MATERNAL AND CHILD HEALTH BUREAU
STRATEGIC PLAN: FY 2003 - 2007
(Updated: December 2003)

INTRODUCTION

The document that follows is divided into four main sections:

Part I: ***Overview of Maternal and Child Health Bureau*** – Mission Statement, History and Focus, MCH Partners, and Organizational Structure.

Part II: ***The Plan*** – Goals, Key Strategies, Performance Measures and Annual Priorities.

Part III: ***Conceptual Framework for the Plan –*** The MCHB Vision, MCHB Guiding Principles, MCH Health Services Pyramid, and Key Documents/Linkages.

Part IV: ***The Planning Cycle*** – Needs Assessment; Development of Goals, Key Strategies and Annual Priorities; Program and Resource Allocation; and Performance Measures and Evaluation.

Part I: OVERVIEW OF MATERNAL AND CHILD HEALTH BUREAU

Mission Statement

The mission of the Maternal and Child Health Bureau (MCHB) is to provide national leadership, in partnership with key stakeholders, to improve the physical and mental health, safety and well-being of the maternal and child health (MCH) population which includes all of the nation's women, infants, children, adolescents, and their families, including fathers and children with special health care needs.

MCHB History and Focus

With roots going back nearly a century, the Federal Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) has the primary responsibility for promoting and improving the health of our nation's women, children and families. This Federal commitment to addressing maternal and child health (MCH) can be traced first to the Children's Bureau (established in 1912) and then to Title V of the Social Security Act (enacted in 1935), which focuses on maternal and child health

services. Today, MCHB administers a broad range of programs that address the needs of the nation's MCH population[1], the largest of which is Title V, the Maternal and Child Health Services Block Grant, which includes State Formula Block Grants, Special Projects of Regional and National Significance (SPRANS) grants and Community Integrated Service Systems (CISS) grants.

Working with a wide range of public and private sector partners, MCHB provides both a framework and a focal point for MCH efforts at the national, State and local levels. Through the MCH Block Grant, the Bureau provides funds to every State and territory to support a statewide MCH program, including a program for children with special health care needs (CSHCN)[2]. The Bureau promotes and supports the development of family-centered, culturally/linguistically competent, community-based systems of care nationwide for CSHCN, and the entire MCH population. MCHB resources and programs are often directed to meet the particular developmental or societal needs of one or more of the target MCH population groups. In addition, MCHB funds are used to train MCH professionals; conduct research to improve MCH status and services; develop standards for MCH services; and build MCH/public health capacity for assessment, planning and quality assurance. Finally, MCHB funds are used to develop and support systems and programs that address specific health and safety issues such as: abstinence education, bioterrorism, emergency medical services for children, genetics, infant mortality, injury prevention, nutrition, oral health, poison control, traumatic brain injury, universal newborn screening and women's health.

MCH Partners

The Maternal and Child Health Bureau works with a wide range of public and private sector partners, including States, communities, professional associations, academic institutions, the research community, faith-based organizations, other organizations and agencies, providers and families. Bureau grantees are included among its MCH partners.

[1]See Appendix A for a listing of current programs administered by MCHB.

[2]Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Organizational Structure

The MCHB is directed by the HRSA Associate Administrator for Maternal and Child Health. In addition to the Office of the Associate Administrator, the Bureau includes the following offices and divisions[3] :

Office of Operations Management
Office of Program Development
Office of Data and Information Management
HRSA Office of Women's Health
HRSA Office of Adolescent Health
HRSA Office of Adolescent Health
Division of Perinatal Systems and Women's Health
Division of Child, Adolescent and Family Health
Division of Services for Children with Special Health Care Needs
Division of Research, Training and Education
Division of State and Community Health

[3]See Appendix B for MCHB organizational chart.

Part II: THE PLAN – GOALS, KEY STRATEGIES, PERFORMANCE MEASURES AND ANNUAL PRIORITIES

Goals for FY 2003 - 2007

In order to fulfill its mission, the Bureau has set the following five broad goals for FY 2003 - 2007:

Goal 1: ***Provide National Leadership for Maternal and Child Health***

Goal 2: ***Promote an Environment that Supports Maternal and Child Health***

Goal 3: ***Eliminate Health Barriers and Disparities***

Goal 4: ***Improve the Health Infrastructure and Systems of Care***

Goal 5: ***Assure Quality of Care***

Key Strategies: FY 2003 - 2007

The MCHB key strategies are the broad, cross-cutting approaches the Bureau uses in order to reach its five-year goals. Key strategies for FY 2003 - 2007 are listed below by goal:

Goal	Key Strategies
Goal 1 – Provide National Leadership for Maternal and Child Health	• Create a shared vision and goals for MCH. • Strengthen the MCH knowledge base and support scholarship within the MCH community. • Forge strong, collaborative, sustainable MCH partnerships both within and beyond the health sector. • Promote family leadership in MCH service delivery, evaluation and program/policy development. • Provide both graduate level and continuing education training to assure interdisciplinary MCH public health leadership nationwide.
Goal 2 – Promote an Environment that Supports Maternal and Child Health	• Using the best available evidence, develop and promote guidelines and practices to assure social, emotional and physical environment that supports the health and well-being of the MCH population. • Work with States and communities to plan and implement policies and programs to improve the social, emotional and physical environment.

