; and provide thousands of hours of training to EMTs, paramedics, and other emergency medical care providers.

The 1987 Surgeon General report on Children and Youth with Special Health Care Needs (CYSHCN) kicks off a campaign to improve the lives of children with special health care needs and their families through family-centered, community-based care.

Institute of Medicine (IOM) publishes *Future of Public Health* in 1988.

OBRA SSA amendments in 1989 — accountability of state programs increased.

After the Reagan administration created the Title V MCH Block Grant in 1981, state MCH leaders recognized the need for a stronger presence to represent their interests in our nation’s capital beyond the volunteer organization that was founded in the 1940s. In 1988 AMCHP established an office in Washington, DC under the direction of Catherine Hess. Over two decades that office has grown with support from the Maternal and Child Health Bureau, the Centers for Disease Control and Prevention, and private foundations, as well as contributions from its members. Today AMCHP provides leadership to states and territories to improve systems of health care for women, children and families, including those with special health care needs. We promote family-centered, culturally and linguistically competent, community-based systems of care for all families in the nation.
90s

Maternal and Child Health Bureau (MCHB) established in 1990 within HRSA to administer Title V and other MCH work federally.

Introduction of the Bright Futures program.

National Institute of Health (NIH) opens Office of Research on Women’s Health.

Healthy Start enacted.

CityMatCH formed.

Back to Sleep campaign launched to address SIDS.

1996 Welfare Reform enacted.

State Children’s Health Insurance Program (SCHIP) created in 1997 to help uninsured children.

A Life Course Approach to Chronic Disease Epidemiology published.

IDEA amendment passed.

Title V Information System (TVIS) established by MCHB in 1998.

First 3-D images of fetuses in womb.

Title V Information System (TVIS)

Currently online at https://perfdata.hrsa.gov/MCHB/TVISReports/default.aspx.

States annually report their Title V MCH Block Grant activities to the MCHB. These reports include qualitative and quantitative data related to state initiatives addressing health needs of women, infants and children. Prior to TVIS, the data were difficult to access or summarize in their paper form. MCHB developed TVIS to receive data from the states electronically, organize the data into summary tables and graphs, and make the data on maternal and child health from the 59 states and jurisdictions that receive Title V MCH Block Grant funds available to interested parties.
Oral Health in America: A Report of the Surgeon General calls for access to oral health care for all Americans, especially the disadvantaged and minority children found to be at greatest risk for severe medical complications resulting from minimal oral care and treatment.

The Program Assessment Rating Tool (PART) is developed in 2002 to help assess the management and performance of federal programs.

CDC publishes Recommendations to Improve Preconception Health and Healthcare in 2006.


SCHIP reauthorized in 2009.


CDC’s autism prevalence report concludes that the prevalence of autism had risen to 1 in every 110 births in the United States and almost 1 in 70 boys.

WIC changes to provide fresh produce and other healthier options to the women, infants and children served.

Social networking sites such as Facebook and MySpace offer new ways to share MCH information.

Text4baby, a free mobile service, is designed to promote maternal and child health.

State and territorial public health programs screen an estimated 4.1 million infants annually for genetic and metabolic disorders. Early detection of these abnormalities can prevent severe disability, intellectual disabilities or even death.
2010

Passage of the Patient Protection and Affordable Care Act (ACA) on March 23, 2010. The law includes numerous provisions to take effect over the next four years, including expanding Medicaid eligibility, subsidizing insurance premiums, providing incentives for businesses to provide health care benefits, prohibiting denial of coverage or claims based on pre-existing conditions, establishing health insurance exchanges, and support for a range of new preventive health services. ACA also created three new sections of the Title V legislation: Section 511 authorizes the Maternal, Infant, and Early Childhood Home Visiting program, Section 512 authorizes grants for Services for Individuals with Postpartum Conditions and Their Families, and section 513 authorizes the Personal Responsibility Education Grant Program. These new sections of Title V acknowledge the state and territorial leadership role in addressing pressing MCH problems and provide a vehicle for states and territories to link their existing MCH programs.

75th Anniversary of Title V Commemoration and Celebration in Washington, DC.

The Title V MCH Block Grant Today ... Leadership, Performance, Accountability

- Title V of the Social Security Act remains the only federal legislation that focuses solely on improving the health of all mothers and children.
- The Title V MCH Block Grant is a partnership with state and territorial MCH and CYSHCN programs, reaching across economic lines to support such core public health functions as resource development, capacity and systems building, population-based functions such as public information and education, knowledge development, outreach and program linkage, technical assistance to communities, and provider training.
- State and territorial MCH programs make a special effort to build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling, which complement and help ensure the success of state Medicaid and SCHIP medical assistance programs.
- Title V funds support programs for children and youth with special health needs to facilitate the development of family-centered, community-based, coordinated systems of care.
- The Title V MCH Block Grant-supported programs provide gap-filling prenatal health services to two million women and primary and preventive health care to more than 17 million children, including almost one million children and youth with special health needs.
- Special projects target underserved urban and rural areas with efforts at the community level that promote collaboration between public and private sectors, leaders, and health care providers.
- A new cadre of trained pediatric emergency specialists, more emergency equipment suited to the special needs of children are available, and protocols to ensure that more young lives can be saved in emergency situations are in place.46

