Federal Update: MCHB

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Introduction & Background
I'm very pleased to be here to share information about the Maternal and Child Health Bureau (MCHB) and its overall goals/strategic plan and, more specifically, about some of the bureau's nutrition activities.

Leadership, performance and accountability. Three words we feel very strongly about in the bureau and try to describe what we're doing within the context of these words. Effective leadership requires collaborative partnerships and excellent communication. We try to maintain high expectations for performance and hold ourselves as well as our grantees and other partners accountable. We feel evaluation is an essential tool for management, and hopefully that will help us guide resources; make good allocations and decisions. Promoting and maintaining a respectful and supportive work environment is key to successful performance.

The MCH Population
What is the Maternal and Child Health (MCH) population? It's not just moms and kids anymore, despite being called the Maternal & Child Health Bureau. We really do serve all America's women, infants, children, adolescents and their families, including women of reproductive age, fathers, and children with special health care needs. We are continually receiving new programs that serve people beyond a traditional maternal and child health age. For example, we have strong programs that transition children with special healthcare needs into adult programs. We do a lot of work in genetics. We have bio-terrorism programs that serve older folks. So we are an expansive bureau that has developed strategic plan principles you will see in our new five-year strategic plan.

MCHB Strategic Plan
We do have a strategic plan/mission. This is to provide national leadership and to work in partnership with states, communities, public/private partners and families. Our new strategic plan has four goals; (1) to provide national leadership for maternal and child health by creating a shared vision and goals for MCH, informing the public about MCH needs and issues, modeling new approaches to strengthen MCH, forging strong collaborative partnerships and fostering a respectful environment that supports creativity, action and accountability for MCH issues; (2) to eliminate health disparities; (3) to assure the highest quality of care by using evidence-based research, translating research into practice and having a well-trained culturally diverse workforce; and (4) to facilitate access to care through the development and improvement of the MCH infrastructure and systems of care.

MCHB Service Pyramid
MCHB describes its services in the shape of a pyramid. Direct healthcare is at the top of the pyramid. Enabling services, which refers to transportation, translation, health education, coordination and care coordination is the second layer down.

Population-based services, which includes, lead screening, nutrition screening, immunization, and injury prevention is the third layer down. And infrastructure resources and capacity building which includes evaluation, planning, policy and standards development, monitoring and training is the fourth layer.

We like to say that the maternal and child health program is the only program that deliberately and intentionally delivers services at all layers of this pyramid at a local, state and national level. There are some Medicaid programs that do provide some good direct and/or enabling services like immunizations, the new Children's Health Insurance Program (S-CHIP), and Early and Periodic Screening, Detection and Treatment (EPSDT) but these are not infrastructures of care. Gaps still exist in service delivery for children with special healthcare needs and paying for nutrition services is another example.

MCHB Budget FY 2002

MCHB's budget was increased from 714 million dollars to 732 million in the MCH block grant. The block grant is made up of two programs. Eighty-five percent of this budget (582 million) goes to state-run MCH programs on a state block grant formula (the number of poor children in a particular state as a percent of all children in the nation). That state figure has increased from 582 to 596 million.

Special Projects of Regional and National Significance (SPRANS) funds about 1,000 grants focused on furthering the aims of maternal and child health at all levels and in different geographic regions. Recipients of these grants include hospitals, institutions, universities, states, communities and some special projects. The SPRANS program also received an increase from 102 to 106 million dollars.

In addition to the maternal and child health block grant, the bureau runs other programs. Funding for the Healthy Start program whose goal is to reduce infant mortality in 100 cities or communities across the nation, increased significantly. Funding for the Newborn Hearing Screening program which attempts to provide hearing screening to every newborn in each state, increased from zero in 2000 to 8 million dollars in 2001 to 10 million in 2002. We have now increased our hearing screening rates for newborns from 37% to about 70% and hope it will go to about 90% next year. The Emergency Medical Services for Children program, EMSC is the only national program that provides for equipment, training, guidance and direction specifically for child-based emergencies.

Funding for the Abstinence Education program increased from 20 to 40 million dollars, and will increase to 73 million next year. The Abstinence Education state program will receive 50 million dollars. Funding for bio-terrorism increased from zero to 135 million dollars, going to 235 million next year. Tommy Thompson announced the grants last week and funds were made available to states. State health departments receive the funds directly, subsequently contracting with local hospitals to increase hospital preparedness. Jurisdiction of funds for bioterrorism was given to MCHB partly due to the bureau's experience working with states. This has allowed MCHB to require or mandate the bioterrorism program to link into many of MCHB's programs such as EMSC Poison Control and Traumatic Brain Injury particularly in planning activities. The Traumatic Brain Injury program provides money to all states to increase services for

people of all ages with brain injuries and traumatic brain injuries.