Goal	Key Strategies
Goal 3 – Eliminate Health Barriers and Disparities	• Develop and promote health services and systems of care designed to eliminate disparities and barriers across the MCH population. • Train an MCH workforce that is culturally competent and reflects an increasingly diverse population.
Goal 4 – Improve the Health Infrastructure and Systems of Care	• Build analytic capacity for assessment, planning, and evaluation. • Using the best available evidence, develop and promote guidelines and practices that improve services and systems of care. • Assist States and communities to plan and develop comprehensive, integrated health service systems. • Work with States and communities to assure that services and systems of care reach targeted populations. • Work with States and communities to address selected issues within targeted populations.
Goal 5 – Assure Quality of Care	• Build analytic capacity to assess and assure quality of care. • Develop and promote health services and systems designed to improve quality of care. • Develop and promote health services and systems that assure appropriate follow-up services.

Performance Measures: FY 2003 - 2007

In keeping with its commitment to accountability and in accordance with the Government Performance Results Act (GPRA), the Bureau has developed performance measures as one means of tracking progress in meeting its five-year goals. These are not the only measures of the Bureau's success in designing and implementing effective strategies to improve maternal and child health; however, they do represent an important component of the Bureau's overall self-evaluation. See below for the MCHB performance measures for FY 2003 - 2007, listed with related goals, strategies, and targets through FY 2007.[4]

[4]For a fully annotated set of performance measures – including objectives, measures, target, definitions, Healthy People 2010 objective s (where applicable), data sources and significance – see the MCHB Website: www.mchb.hrsa.gov. .

MCHB PERFORMANCE MEASURES: FY 2003 – 2007

Goal 1: Provide National Leadership for Maternal and Child Health

Key Strategies	**Performance Measures**
A. Create a shared vision and goals for MCH.	• The percent of MCHB supported programs that are satisfied with the leadership of and services received from MCHB. *2002 Baseline: 73%. 2007 Target: 80%.* • The percent of MCHB customers (clients) of MCHB programs that are satisfied with services received from MCHB supported projects. *2007 Target: 80%.**
B. Strengthen the MCH knowledge base and support scholarship within the MCH community.	• The percent of completed MCHB supported projects publishing findings in peer-reviewed journals. *2007 Target: 5%.** • The number of publications, including peer-reviewed manuscripts, authored or co-authored by MCHB staff. *2002 Baseline: 4. 2007 Target: 8 per year.*
C. Forge strong, collaborative, sustainable MCH partnerships both within and beyond the health sector.	• The percent of MCHB supported projects that are sustained in the community after the federal grant project period is completed. *2007 Target: 50%.**
D. Promote family leadership in MCH service delivery, evaluation and program/policy development.	• The degree to which MCHB supported programs ensure family participation in program and policy activities. *2007 Target: Average score of 12 out of 18 total.** • The degree to which the State ensures family participation in program and policy activities in the State CSHCN program. *2001 Baseline: Average score of 12.6 out of 18 total. 2007 Target: Average score of 15 out of 18 total*.
E. Provide both graduate level and continuing education training to assure interdisciplinary MCH public health leadership nationwide.	• The percent of graduates of MCHB long-term training programs that demonstrate field leadership after graduation. *2007 Target: 70%.**

*New Indicator, no baseline

Goal 2: Promote an Environment that Supports Maternal and Child Health.

Key Strategies	**Performance Measures**
A. Using the best available evidence, develop and promote guidelines and practices to assure social, emotional and physical environment that supports the health and well-being of the MCH population.	• The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. *2001 Baseline: 3.87/100,000. 2007 Target: 3.0/100,000.* • The rate (per 100,000) of suicide deaths among youths aged 15 through 19. *2001 Baseline: 7.5/100,000 2007: Target: 7.5/100,000.*
B. Work with States and communities to plan and implement policies and programs to improve the social, emotional and physical environment.	• The degree to which States promote and protect the health and safety of children age 1 through 6 in child care settings. *2007 Target: Average score of 10 out of 15 total.** • The degree to which States have implemented injury and violence prevention activities. *2007 Target: Average score of 25 out of 36 total.**