![MCH Block Grant Appropriation 2003 to 2010](image-url)
Challenges and Opportunities

Much as the Great Depression dictated the essential need for maternal and child health services in the early 1900s, the economic climate of our nation one century later reinforces the critical need for state and territorial MCH programs. In October 2009, The Census Bureau estimated 47.4 million Americans to be living in poverty, which translates to one in six Americans.

Poverty is tied to serious health problems such as low birth weight, cardiovascular disease, hypertension, arthritis, diabetes and cancer.47 A study of socio-economic status (SES) and health revealed income to be directly linked to health status.48 SES also indicates the likelihood of contact with harmful agents in the environment, including lead, asbestos, carbon dioxide and industrial waste. A greater number of economically depressed neighborhoods are situated near highways, industrial areas, and toxic waste sites. Housing conditions are also poorer for low-SES families. Consequently, compared with high-income families, children and adults from poor families show a six-fold increase in rates of high blood lead levels.49

<table>
<thead>
<tr>
<th>10 Leading Causes of Death by Age Group, United States – 2007</th>
<th>AGE &lt;1</th>
<th>AGE 1-4</th>
<th>AGE 5-9</th>
<th>AGE 10-14</th>
<th>AGE 15-24</th>
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<tr>
<td>Congenital Anomalies</td>
<td>5,785</td>
<td>Unintentional Injury</td>
<td>1,588</td>
<td>Unintentional Injury</td>
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<td>Short Gestation</td>
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<td>Malignant Neoplasms</td>
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<td>SIDS</td>
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<td>Homicide</td>
<td>398</td>
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<td>Maternal Pregnancy Complications</td>
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<td>Malignant Neoplasms</td>
<td>364</td>
<td>Homicide</td>
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<td>Placenta Cord Membranes</td>
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<td>Influenza and Pneumonia</td>
<td>109</td>
<td>Chronic Lower Respiratory Disease</td>
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<td>Bacterial Sepsis</td>
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<td>Septicemia</td>
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<td>Influenza and Pneumonia</td>
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<td>Respiratory Distress</td>
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<td>Perinatal Period</td>
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<td>Chronic Lower Respiratory Disease</td>
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<td>Circulatory System Disease</td>
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<td>Benign Neoplasms</td>
<td>59</td>
<td>Influenza and Pneumonia</td>
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<td>Neonatal Hemorrhage</td>
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<td>Chronic Lower Respiratory Disease</td>
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<td>Cerebrovascular</td>
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<td>Sepicemia</td>
<td>36</td>
<td>Cerebrovascular</td>
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<td>Benign Neoplasms</td>
<td>43</td>
<td>Influenza and Pneumonia</td>
<td>163</td>
</tr>
</tbody>
</table>

*The three causes are: Complicated Pregnancy, HIV, Septicemia

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22 75 Years of State and Federal Partnership to Improve Maternal and Child Health
In the United States, unintentional injury, homicide and suicide are the first, second and fourth leading causes of death among persons aged 1-19 years, respectively; the highest rates have occurred among minority populations.\textsuperscript{51}

Most deaths among children and adolescents aged 5-19 years are from injury-related causes, including motor vehicle crashes. Highly associated with these injuries are certain adolescent behaviors such as physical fights, carrying weapons and not using seatbelts.\textsuperscript{52}

Obesity has become a major health concern. Nearly one in five youth between the ages of six and 19 is obese (BMI ≥ 95th percentile of the CDC growth chart).\textsuperscript{53} Childhood obesity has more than tripled in the past 30 years. The prevalence of obesity among children aged six to 11 years increased from 6.5 percent in 1980 to 19.6 percent in 2008. The prevalence of obesity among adolescents aged 12 to 19 years increased from 5.0 percent to 18.1 percent.\textsuperscript{54} Obesity is a major risk factor for cardiovascular disease, certain types of cancer and Type 2 Diabetes.\textsuperscript{55} In 2009, only Colorado and the District of Columbia had a prevalence of obesity less than 20 percent.\textsuperscript{56} Researchers examining the effect of obesity on longevity have concluded that the steady rise in life expectancy during the past two centuries may come to an end.\textsuperscript{57}

Unintentional injury was the leading cause of death for Kansas’ adolescents ages 15 to 19 in 2007 with motor vehicle crashes (MVC) causing the majority of deaths. The adolescent death rate due to motor vehicle crashes without using a seatbelt is 42 percent higher for Kansas (13.9 percent) than for the United States (9.8 percent). The Kansas 2007 Youth Risk Behavior Survey data showed that 15 percent of high school students never or rarely wore a seatbelt.