Performance
The number of individuals MCHB has served has increased from 26 million to over 27 million in three years. MCHB serves 55 to 60% of pregnant women in the nation through state-based MCH funded programs such as prenatal care and associated services. Each year there are 4 million pregnant women and 4 million babies born. MCHB serves 95% to 100% of all infants through programs such as newborn screening for PKU, or the other metabolic disorders. MCHB serves a 25% of all children. There are 80 million children up to the age of 21 in the United States and almost a million children with special health care needs.

Another group served by MCHB is comprised largely of women seeking family planning services. Statutory requirements limit MCHB to data collection on numbers of pregnant women, children, and children with special health care needs.

Accountability
Accountability, we think we're getting better all the time at accountability. The bureau, states and many MCH grantees conduct needs assessments. When conducting a needs assessment you look at indicators, national indicators, Healthy People 2010, national and state priorities. You get input from your partners and conduct a needs assessment. That needs assessment should lead to a set of priorities. Whether the priorities are to decrease disparities, increase quality, improve infrastructure, improve national leadership, or more specific to your program, they should be based on identified needs. Once you have the priorities, then you have write a plan and allocate resources. The bureau has written a five-year strategic plan, which will be out for comment in the next month. States also submit five-year plans. Then in an attempt to broadly measure performance, there is a set of 18 state block grant performance measures. MCHB is also in the process of developing a set of performance measures for SPRNS grants. The Healthy Start, EMSC, and Traumatic Brain Injury programs have a set of performance measures against which they try to hold themselves accountable. Hopefully, these measures will contribute to improving outcomes in infant mortality, neonatal mortality, and infant morbidity. These are the outcome measures that the bureau's programs are working towards to improve.

Discretionary Grants
A discretionary grant refers to every MCHB grant other than the state block grant. There are 18 national performance measures that all states are required to report for the block grant. States are also allowed to report on an additional seven to ten state-selected measures. These vary state to state. MCHB has a web-based system that automatically displays these measures. MCHB is in the process of doing the same for all 1,000 discretionary grants (Abstinence, Healthy Start, etc.). Currently, MCHB is developing a set of 30 or 35 national performance measures that all SPRNS grantees would have to answer. Each program may be required to report on up to five of these measures from a family of 30 or 35 performance measures. This information will be included in the grant's application guidance. There also will be a set of standardized forms in that guidance, similar to those found in the block grant that asked questions related to how much money are you spending? Do you have match money? Do you have state money? Do you have local money? Are there other funds into that program? What kind of people do you

serve? Age of service population? There will be a standardized set of forms appropriate to your family of grants. Additionally, the bureau will maintain a minimum set of data for each division's use, some of which you will provide. Other data can be added like CDC data, information from a health interview survey or from a children with special healthcare needs survey. Larger grantees are developing their own performance measures, which will be entered into this system, like a state negotiated measure. Administrative data will also be maintained in the database.

This system will all be automated. Applications will be submitted on a disk similar to the block grant and data will be posted on the web. This package will be sent to the Office of Management and Budget (OMB) for approval next month with implementation beginning in the next 12 to 15 months.

MCHB & Nutrition

MCHB has worked collaboratively with ASTPHND for many years. Examples of projects supported by MCHB are the biannual surveys (USDA funded the most recent survey), the 1997 publication Moving *to the Future: Developing Community-Based Nutrition Services Workbook and Training Manual*, funding support for ASTPHND's annual meeting and sponsoring the first Leadership Institute at this year's annual meeting. In the bureau, Michele Lawler is the nutrition coordinator and does abstinence in her spare time. Sharon Adomo does breastfeeding coordination. Denise Satka manages the nutrition training programs and is very busy managing training programs in the Division of Research Training and Education. This cross-division framework provides for cross division collaboration and coordination developing and implementing nutrition and breastfeeding activities in the bureau. Unfortunately we don't have somebody dedicated directly for nutrition services any more. There is no bureau within HRSA, and I think rare to have bureaus outside of HRSA even with discipline-specific leads with no other responsibilities. And there are many states that don't have that as well.