*New Indicator, no baseline

Goal 3: Eliminate Health Barriers and Disparities

Key Strategies	**Performance Measures**
A. Develop and promote health services and systems of care designed to eliminate disparities and barriers across the MCH population.	• The degree to which MCHB supported programs have incorporated cultural competence elements into their policies, guidelines, contracts and training. *2007 Target: Average score of 55 out of 69 total.** • The percent of children under age 21 enrolled in Medicaid for at least 6 months continuously during the year who receive any preventive or treatment dental service. 2000 Baseline: 30%. *2007 Target: 50%.* • The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and sub-specialty services, including care coordination, not otherwise accessible or affordable to its clients. *2001 Baseline: Average score 8.19 out of 23 total. 2007 Target: Average score of 12 out of 23 total.* • Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care. *2001 Baseline: 88.2%. 2007 Target: 90%.* • Percent of children without health insurance. *2001 Baseline: 13.06%. 2007 Target: 10%.* • Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. *2001 Baseline: 77.34%. 2007 Target: 85%.* • The degree to which grantees assist families of children with special health needs to partner in decision making and be satisfied with services they receive. *2007 Target: Average score of 100 out of 125 total.**
B. Train an MCH workforce that is culturally competent and reflects an increasingly diverse population.	• The degree to which MCHB long-term training grantees include cultural competency in their curricula/training. *2007 Target: Average score of 21 out of 27 total.** • The percent of participants in MCHB long-term training programs who are from under-represented groups. *2007 Target: 20%. **

*New Indicator, no baseline

Goal 4: Improve the Health Infrastructure and Systems of Care

Key Strategies	**Performance Measures**
A. Build analytic capacity for assessment, planning, and evaluation.	• The degree to which States electronically link vital statistics data sets, Medicaid, and other health information systems data sets. *2007 Target: Average score of 19 out of 32 total.** • The degree to which grantees electronically link vital statistics data sets, Medicaid, and other health information systems data sets. *2007 Target: Average score of 58 out of 72 total.** • The degree to which MCHB supported programs facilitate health providers' screening of women participants for risk factors. *2007 Target: Average score of 47 out of 72 total.**
B. Using the best available evidence, develop and promote guidelines and practices that improve services and systems of care.	• The percent of States with pediatric guidelines for acute care facilities to provide emergency and critical care. *2001 Baseline: 73%. 2007 Target: 80%.* • The degree to which a State system for nutrition services has been established for MCH populations. *2007 Target: Average score of 19 out of 24 total.** • The number of States that include in their oral health plans at least 5 of the 10 essential elements of the guidelines included in ASTDD's "Building Infrastructure & Capacity in State and Territorial Oral Health Programs." *2000 Baseline: 20 State and Territories. 2007 Target: 37 States and Territories.*
C. Assist States and communities to plan and develop comprehensive, integrated health service systems.	• The degree to which States and Communities have implemented comprehensive systems for women's health services. *2007 Target: Average score of 22 out of 28 total.** • The degree to which grantees have assisted States in organizing community-based service systems so that families of children with special health care needs can use them easily. *2007 Target: Average score of 9 out of 21 total.** • The degree to which States have developed a comprehensive adolescent health strategic planning process. *2007 Target: Average score of 50 out of a combined total score of 63.** • The degree to which State agencies work collaboratively to develop a Plan for building early childhood service systems. *2007 Target: Average score of 19 out of 24 total.**

*New Indicator, no baseline

Goal 4: Improve the Health Infrastructure and Systems of Care

Key Strategies	**Performance Measures**
D. Work with States and communities to assure that services and systems of care reach targeted populations.	• The percent of pregnant participants of MCHB supported programs who have a prenatal care visit in the first trimester of pregnancy. *2007 Target: 80%.* • The degree to which grantees have assisted States in increasing the percentage of youth with special health care needs who have received services necessary to make transitions to all aspects of adult life, including adult health care, work and independence. *2007 Target: Average score of 7 out of 9 total.** • 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. *2001 Baseline: 24.68%. 2007 Target: 50%.* • Percent of newborns in the State with at least one screening for each of the following: PKU, hypothyroidism, galactosemia, hemoglobinopathies [(e.g. the sickle cell diseases) (combined)] *2001 Baseline: 99.27%. 2007 Target: 99.5%.* • Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B. *2001 Baseline: 76.84% . 2007 Target: 85%.* • Percent of third grade children who have received protective sealants on at least one permanent molar tooth. *2001 Baseline: 25.12%. 2007 Target: 35%.* • Percentage of mothers who breastfeed their infants at hospital discharge. *2001 Baseline: 59.32%. 2007 Target: 75%.* • Percentage of newborns who have been screened for hearing impairment before hospital discharge. *2001 Baseline: 63.54%. 2007 Target: 80%.* • Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. *2001 Baseline: 73.83%. 2007 Target: 85%.* • Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. *2001 Baseline: 81.34%. 2007 Target: 85%.*
E. Work with States and communities to address selected issues within targeted populations	• The rate of birth (per 1,000) for teenagers aged 15 through 17 years. *2001 Baseline: 27.28/100,000. 2007 Target: 25/1,000* • Percent of very low birth weight live births. *2001 Baseline: 1.46%. 2007 Target: 1.35%.*