The Kansas Driving Force Campaign was created to decrease death and injury on Kansas roadways. The first step in the campaign was to raise awareness about the number of people being killed and injured on Kansas roadways. Kansas Department of Transportation (KDOT) Secretary Deb Miller, Kansas Highway Patrol (KHP) Col. William Seck, and Kansas Department of Health and Environment (KDHE) Secretary Roderick Bremby hosted community forums across the state to start a discussion with citizens, city/county officials, and legislators about their perspective on traffic crashes and the overall impact. The consensus was that this multi-faceted problem would require a strategic plan.

KDOT established the Kansas Traffic Safety Resource Office (KTSRO) to assist in reducing drinking drivers, promote prevention of underage alcohol consumption and enhance current safe driving activities. State MCH collaborates with KTSRO, KHP, local law enforcement, the Kansas Drivers Safety Education Association, American Automobile Association, Kansas Safe Kids, Students Against Destructive Decisions (SADD) and Family Health Partners to provide traffic safety education and to enhance laws protecting Kansas citizens from MVC injuries. This collaboration promoted legislation that resulted in a primary seatbelt law for those under the age of 18 and an upgraded graduated driver’s license law which included restrictions on wireless devices.
The rate of infant mortality in the United States declined by 74 percent between 1960 and 2000, but the degree of decline has slowed in the past decade. A report issued in 2008 by the CDC found that at least 28 other countries now have lower death rates for infants in the first year of life than the United States. Previously, the United States’ international ranking in infant mortality was 12th in 1960 and 23rd in 1990. Additionally, there are significant differences in infant mortality rates by race and ethnicity. Non-Hispanic black, American Indian or Alaska Native, and Puerto Rican women have the highest infant mortality rates; rates are lowest for Asian or Pacific Islander, Central and South American, and Cuban women.

Food insecurity and malnutrition, major concerns at the turn of the century, have been replaced by inactivity and obesity as detriments to the health of children in the United States. Clearly there are serious maternal and child health issues to be addressed in the United States today, and the struggle to overcome inequality in health status across socioeconomic lines remains. The Title V MCH Block Grant provides investment to states and territories to address these issues and improve health.

STATE SPOTLIGHT

Prevention of Child Abuse and Neglect

Becoming a parent for the first time is a learning experience, but the Kentucky Department for Public Health (DPH) has an innovative program proven to be an invaluable resource for new moms and dads.

Known as Kentucky’s Health Access Nurturing Development Services, HANDS provides home visitation for first-time families to help meet the challenges of parenting, beginning with pregnancy and continuing through the child’s first two years of life.

HANDS is modeled after Healthy Families and Healthy Start programs, which are used nationwide. Kentucky combined these approaches to integrate pieces of the social and medical concepts from each, creating a program that addresses such issues as low birth weight, pre-term infants, child abuse and neglect, domestic violence, underdeveloped parenting skills, teen pregnancy, financial difficulties, and substance abuse. Piloted in 1999, HANDS expanded to 15 counties in 2000 and was established in all of Kentucky’s 120 counties by the end of 2003. The program has worked with more than 40,000 families from inception to date.
Children’s Medical Services, Florida Department of Health

Children’s Medical Services (CMS) is designed to provide or assure the provision of a comprehensive set of programs and services along a continuum for children with special health care needs through a unique public/private partnership. The Title V MCH Block Grant supports some of its prevention programs including newborn screening, primary care through a medical home, transition initiatives, family resource specialists, and a significant quality measures and performance improvement system. CMS provides a variety of services for high risk expecting moms, newborn babies, infants and toddlers at risk for developmental delay, school-aged children and adolescents/young adults with special health care needs. Health and medical services are provided through a credentialed panel of private and academic sector providers, licensed hospitals and other facilities, and selected programs of excellence. The following programs are considered the hallmarks of the CMS program.

**Newborn Screening** – identification and follow-up for 35 conditions, including hearing impairments. This program has a return on investment of $5.40 for every $1 spent in Florida on newborn screening.

**Child Protection & Safety** – for infants, children and adolescents alleged to have been abused or neglected.

**Child & Family Information** – for families seeking information about parenting, family care and support, and overall well-being of their child or children.

**Early Intervention / Child Development** – for young children whose development is behind their peers and the families of those children. This program has a return on investment of $7 for every $1 spent on early intervention in Florida.

**The CMS Network** – a managed specialty plan under CHIP and Title XIX in Florida for children and youth with special health care needs. It offers a comprehensive benefit package for those children and services are delivered through integrated provider networks under contract with the CMS Program. It is consistently ranked as one of the highest performing health plans in Florida’s reform sites based on audited HEDIS measures and CAHPS surveys. Focus is on the child’s medical home.

