

Leading State Maternal and Child Health Programs: A Guide for Senior Managers

FOREWORD

Managing state programs for maternal and child health and children with special health care needs is never easy, although it is greatly rewarding. Ours is a complex and demanding job that often challenges conventional wisdom and requires a high degree of sophistication and creativity. There will be times that you'll feel like you have a split personality — you will experience many days filled with routine, mundane and even boring administrative tasks that seem to never end. Other days will be filled with fast-paced decisions made-on-the-run that fill you with terror of making an error that may cost your programs dearly. Just by virtue of the position you hold, you have the most incredible opportunity to make a lasting and positive impact on the health of your jurisdiction's women, infants, children, youth, children with special health care needs and their families. Fortunately you will not be alone in your work - you will find that there are others dedicated to quality health services.

Many people will help you along the way if you are willing to ask questions, listen to their ideas and give them a try, including your peers across the country, federal Maternal and Child Health Bureau (MCHB) staff, Association of Maternal and Child Health Programs (AMCHP) members and staff, academic and research centers, and informed families, to name just a few. Asking others knowledgeable about Title V programs and acting on their advice may mean the difference between being able to "just get by" in the job or really excelling as an outstanding and respected state Title V leader.

For many years, the leadership of AMCHP observed the rapid changes in the states, such as reorganization of state agencies, strained and disappearing state and federal budget resources, and shortages of trained maternal and child health personnel. With the turnover of state Title V leaders and the approaching retirement of the Baby Boom generation, we saw a need to assure a common grounding in the "basics" of maternal and child health services for the newest leaders of state MCH and CSHCN programs.

To create a manual for the next generation of leaders, AMCHP contracted with two experts in the field, Kathy Peppe and Catherine Hess. The following guide will give you an overview of block grant history, administrative know-how and tips for success from [MCH leaders](#).*

AMCHP represents state public health leaders and others working to improve the health and well-being of women, children, youth and families, including those with special health care needs. AMCHP is proud to bring you this guide for new MCH leaders. Deborah Dietrich, Stephanie McDaniel, Meg Booth and Lisa Gain played key staff roles in the development of this guide. AMCHP members served on the focus group to help shape the manual, and AMCHP board members provided vital input. We envision this manual as a timeless tool to help a new MCH leader gain the confidence necessary to perform well, set priorities and maintain accountability during the first year on the job. We want this to be a tool that can be shared at national workshops and meetings or wherever new Title V managers may gather. We hope you find this guide to be a useful reference when you are pondering your role and the direction in which you want to take your MCH program.

Welcome to the maternal and child health family!

Sally Fogerty, B.S.N., M.Ed.
AMCHP President
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AUTHORS' PREFACE

Leading State Maternal and Child Health: A Guide for Senior Managers is designed to help you succeed at your job. If you are a senior manager in your agency responsible for the oversight or management of all or part of the Maternal and Child Health Services Block Grant, this manual is for you. Titles, duties, and scopes of responsibility for family health related federal and state programs vary between agencies and states, but this guide was written to be adaptable to your situation regardless of your specific position title or responsibilities. It is also useful whether you are from a state where you are the only staff member or from a state having a large number of staff devoted to block grant programs.

As requested by an advisory focus group of state leaders and other experts in the field, the guide is framed around major leadership concepts of vision, change and relationships as well as current management concepts including planning. We reviewed conceptualizations of leadership roles by key thinkers whose writings have been used in national public health leadership institutes. These experts include Stephen Covey, Peter Senge, Edgar Schein, John Kotter and David Campbell. While varying in conceptualization of major leadership roles, this literature makes a clear distinction between leadership and management. Stuart Capper's curriculum "The Mystical Reality of Leadership," part of the MCH Leadership Institute on Systems, includes some concise comparisons of the two roles noting, "management and leadership may be different - but they are not separate." The content for this guide is consistent with Capper's idea, framing the guide around leadership roles as well as providing practical information, tips and resources for senior managers of MCH block grant and related federal and state programs.

In preparing this guide, we sought the advice of many people across the country. We would especially like to acknowledge with gratitude the following people for their assistance and support:

- Deborah Dietrich, acting executive director, AMCHP
- Stephanie McDaniel, Director, Center for Best Practices, AMCHP
- Meg Booth, policy analyst, AMCHP
- Lisa Cain, director of center for membership & communications, AMCHP
- Sally Fogerty, president, AMCHP
- Members of the focus group listed in Appendix B

Each of these people gave freely of their knowledge, skill, expertise and time. They believed that we would translate their perspectives into a document that meets its ultimate goal - passing along to the next generation of state leaders in family health, MCH and CSHCN programs the wisdom gained from the perspective of the program's rich history combined with the experience of past and present program leaders. We trust that we have met that expectation.