*New Indicator, no baseline

Goal 5: Assure Quality of Care

Key Strategies	**Performance Measures**
A. Build analytic capacity to assess and assure quality of care.	• The percent of States that have MCH staff who perform specific epidemiological activities and other MCH evaluations and analyses. 2002 Baseline: 80%. *2007 Target: 90%.* • The degree to which States and communities use "morbidity/mortality" review processes in MCH needs assessment, quality improvement, and/or data capacity building. *2007 Target: Average score of 3 out of 9 total.**
B. Develop and promote health services and systems designed to improve quality of care.	• 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 needed services. *2007 Target: Estimated 80%.* • The degree to which grantees have assisted States in increasing 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 needed services. *2007 Target: Average score of 14 out of 18 total.** • The percent of all children from birth to age 18 participating in MCHB supported programs who have a medical home. *2007 Target: 80% .** • The percent of children with special health care needs age 0 through 18 who receive coordinated, ongoing, comprehensive care within a medical home. *2007 Target: 80%* • The degree to which grantees have assisted States in increasing the percent of children with special health care needs age 0 through 18 who receive coordinated, ongoing, comprehensive care within a medical home. *2007 Target: Average score of 12 out of 15 total** • The percent of women participating in MCHB supported programs who have an ongoing source of primary and preventive care services for women. *2007 Target: 80%** • The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home". *2001 Baseline: 56.37% 2007 Target: 75%.*
C. Develop and promote health services and systems that assure appropriate follow-up services.	• The number of women participating in MCHB supported programs requiring a referral, who receive a completed referral. *2007 Target: 80%.* • The degree to which grantees have assisted States in increasing the percentage of children who are screened early and continuously for special health care needs and linked to medical homes, appropriate follow-up, and early interventions. *2007 Target: Average score of 14 out of 18 total.** • The percent of program participants who successfully complete or remain enrolled in an MCHB supported abstinence-only program. *2007 Target: 80%.**

*New Indicator, no baseline

PART III: CONCEPTUAL FRAMEWORK FOR THE PLAN

The MCHB Vision

MCHB believes in and strives to shape a future America in which:

- All children are wanted, nurtured and provided the assistance they need to mature into healthy, productive adults.
- Women's health, safety and well-being throughout the life cycle are a priority.
- Families and individuals, young and old alike, are engaged in health promoting activities that are supported at the community level.
- The right to achieve one's full potential is universally assured through attention to the comprehensive physical, biological, intellectual, emotional and social needs of the MCH population.
- There is equal access for all to comprehensive, quality health care provided in a supportive, culturally competent environment, which is family-centered and community-based.
- All women and children, especially children with special health care needs, are linked to a comprehensive, community-based service system through a medical home.
- Health disparities by racial, ethnic, geographic area and economic status have been eliminated.
- MCH/public health agencies exemplify the highest standards of excellence: building systems of care grounded in the best available knowledge, developing essential public health capacities and competencies in the service of the MCH population; employing a highly qualified, diverse workforce; and providing a respectful and supportive work environment.
- Society recognizes and fully supports the important role that public health plays in promoting the health of the MCH population, including building, strengthening and assuring MCH health services and infrastructure at all levels.

MCHB Guiding Principles

The following principles guide the work of the Bureau and the development and implementation of its strategic plan:

Principles for MCHB Leadership Roles and Responsibilities

- Leadership, performance and accountability form the basis for the Bureau's approach to doing business.
- Effective leadership requires collaborative partnership as well as excellent communication among key stakeholders.
- In accordance with the Government Performance and Results Act (GPRA), and as part of its national leadership role, the Bureau maintains high expectations for performance and holds itself, its grantees and other partners accountable for the use of MCHB resources.
- Evaluation is an essential tool for program management: evaluations provide the information needed to assess impact, strengthen programs and make sound decisions about future allocation of resources.
- Promoting and maintaining a respectful, supportive work environment is key to successful performance.

Principles for the Organization of MCH Systems and Services

- In order to assure the health of the nation, it is necessary to build and maintain a public health infrastructure and a highly competent public health workforce, with the capacity to monitor, assess and address changing health needs across the population in a timely and effective manner.
- The health, safety and well-being of the MCH population is best assured when there is an MCH/family health focus within health systems and services.
- Family and community participation and engagement are key to the development of effective, quality health systems and services.
- Women, infants, children, adolescents and children with special health care needs each present unique developmental or life cycle needs and opportunities that must be recognized and addressed by health systems and services.
- Health systems and services should be sensitive to the unique gender, race, age and cultural contexts of women, children and their families.

- Health systems should include a full array of services including, among others, mental, nutritional and oral health services.

- Health systems and services should be scientifically-based.

- Health systems and services should work closely with partners both within and beyond the health sector, to assure that the broader environment in which children and families live and develop is supportive and nurturing.