**Pediatric Palliative Care - Partners Together in Care** – a program designed to offer palliative care services for children with life-limiting conditions. It was the first program to exist in the nation under a Medicaid waiver.
State and territorial MCH programs are at an important crossroads. We can look back on 75 years of what we have accomplished and be proud. In 2009, the Title V MCH Block Grant was rated as one of the most highly effective, well managed programs in the federal government, recognizing the accountability and leadership of state and territorial MCH programs and the state-federal MCH partnership.

The focus on performance standards and outcome measures has proven to be ahead of its time. The work of state and territorial MCH programs is innovative, creative and essential. The Title V MCH Block Grant gives states and territories flexibility with accountability for systemic approaches to improve health access and outcomes for ALL women, children, youth and families. The Title V MCH Block Grant has been dubbed the framework, the infrastructure and even the “glue” for states’ and territories’ overall strategies, policies and programs. Over the years, many strong points have evolved from the Title V MCH Block Grant: flexibility, adaptability, a broad mission focused on national health objectives, responsiveness to

The White House Office of Management & Budget’s PART review found that the Title V MCH Block Grant has a “positive impact." It has contributed to reductions in the infant mortality rate and increases in the percentage of pregnant women who receive prenatal care in the first trimester. The report also found that “the program has strong and effective collaborations with other groups concerned about MCH. The program collaborates with a wide range of federal, state, local and private-sector partners. Needs and priorities are identified, resources are leveraged, and linkages are forged to help the MCH population receive needed coordinated care and support services."61

Looking Forward: Shaping the Future

The Title V MCH Block Grant gives states and territories flexibility with accountability for systemic approaches to improve health access and outcomes for ALL women, children, youth and families. The Title V MCH Block Grant has been dubbed the framework, the infrastructure and even the “glue” for states’ and territories’ overall strategies, policies and programs. Over the years, many strong points have evolved from the Title V MCH Block Grant: flexibility, adaptability, a broad mission focused on national health objectives, responsiveness to
states’ and territories’ needs, and accountability for performance. While the dollars for the Title V MCH Block Grant may be a relatively small proportion of a state or territory’s total budget for family health programs, when used effectively they can have a big impact.

The Title V MCH Block Grant Improves the Health of America’s Women and Children by:

- **Supporting programs that work.** The White House Office of Management and Budget found that Title V MCH Block Grant-funded programs helped to decrease the infant mortality rate, prevent disabling conditions, increase the number of children immunized, increase access to care for uninsured children, and improve the overall health of mothers and children. Reduced funding threatens the ability of these programs to carry on this vital work.

- **Addressing the growing needs of women, children and families.** As states and territories face economic hardships and limits on their Medicaid and SCHIP programs, more women and children seek care and services through MCH-funded programs. Resources are needed to reduce infant mortality, provide mental health care to those in need, improve oral health care, reach more children and youth with special health care needs, and reduce racial disparities in health care.

- **Supporting health systems and leveraging other federal funding such as community health centers, Healthy Start, WIC, autism, SCHIP and Medicaid.** The Title V MCH Block Grant invests in needs assessments, planning and policy development, quality assurance and standards development, training, collection of health care data and analysis, and development of information systems that complement health care services and promote prevention for all populations. Close coordination with other health programs assures that funding is maximized and services are not duplicated.

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**Preventing for a Lifetime, It’s Everyone’s Responsibility**

Part of Oklahoma’s Infant Mortality Campaign, the information covered by the campaign includes what a couple needs to know before and after they become pregnant. You can access the tools for the initiative online at [www.ok.gov/health/Child_and_Family_Health/Improving_Infant_Outcomes/index.html](http://www.ok.gov/health/Child_and_Family_Health/Improving_Infant_Outcomes/index.html).

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**A Pathway to Healthy Pregnancy Booklet**

*Coming of the Blessing, a Pathway to a Healthy Pregnancy,* an informational booklet specific to both major tribes represented in Wyoming, is distributed to American Indian clients. Culturally sensitive information includes the role of the father during pregnancy and postpartum, the importance of preconception health, nutrition (including folic acid use), risk of substance use and domestic violence to birth outcomes, preterm labor signs and symptoms, and importance of prenatal care.
How Do We Address MCH Needs Today?

While the health of women and families has dramatically improved over the last 75 years, chronic diseases, environmental factors and health inequities threaten to erode America’s health status. The differences in infant mortality rates by race and ethnicity are stark reminders that we have far to go in our quest to assure the health and well-being of all women and children in this nation.

Those that led state and territorial MCH programs before faced similar hardships to those we are confronted with today head-on and laid a strong foundation for our current federal-state MCH partnership. Despite many political, social and economic challenges, the federal-state MCH partnership has survived, thrived and expanded to address some of the most urgent health needs of our country. Let us use the legacy of our MCH foremothers and forefathers to inspire our current work, and help us move forward to a healthier future.