MCHB has been hard at work on a five-year nutrition strategic plan. The goal of this strategic plan is to try to document all the initiatives of the bureau and put down the funding and the funding sources next to them. This will be a plan that we try to fund and have funded so everybody knows where we're going. The strategic plan has four major areas: breastfeeding promotion and support, overweight/obesity prevention and healthy lifestyle promotion, public health nutrition leadership and training, and coordination and collaboration of federal, state and local partners. We would be glad to share it with you before it is completed in a final draft stage.

New Initiative

The President's 2003 budget includes a new initiative called the Healthy Communities Innovation Initiative. Tommy Thompson often refers to it as the community health initiative or the program that is going to help prevent diabetes, obesity and asthma. It currently proposes to provide 20 million dollars for up to five communities over a period of five years. The initiative will bring together the resources in a selected community, not for the purposes of direct care, but for prevention activities and resource development aimed at preventing or ameliorating diabetes, asthma and obesity. There is some indication that Congress is really quite in favor of this program. So listen to the community for the Health Community Innovation Initiative.

Nutrition Performance Measures

One of the 18 core performance measures, number 9 monitors the percentage of mothers who breastfeed their infants at hospital discharge. Beginning five or six years ago, states had to begin trying to report on this measure and the bureau began to monitor state's performance. States perform against their own state-set targets, and the bureau tries to set practical targets. In addition, states select seven to ten priorities based on their own needs assessment. We call these negotiated performance measures. We conduct in-person reviews every year with each state and go over MCHB performance measures, in addition to their state-negotiated measures. States also set priority needs. All these data are on the website MCHData.net. You can look up any state, their negotiated measures and priority needs.

Each state chooses five to ten priority needs driven by their statewide or their local health assessment. Thirty-one states selected priority needs related to nutrition and physical activity in their 2002 applications last year. A total of 42 nutrition or physical activity related priority needs were identified.

For state performance measures, 41 states developed a performance measure related to nutrition and physical activity to be reported in addition to the national performance measure. Currently, there are about 60 nutrition activity related state performance measures out of those 41 states. So many states have more than one.

We look at the priority needs, 14 of those states had a priority need. Remember they only can get seven. Most states write seven. So 14 states had one related to improved health, nutrition, physical fitness or activity of MCH populations. Eleven states reduced incidents of obesity/overweight among children/adolescents. Five improved breastfeeding rates. Five for promotion of lifestyle. Three for provision and nutrition services. And two for increased percentage of women with recommended daily folic acid intake.

Between 1997 and 2000 the number of state measures increased from 13 to 20 in the child and adolescent overweight and obesity, which I see as a testament to your work with the states and your encouragement with the states to try to develop nutrition oriented programmatic efforts. Nutrition services, nutrition education assessment, counseling. WIC participation went down in the number of performance measures from 11 to 6. Breastfeeding initiation as you can see has remained fairly consistent. Recommended prenatal weight gain fairly flat. Folic acid intake increased to six performance measures. Number of state performance measures on nutrition and physical activity increased.

One of the discretionary grant performance measures is aimed at nutrition. It is the degree to which a state system (plan) for nutrition services has been established for MCH populations. The measure incorporates eight elements that will be assessed using a rating scale. These elements include: (1) establish and maintain a state-based nutrition surveillance system for ongoing monitoring, timely communication of findings and use of data to initiate and evaluate interventions; (2) promote leadership to address nutrition health promotion and disease prevention programs with a full-time state nutrition director and an adequately staffed public health nutrition unit; (3) develop and maintain a state nutrition plan and through collaborative process select appropriate strategies for target populations; (4) promote

and develop policies for nutrition services; (5) develop a nutrition physical activity communication plan to target key audiences; (6) Build linkages with partners to promote healthy eating and physical activity by establishing state advisory committee, community coalition, community work group; (7) incorporate *Bright Futures* nutrition and *Bright Futures* physical activity guidelines and state community programs; and (8) leverage resources to adequately fund public health nutrition physical activity prevention programs. These are the eight elements against which the states will be graded for their success in determining this performance measure. I spoke at the National Mental Health Association national meeting last week. We've been doing a lot of work around youth suicide. We have found that the states that have the highest teen suicide rates are often are the states without a prevention plan. We can do a similar comparison using data from this one performance measure around state nutrition activities/plan and obesity in children for example, which could lead to some action.

You do wonderful work. I applaud you for your efforts, and I think particularly with the new attention to lifestyle changes, there will be an increasing demand for your services. We look forward to continuing to work with you. Thank you very much.