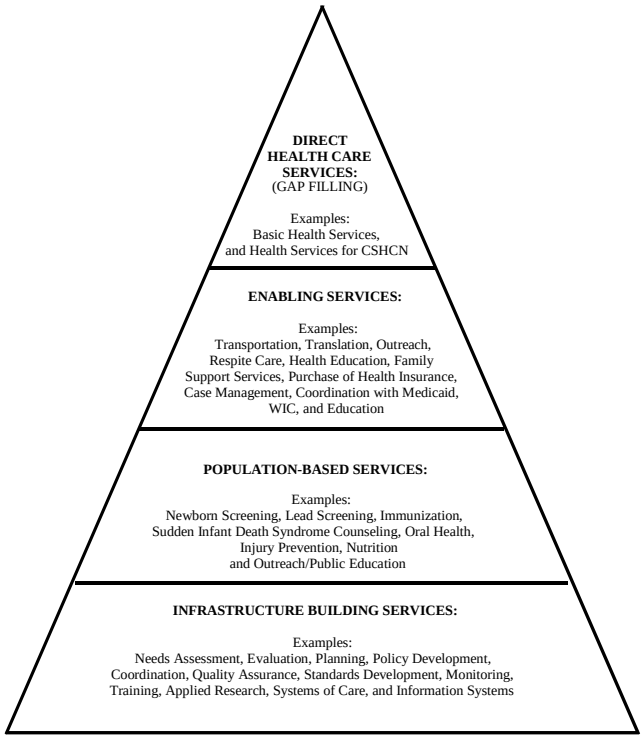
- Health systems and services can best reach and serve our increasingly diverse MCH population by providing community-based, culturally competent care delivered by a highly qualified, interdisciplinary and culturally diverse workforce that is sensitive to those with special needs.

- Health systems and services need to address societal and community risk factors in addition to individual factors affecting health.

MCH Health Services Pyramid

MCHB uses the construct of a pyramid to describe the four levels of core public health services for the MCH population. Starting at the base, these are: (1) infrastructure building services, (2) population-based services, (3) enabling services, and (4) direct health care (gap-filling) services. Infrastructure-building and population-based services provide the broad foundation upon which enabling and direct care services rest. (See Figure below) The MCH health services pyramid provides a useful framework for understanding programmatic directions and resource allocation by the Bureau and its partners as they work collaboratively to carry out the MCHB mission and accomplish the MCHB goals.

CORE PUBLIC HEALTH SERVICES
DELIVERED BY MCH AGENCIES



Key Documents/Linkages

The plan is informed by and linked to a wide range of documents. Among the key documents that are essential to the plan's development are the following:

Healthy People 2010 Objectives
Ten Year Action Plan for CSHCN and their Families
DHHS Strategic Plan
HRSA Strategic Plan
MCHB Division and Office Strategic Plans
State Title V Performance Measures
Draft Performance Measures for MCHB Discretionary Grants
Title V Information System (www.mchdata.net)
MCH Partners' Strategic Plans

PART IV: THE PLANNING CYCLE

While MCHB develops a new Strategic Plan once every five years, the planning cycle is ongoing and iterative and includes the following components:

Needs Assessment

The Bureau reviews available data, documents, and program evaluations; identifies national, State and local MCH issues and concerns; and consults with MCH partners on a regular basis to assess assets and needs related to the MCH population and to MCH/public health infrastructure and service systems. In addition, every five years in preparation for developing a new plan, the Bureau explicitly solicits feedback on strategic planning directions from its many MCH partners.

Development of Goals, Key Strategies and Annual Priorities

Every five years, the Bureau reviews and revises its broad goals. The new goals are based on findings from the Bureau's needs assessments and environmental scans, and are consistent with the overall direction and goals of HRSA, and DHHS. The key strategies describe the broad, cross-cutting approaches by which the Bureau will reach its goals. In order to address emerging issues and to highlight priority activities and issues for each year, the Bureau also develops a short list of annual priorities for its work. Together, the goals, key strategies and annual priorities inform MCHB's resource allocation.

Program and Resource Allocation

Bureau goals, key strategies and annual priorities are operationalized by MCHB's divisions and offices, which work with the Associate Administrator to determine specific programmatic priorities, allocate resources and oversee implementation of programs and policies. The Bureau's policy and program priorities encompass a wide range of health conditions and issues: some are specific to an age or population group, while others cut across populations. The priorities are implemented through the Bureau's State Block Grants, discretionary grant programs and special initiatives.

Performance Measurement and Evaluation

MCHB uses performance measurement and program evaluation to assess progress in attaining goals, implementing strategies and addressing priorities. Bureau performance measures are keyed to the MCHB strategic goals. Each Bureau performance measure has six major components: five-year objectives, measures to be used, definition of the measures, relevant Healthy People 2010 objectives (where applicable), data source and significance. The MCHB performance measures are a "work in progress" – reflecting various developmental stages in measurement and availability of data.[5] Bureau evaluation activities focus on specific programmatic priorities and are guided by an internal Bureau Evaluation Coordinating Committee. Evaluation is critical to MCHB policy and program development, program management and funding. Findings from program evaluations and performance measurement become part of the ongoing needs assessment activities of the Bureau. Thus, the planning cycle begins again.

[5] See Appendix D for a description of the criteria used in selecting MCHB performance measures.