Grace Abbott’s “Baby Carriage in Washington Traffic” Speech

Sometimes when I get home at night in Washington I feel as though I had been in a great traffic jam. In that traffic jam there are all the kinds of vehicles moving up toward the Capitol. There are all kinds of vehicles, for example, that the Army can put into the street — tanks, gun carriages, trucks, the dancing horses of officers, and others which I have not even the vocabulary to describe. They all finally reach the Hill and they make a plea that is a very old plea — one which I find in spite of the reputation for courage they bear, men respond to rather promptly. The Army says to them, “Give, lest you perish”; and fear as a motive is still producing results on a scale which leave the rest of us feeling very envious of the kind of eloquence the Army and Navy can command. But there are other kinds of vehicles in this traffic jam — great numbers of them which, coming from Nebraska as I do, do not seem to me to get the attention they should as they move down the street. There are the hayricks and the binders and the ploughs and all the other things that the Department of Agriculture manages to put in the streets. But when the drivers get to the hill they have an argument which Congressmen understand. They say to them when they ask for appropriations for research in animal husbandry, in the chemistry of soils, or in agricultural economies, “Dollars invested on this side of the ledger will bring dollars in geometrical or arithmetical progression”— depending on the enthusiasm with which they speak — on the other side. And, if there is one thing that a Congressman, and for that matter people in general understand, it is a balance on the profit side of the ledger. . . .

Then there are other vehicles. The handsome limousines in which the Department of Commerce rides . . . the barouches in which the Department of State rides with such dignity . . . the noisy patrols in which the Department of Justice officials sometimes appear. . . . Because the responsibility is mine and I must, I take a very firm hold on the handles of the baby carriage and I wheel it into the traffic. There are some people who think it does not belong there at all, there are some who wonder how I got there with it and what I think I am going to be able to do, and there are some who think the baby carriage is the symbol of bolshevism instead of the symbol of the home and the future of America.

Excerpt from U.S. Children’s Bureau Chief Grace Abbott’s speech in accepting an award from the National Institute of Social Sciences in 1931. Copy located in the U.S. Children’s Bureau Records, RG 102, National Archives, College Park, Maryland.
## Top State and Territorial MCH Needs Over The Past Ten Years

### Priorities That Saw an Increase, 2005 – 2010

<table>
<thead>
<tr>
<th>Category</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and youth with special health care needs</td>
<td>22 states</td>
<td>38 states</td>
<td></td>
</tr>
<tr>
<td>Health improvement or access to health care</td>
<td>36 states</td>
<td>43 states</td>
<td></td>
</tr>
<tr>
<td>Preconception or interconceptional care</td>
<td>3 states</td>
<td>13 states</td>
<td>28 states</td>
</tr>
<tr>
<td>Pregnancy outcomes</td>
<td>28 states</td>
<td>26 states</td>
<td>29 states</td>
</tr>
</tbody>
</table>

### Areas That Remained Constant, 2005 – 2010

<table>
<thead>
<tr>
<th>Category</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity and overweight</td>
<td>10 states</td>
<td>33 states</td>
<td>34 states</td>
</tr>
<tr>
<td>Nutrition/physical exercise</td>
<td>9 states</td>
<td>15 states</td>
<td>15 states</td>
</tr>
<tr>
<td>Mental health and mental health care</td>
<td>14 states</td>
<td>30 states</td>
<td>29 states</td>
</tr>
<tr>
<td>Injury prevention (includes suicide, child abuse, domestic violence)</td>
<td>41 states</td>
<td>33 states</td>
<td>33 states</td>
</tr>
<tr>
<td>Legal and illegal substance abuse</td>
<td>34 states</td>
<td>26 states</td>
<td>24 states</td>
</tr>
<tr>
<td>Surveillance, data collection, health information systems and MCH data issues</td>
<td>n/a</td>
<td>14 states</td>
<td>15 states</td>
</tr>
</tbody>
</table>

### Priorities That SAW a Decrease, 2005 – 2010

<table>
<thead>
<tr>
<th>Category</th>
<th>2000</th>
<th>2005</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical home/ Care coordination</td>
<td>17 states</td>
<td>28 states</td>
<td>24 states</td>
</tr>
<tr>
<td>Oral health or access to Oral health care</td>
<td>34 states</td>
<td>35 states</td>
<td>26 states</td>
</tr>
<tr>
<td>Pregnancy, fertility and birth rates</td>
<td>35 states</td>
<td>25 states</td>
<td>21 states</td>
</tr>
</tbody>
</table>

*2010 Data for 51 of 59 states and territories that provided needs assessment reports to AMCHP (October, 2010). All state and territorial assessments will be available via www.mchb.hrsa.gov in late 2010.
What Will The Title V MCH Block Grant Look Like 75 Years From Now?

With the historic expansion of health care services presented by the Affordable Care Act (ACA), more Americans will have access to health care services. Will this mean less need for state and territorial MCH programs to provide direct services? While we cannot predict the future, we know that even the most well-designed insurance package will leave gaps in benefits or limits in coverage, especially for CYSHCN. As more people access primary care, the need for enabling services may actually increase — and these are services not traditionally covered by most insurers or providers. The Title V MCH Block Grant has historically supported state and territorial efforts to connect with populations that need services and enroll them in health care plans. The Title V MCH Block Grant of the future will almost certainly play a role in both direct care and enabling services. The exact nature of that role remains to be seen as states and territories address the opportunities and challenges of implementing health insurance reform. Certainly the new section of the Title V legislation for the Maternal, Infant and Early Childhood Home Visiting Program asserts state and territorial leadership in coordinating home visitation services and signals the need for continued support for the Title V MCH Block Grant as this important program is implemented and evaluated.

We know that preventing disease saves lives and precious health care dollars. Population-based services, such as SIDS prevention, newborn screening, tobacco control, fluoridation and obesity prevention, will continue to be needed even if everyone has health care and access to a physician or other health care provider. State and territorial MCH programs currently support many population-based public health interventions. These activities will continue to be a part of state and territorial health care services.

STATE SPOTLIGHT

Child Passenger Safety Training

Connecticut has used Title V MCH Block Grant funding to develop child passenger safety (CPS) training for child care providers, child care health consultants, and the Department of Public Health’s child care licensing staff. The workshops cover CPS basics, state laws, and local resources so that child care professionals can provide accurate information to the families with which they work. The MCH program also offers booster seat distribution and education at child care programs serving low-income families (such as Head Start) and has run several classes titled “Safe Travel for All Children: Transporting Children with Special Health Care Needs.” These activities are conducted in cooperation with state and local Safe Kids coalitions.
agency efforts in the future. The ACA increased the resources available to states and territories to carryout prevention work and included a number of provisions that support state and territorial health agency programs that address the needs of women, children and families.

The Title V MCH Block Grant is the only federal program that supports a territory or state’s efforts to assess MCH needs, identify urgent MCH issues, and convene partners to address MCH challenges. While often unseen and underappreciated, the capacity-building aspects of the Title V MCH Block Grant-funded work are essential to its effectiveness and will no doubt be needed well into the future.

For these, and many other reasons, AMCHP anticipates the need for the Title V MCH Block Grant in the years to come. Will state and territorial MCH programs of the future be exactly the same as they are today? No. But Title V of today is not the same as it was 75 years ago, either.

As MCH leaders and Americans who care deeply about the health of women, children and families, let us use this celebration of Title V and all that it has done to re-commit ourselves to our shared goal of improved health for America’s most precious asset: our children, our mothers and our families.

### Change in Four Major Indicators of Health (rate per 100,000 people)

<table>
<thead>
<tr>
<th></th>
<th>THEN</th>
<th>NOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infant Mortality</strong></td>
<td>55.7 in 1935*</td>
<td>6.9 in 2009</td>
</tr>
<tr>
<td><strong>Maternal Death in Childbirth</strong></td>
<td>850 in 1900*</td>
<td>13.3 in 2006</td>
</tr>
<tr>
<td><strong>Childhood Obesity</strong></td>
<td>6.5 in 1980*</td>
<td>19.6 in 2008*</td>
</tr>
<tr>
<td><strong>Injury</strong></td>
<td>19.3 from 1980-85*</td>
<td>15.0 from 2000-2005*</td>
</tr>
</tbody>
</table>

*Percent of children aged 6-11 years

### Infant Mortality Task Force in Delaware

In conjunction with preliminary results from the State Infant Mortality Collaborative, an Infant Mortality Task Force assembled 20 recommendations aimed at reducing infant mortality (IM) in Delaware. The Delaware IM initiative, composed of a consortium of public health professionals, is fully endorsed and supported as a Governor’s initiative and thus receives state funds dedicated to research and intervention aimed at reducing infant mortality. The goal of the initiative is to reduce IM through collaborative research, program implementation and evaluation. Title V MCH Block Grant resources supported this critical state effort.

Since the initiative began in late 2005, the Delaware Division of Public Health (DPH) has implemented an evidence-based intervention during the prenatal and postpartum period for women considered high-risk (i.e., uninsured or underinsured, member of a minority, residing in a ZIP code identified as having a high proportion of infant deaths, living with a chronic disease, or experienced a previous poor birth outcome such as premature delivery, low birth weight delivery, stillbirth, fetal or infant death) providing supplemental care during pregnancy and up to two years postpartum for mothers and infants.

As of June 2008, the prenatal and postpartum program has served more than 4,000 pregnant women in Delaware. In a state that averages 11,226 births per year, the program impacted 23 percent of all live births. Of the number served, nine infant deaths occurred, much less than expected in this high-risk population. Similarly, the preconception program has served 19,663 in the first 16 months of operation, 11 percent of the population of women of childbearing age in Delaware.

www.dhss.delaware.gov/dhss/dph/pubs2.html
About AMCHP

The Association of Maternal and Child Health Programs is a national resource, partner and advocate for state public health leaders and others working to improve the health of women, children, youth and families, including those with special health care needs.