APPENDIX A

CURRENT PROGRAMS ADMINISTERED BY MCHB

Over the years, the Federal commitment to maternal and child health has broadened to meet new needs, so that the Maternal and Child Health Bureau now administers ten major programs funded largely by Congress. In FY2002, these programs had a total Federal budget of more than $1.1 billion, including the following:

(1) ***Maternal and Child Health Services Block Grant*** – Title V, Social Security Act (includes SPRANS, CISS and State Formula Grants);

(2) ***Healthy Start Initiative*** – Section 330H, Public Health Service Act;

(3) ***Universal Newborn Hearing Screening*** – Section 399M, Public Health Service Act;

(4) ***Abstinence Education Program*** – Section 510, Title V, Social Security Act;

(5) ***Community-Based Abstinence Education Program*** – Section 501(a)(2), Title V, Social Security Act, and the Appropriations Act for the Departments of Labor, Health and Human Services, Education and Related Agencies;

(6) ***Traumatic Brain Injury*** – Section 1252, Public Health Service Act;

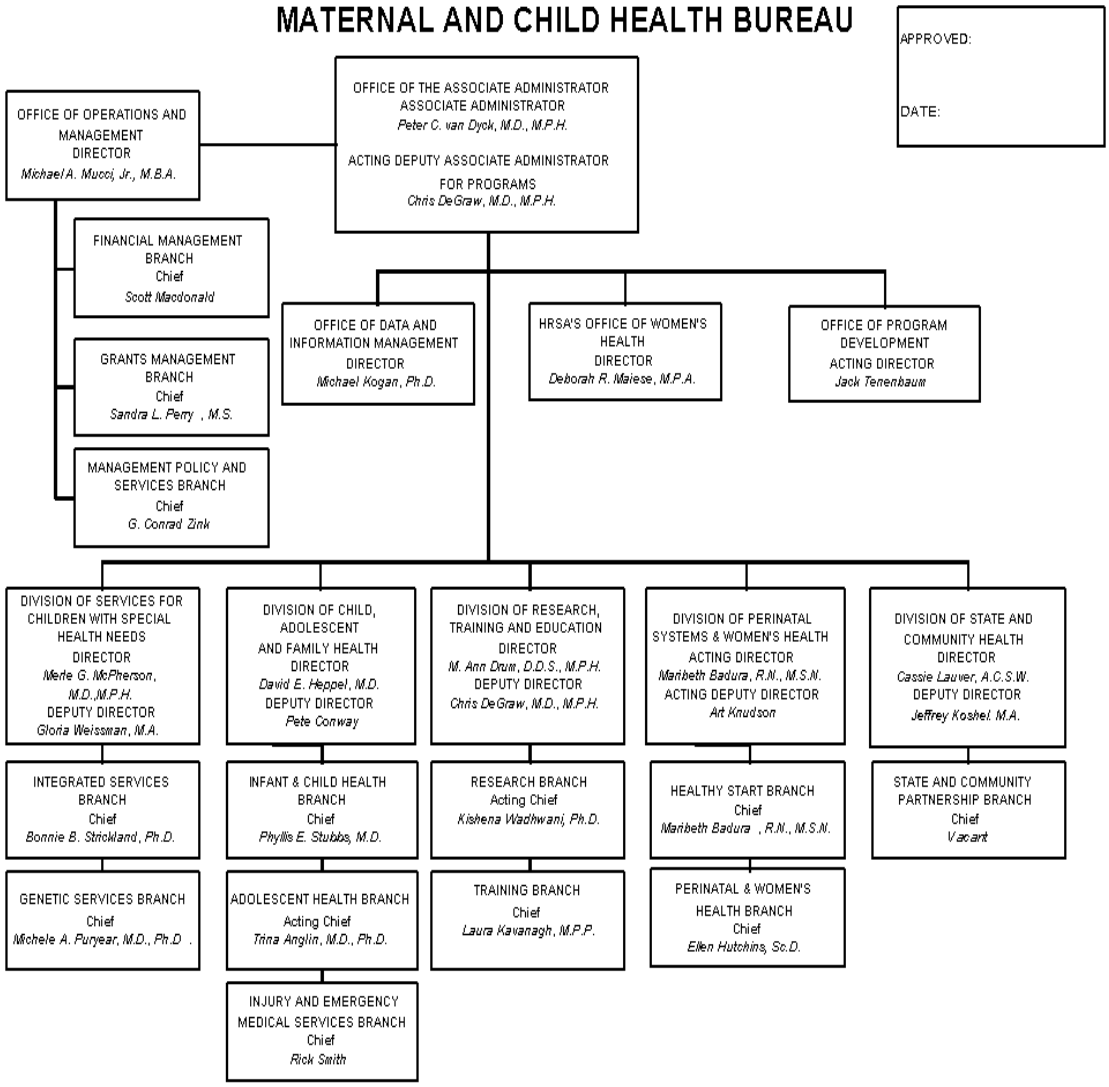
(7) ***Emergency Medical Services for Children Program*** – Section 1910, Public Health Service Act;

(8) ***Poison Control Centers Program*** – Poison Control Center Enhancement and Awareness Act;

(9) ***Trauma/Emergency Medical Services*** – Section 1232, Public Health Service Act; and

(10) ***Hospital Preparedness (Bioterrorism)*** – Section 319, Public Health Service Act.