AMCHP’s members come from the highest levels of state government and include directors of maternal and child health programs, directors of programs for children with special health care needs, and other public health leaders who work with and support state maternal and child health programs. Our members directly serve all women and children nationwide, and strive to improve the health of all women, infants, children and adolescents, including those with special health care needs, by administering critical public health education and screening services, and coordinating preventive, primary and specialty care. Our membership also includes academic, advocacy and community based family health professionals, as well as families themselves.

AMCHP builds successful programs by disseminating best practices; advocating on their behalf in Washington; providing technical assistance; convening leaders to share experiences and ideas; and advising states about involving partners to reach our common goal of healthy children, healthy families, and healthy communities.
Endnotes

2 Oregon’s Use of Data to Create and Pass a State Policy. AMCHP. Retrieved September 15, 2010 from http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Archive/2008/July08/Pages/MoversShakers.aspx.
3 Movers & Shakers: Member Spotlight on Valerie Ricker, Director of Maine’s Family Health Division. AMCHP. Retrieved September 15, 2010 from http://www.amchp.org/AboutAMCHP/Newsletters/Pulse/Archive/2008/July08/Pages/SuccessStories.aspx.
Endnotes


39 Reproduction number: LC-USF34-9058-C (film negative). Caption: “Destitute peapickers in California; a 32 year old mother of seven children. February 1936.” (retouched version). Location: FSA/OWI - J339168 (the original photographic print has been replaced by a copy print) (Also available on microfilm and microfiche: Microfilm LOT 344; Chadywick-Healey Far West fiche #29:E11.)

40 Codman Square Health Center is part of the country’s first network of health centers. Image retrieved September 17, 2010 from http://www.bostonhistorycollaborative.org/bostoninnovation/community-health.htm.


43 The Child Abuse Prevention and Treatment Act (CAPTA) is one of the key pieces of legislation that guides child protection. CAPTA, in its original inception, was signed into law in 1974 (P.L. 93-247).


45 For more information on government program PART ratings, see www.ExpectMore.gov.


Appendices
Appendix A: Title V MCH Services Block Grant Performance Measures

Performance Measurement is Key to Improving Maternal & Child Health

As part of Title V MCH Block Grant requirements, all states and territories must report on key indicators of maternal and child health systems and program capacity: 18 national performance measures each year, on six national outcome measures every five years (optional in the interim years), nine health systems capacity indicators and 12 health status indicators.

The Title V Information System (TVIS) electronically captures data from annual Title V MCH Block Grant applications and reports submitted by all 59 states, territories and jurisdictions and provides information on key measures and indicators of maternal and child health in the United States.

More information is available online at https://perfdata.hrsa.gov/MCHB/TVISReports/default.aspx.

### 18 National Performance Measures

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

**PERFORMANCE MEASURE #2:** The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN Survey).

**PERFORMANCE MEASURE #3:** The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey).

**PERFORMANCE MEASURE #4:** The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey).

**PERFORMANCE MEASURE #5:** Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey).

**PERFORMANCE MEASURE #6:** The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.

**PERFORMANCE MEASURE #7:** Percent of 19 to 35 month olds who have received full schedule of age-appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B.

**PERFORMANCE MEASURE #8:** The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

**PERFORMANCE MEASURE #9:** Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

**PERFORMANCE MEASURE #10:** The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

**PERFORMANCE MEASURE #11:** The percent of mothers who breastfeeding their infants at 6 months of age.

**PERFORMANCE MEASURE #12:** Percentage of newborns who have been screened for hearing before hospital discharge.

**PERFORMANCE MEASURE #13:** Percent of children without health insurance.

**PERFORMANCE MEASURE #14:** Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
PERFORMANCE MEASURE #15: Percentage of women who smoke in the last three months of pregnancy.

PERFORMANCE MEASURE #16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

PERFORMANCE MEASURE #17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

PERFORMANCE MEASURE #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

National Outcome Measures

OUTCOME MEASURE #1: The infant mortality rate per 1,000 live births.

OUTCOME MEASURE #2: The ratio of the black infant mortality rate to the white infant mortality rate.

OUTCOME MEASURE #3: The neonatal mortality rate per 1,000 live births.

OUTCOME MEASURE #4: The post neonatal mortality rate per 1,000 live births.

OUTCOME MEASURE #5: The perinatal mortality rate per 1,000 live births plus fetal deaths.

OUTCOME MEASURE #6: The child death rate per 100,000 children aged 1 through 14.

Health Systems Capacity Indicators (HSCI)

HSCI 1: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

HSCI 2: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

HSCI 3: The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

HSCI 4: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

HSCI 7A: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.

HSCI 7B: The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

HSCI 8: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

Health Status Indicators (HSI)

HSI 1A: The percent of live births weighing less than 2,500 grams.