APPENDIX B
MCHB ORGANIZATIONAL CHART



MCHB ORGANIZATIONAL CHART DESCRIPTION

Organization Chart for the Maternal and Child Health Bureau, in the Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services

Office of the Associate Administrator
Associate Administrator
Peter C. van Dyck, M.D., M.P.H.

Deputy Associate Administrator
Steven Pelovitz. J.D.

4 Offices and 5 Divisions report directly to the Office of the Associate Administrator:

- HRSA's Office of Women's Health
  Acting Director
  Sabrina Matoff, M.A.
- Office of Operations and Management
  Director
  Michael A Mucci, Jr., M.B.A.
- Office of Data and Information Management
  Director
  Michael Kogan, Ph.D.
- Office of Program Development
  Acting Director
  Jack Tenenbaum
- Division of Services for Children with Special Health Needs
  Director
  Merle G. McPherson, M.D., M.P.H.
  Deputy Director
  Vacant
- Division of Child, Adolescent, and Family Health
  Director
  David E. Heppel, M.D.
  Deputy Director
  Pete Conway
- Division of Research, Training, and Education
  Director
  M. Ann Drum, D.D.S., M.P.H.
  Deputy Director
  Chris DeGraw, M.D., M.P.H.
- Division of Perinatal Systems & Women's Health

Acting Director
Maribeth Badura, R.N., M.S.N.
Acting Deputy Director
Art Knudson

- Division of State and Community Health
  Director
  Cassie Lauver, A.C.S.W.
  Deputy Director
  Jeffery Koshel, M.A.

2 Branches report directly to the Office of Operations and Management:

- Financial Management Branch
  Chief
  Scott Macdonald
- Management Policy and Services Branch
  Chief
  G. Conrad Zink

2 Branches report directly to the Division of Services for Children with Special Health Needs:

- Integrated Services Branch
  Chief
  Bonnie B. Strickland, Ph.D.
- Genetic Services Branch
  Chief
  Michele A. Puryear, M.D., Ph.D.

3 Branches report directly to the Division of Child, Adolescent, and Family Health:

- Infant & Child Health Branch
  Chief
  Phyllis E. Stubbs, M.D.
- Adolescent Health Branch
  Chief
  Trina Anglin, M.D., Ph.D.
- Injury and Emergency Medical Services Branch
  Chief
  Vacant

2 Branches report directly to the Division of Research, Training, and Education:

- Research Branch

Chief
Vacant

- Training Branch
  Chief
  Laura Kavanagh, M.P.P.

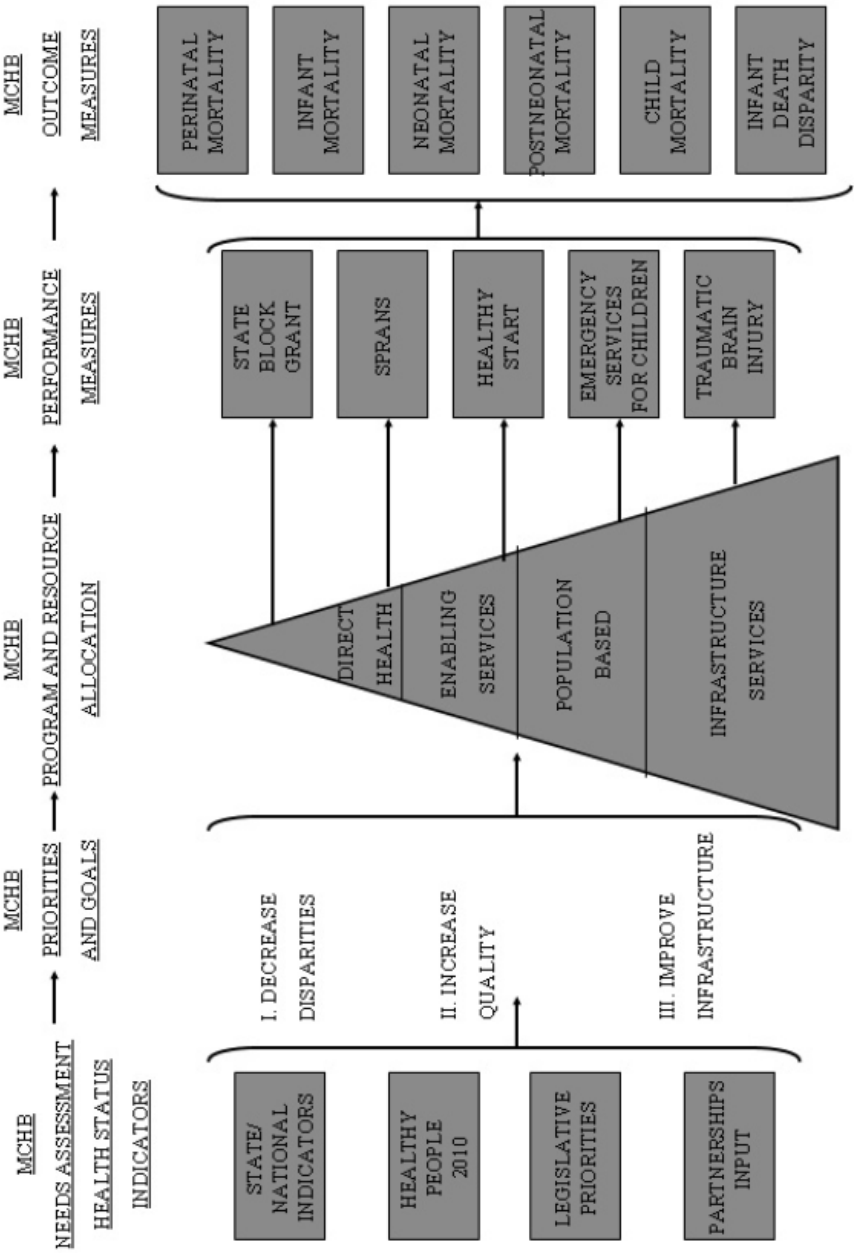
2 Branches report directly to the Division of Perinatal Systems & Women's Health:

- Healthy Start Branch
  Chief
  Maribeth Badura, R.N., M.S.N.
- Perinatal & Women's Health Branch
  Chief
  Ellen Hutchins, Sc.D.

1 Branch report directly to the Division of State and Community Health:

- State and Community Partnership Branch
  Chief
  Vacant

APPENDIX C
SCHEMATIC OF MCHB PLANNING CYCLE



SCHEMATIC OF MCHB PLANNING CYCLE DESCRIPTION

The MCHB planning cycle includes the following five components:

1. **MCHB Needs Assessment Health Status Indicators**
   The MCHB needs assessment and health status indicators are developed through state national indicators, Healthy People 2010 goals, legislative priorities, and partnership input.
2. **MCHB Priorities and Goals**
   The MCHB Priorities and Goals include 1) decrease disparities; 2) increase quality; and 3) improve infrastructure.
3. **MCHB Program and Resource Allocation**
   The MCHB Program and resource allocation are operationalized by the MCHB Pyramid. The pyramid consists of four levels of service and funding that build upon each other and provide comprehensive coverage. The collective effort of all States, in all levels of the pyramid, contributes to the national health of mothers and children.
4. **MCHB Performance Measures**
   MCHB uses performance measurement and program evaluation to assess progress in attaining goals, implementing strategies and addressing priorities. The five areas measured are: 1) State Block Grant; 2) Special Projects of Regional and National Significance (SPRANS); 3) Healthy Start; 4) Emergency Services for Children; 5) Traumatic Brain Injury
5. **MCHB Outcome Measures**
   The MCHB outcome measures are the following: 1) perinatal mortality; 2) infant mortality; 3) neonatal mortality; 4) postneonatal mortality; 5) child mortality; and 6) infant death disparity.

Performance Measurement and Evaluation

MCHB uses performance measurement and program evaluation to assess progress in attaining goals, implementing strategies and addressing priorities. Bureau performance measures are keyed to the MCHB strategic goals. Each Bureau performance measure has six major components: five-year objectives, measures to be used, definition of the measures, relevant Healthy People 2010 objectives (where applicable), data source and significance. The MCHB performance measures are a "work in progress" – reflecting various developmental stages in measurement and availability of data.[5] Bureau evaluation activities focus on specific programmatic priorities and are guided by an internal Bureau Evaluation Coordinating Committee. Evaluation is critical to MCHB policy and program development, program management and funding. Findings from program evaluations and performance measurement become part of the ongoing needs assessment activities of the Bureau. Thus, the planning cycle begins again.

APPENDIX D

SELECTION CRITERIA FOR MCHB PERFORMANCE MEASURES

The Bureau recognizes that performance measures have some inherent limitations: (1) they may often highlight the priorities that best lend themselves to direct measurement; (2) some are still in the developmental stage, particularly with regard to complex, community-based interventions; and (3) the full impact of MCHB efforts can never be captured by a single set of performance measures and related indicators.

With the above caveats in mind, the Bureau has used the following criteria in selecting performance measures:

- The measure should be relevant to major MCHB priorities, activities, programs and dollars.
- The measure should be important and understandable to MCH partners, policy makers and the public.
- Data for the measure should generally be available.
- There should be a logical link between the measure and the desired outcome.
- It should be reasonable to expect measurable change in the indicator within five years or less.
- Consideration should be given to the magnitude of the problem and the feasibility of improving performance related to the measure.
- Special consideration should be given to measures that are prevention focused.