HSI 1B: The percent of live singleton births weighing less than 2,500 grams.

HSI 2A: The percent of live births weighing less than 1,500 grams.

HSI 2B: The percent of live singleton births weighing less than 1,500 grams.

HSI 3A: The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

HSI 3B: The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

HSI 3C: The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

HSI 4A: The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.

HSI 4B: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.

HSI 4C: The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

HSI 5A: The rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia.

HSI 5B: The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia.
Appendix B: State and Territorial MCH Program Workforce Development Survey Results, 2008

Seeking to better understand and address state and territorial MCH and CYSHCN workforce and leadership needs, the AMCHP and the Association of Teachers of Maternal and Child Health (ATMCH), with support from the Maternal and Child Health Bureau, surveyed state and territorial programs between May and August 2008. Programs in all 59 jurisdictions were requested to complete a web-based survey instrument to provide a national profile of the state programs’ components and functions, and indicate priority needs and preferred strategies with respect to workforce development. All 50 states and the District of Columbia provided at least one program response; of these, 49 MCH (96%) and 44 CYSHCN (86%) programs completed the survey. Four of the eight U.S. territories completed the survey.

Figure 1: Top 10 MCH Program Activity Areas
(n=49)

- MCH Surveillance (PRAMS, YRBS, Birth Defects Surveillance, etc.) 63%
- Birth Defects/Genetics 67%
- Newborn Hearing Screening 69%
- Infant Mortality Reduction (including Healthy Start) 71%
- Infant/Child Death Review 73%
- Women’s Health 78%
- Reproductive Health - including family planning (Title X) 82%
- MCH Epidemiology 86%
- Early Childhood 88%
- Adolescent Health 88%

Percent of State Programs
The figures below present preliminary descriptive data from selected portions of the survey. They provide a national level glimpse of the MCH and CYSHCN program areas, functions and leadership.

**Program Scope:** The activities that constitute state and territorial MCH programs vary across states and regions. In any given jurisdiction, the scope of program activities are configured to best address the population needs and resources in that state. State programs indicated the specific MCH and CYSHCN activity areas they administer. Most MCH programs administer adolescent health, early childhood, epidemiology, reproductive health (including family planning) and women’s health programs (Figure 1). The most frequently cited activity areas within CYSHCN programs are direct care, care coordination and financial assistance, medical home programs and transition programs (Figure 2).

All MCH programs in the territories oversee activities relating to adolescent health and birth defects/genetics. In addition, the majority administer newborn blood spot screening, reproductive health (including family planning) and women’s health activities.

### Figure 2: Top 10 CYSHCN Program Activity Areas (n=41)

<table>
<thead>
<tr>
<th>Activity Area</th>
<th>Percent of State Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Intervention – Part C IDEA</td>
<td>24%</td>
</tr>
<tr>
<td>Supplemental Security Income (SSI) Disabled Children’s Program</td>
<td>27%</td>
</tr>
<tr>
<td>Other</td>
<td>29%</td>
</tr>
<tr>
<td>Newborn Blood Spot Screening</td>
<td>41%</td>
</tr>
<tr>
<td>Birth Defects/Genetics</td>
<td>44%</td>
</tr>
<tr>
<td>Newborn Hearing Screening</td>
<td>49%</td>
</tr>
<tr>
<td>Transition Program</td>
<td>63%</td>
</tr>
<tr>
<td>Medical Home Program</td>
<td>68%</td>
</tr>
<tr>
<td>Program for Care Coordination and Financial Assistance</td>
<td>73%</td>
</tr>
<tr>
<td>Direct Care CYSHCN Program</td>
<td>78%</td>
</tr>
</tbody>
</table>

### Figure 3: Title V Program Functions

<table>
<thead>
<tr>
<th>Function</th>
<th>Percent of State Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-laboratory research/demonstration</td>
<td>12%</td>
</tr>
<tr>
<td>Workforce development</td>
<td>24%</td>
</tr>
<tr>
<td>Community mobilizing</td>
<td>20%</td>
</tr>
<tr>
<td>Surveillance</td>
<td>59%</td>
</tr>
<tr>
<td>Quality assurance/Protective legislation</td>
<td>63%</td>
</tr>
<tr>
<td>Public education about MCH/health</td>
<td>63%</td>
</tr>
<tr>
<td>Link clients with needed health care (Assure)</td>
<td>83%</td>
</tr>
<tr>
<td>Program evaluation</td>
<td>73%</td>
</tr>
<tr>
<td>Data collection and analysis</td>
<td>78%</td>
</tr>
<tr>
<td>Assessment, planning and policy</td>
<td>76%</td>
</tr>
<tr>
<td>Program management</td>
<td>88%</td>
</tr>
</tbody>
</table>

Four MCH directors provided combined responses for their state MCH and CYSHCN programs. As a result, information on specific activity areas, functions, leadership and staffing are not available for these CYSHCN programs.
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