We have enjoyed the challenge presented to us in terms of meeting all of the desired content, format and utility of the guide expressed by those with whom we conferred. We have been mindful that this is a document that must remain somewhat "ageless" in its content; practical in its advice to those newly embarking on leadership positions in family health, MCH and CSHCN programs in the states, territories or District of Columbia; helpful to the more "seasoned" leaders who may just need a reason to rethink their approach to the job; and inspiring to all senior managers who need to find their own way to do the best job they possibly can. Our bottom line message is: You Can Do It!

Catherine Hess, M.S.W.

Kathy Peppe, R.N., M.S.

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GETTING STARTED

"The one common denominator of all MCH/CSHCN leaders over the many years has been the COMMITMENT to helping the people they serve. That commitment is what makes the MCH family."

Dennis Rubino, Director, Children with Special Health Care Needs Program, Delaware

"Given all we have to learn and then put into practice as Title V'ers, having this guidance is one of the best support systems around. If I can't have one of the seasoned MCH Title V experts in my back pocket, this guidance is the next best thing."

Millie Jones, Director, Bureau of Family and Community Health, Wisconsin

Are You a State Title V Leader?

If you are a senior manager in a state agency and your responsibilities include components of the MCH Block Grant - also known as Title V of the Social Security Act - yes, you are! You are:

- Responsible for improving service systems and health outcomes for ALL women, children, youth and families, including those with special needs, consistent with national health goals and state needs assessments
- Part of one of the 59 MCH leadership teams in the nation
- Involved with the WIC nutrition program, the Title X family planning program, the Part C early intervention program and various Centers for Disease Control and Prevention (CDC) programs, among others. Title V provides a framework for linking these programs to comprehensive strategies.
- Working in a state agency called Health, Public Health, Human Services or many other titles that convey responsibility for assuring the public's health. Some of you working specifically with Children With Special Health Care Needs (CSHCN) programs are located in state universities
- Within a bureau, division or branch called Maternal and Child Health (MCH), CSHCN, Family Health, Community Health or something similar.
- In a position to make real a longstanding national commitment to the health of this nation's women, children, youth and families, including those with special needs!

Your title, specific duties, position and scope of responsibility vary from your counterparts across the nation. But the common denominator - responsibility for the Title V MCH Block Grant - provides a common mission. It is up to you and your colleagues to deliver on a national mission, legacy and promise for improved health of women, children, youth and families. AMCHP's Guide for Senior Managers will help you get started.

Your First Months as a New MCH Leader

Understand the job that you have been hired to do. How has the job been performed in the past and does that impact your ability to do the job now? Where do you and the Title V programs fit in the organization of the agency? What authority do you have for decision-making? Talk to your supervisor or agency director about these questions.

Ask for briefing documents from program directors under your supervision. Ask that briefings include a description of the program(s), information about current program strengths and needs, budgets and contracts, staffing, statutory requirements, current performance reports, a schedule of key deadlines, needs assessment and data specific to the program area, "hot" issues, pending or proposed legislation, key stakeholders and constituencies, and any other issues that you should know.

Get to know the program staff as quickly as possible and personally meet as many of them as you can. Attend program staff meetings. Obtain a directory of your staff including their work, home, and cell phone numbers and background information on your key staff members.

Seek opportunities for involvement through AMCHP, your national association. Understanding what is happening at the national level helps you to be a strong MCH leader in your state, territory or jurisdiction. The Association of Maternal and Child Health Programs (AMCHP) annual meeting is an excellent training forum for learning about current issues, discussing federal directives and plans, and expanding your knowledge about managing Title V programs and funds.

Participate in AMCHP's mentorship program for new Title V leaders. Take advantage of this opportunity to learn from your peers. The AMCHP website also provides many publications, issue papers, fact sheets and other policy documents that you will find helpful.

Read the first two chapters of this guide as soon as you can. They give a sense of the rich history of the nation's MCH programs and the commitment to family health we all share.

CHAPTER 1 The Big Picture: Title V as a Foundation for Family Health

The Roots and Evolution of Title V

Back to the future - that's how current public health emphases on assessment and policy might be viewed from a Title V perspective. Because the roots of Title V of the 1935 Social Security Act date back to the dawn of the 20th century, and it grew from a focus on using data to affect policy.

The Federal Children's Bureau was created in 1912 "to investigate and report on the status of children and on their common as well as special needs" and on "the welfare of children and child life among all classes of our people." The bureau used these reports to stimulate action. Results included uniform birth registration, the school lunch program, child labor laws, maternal health standards and the basis for the...

Sheppard-Towner Maternity and Infancy Act of 1921, which provided the first federal grants to states for public health. The controversial act's support for an activist governmental role in health was viewed as "radical" and "socialistic." The American Medical Association, the Catholic Church and the Public Health Service were instrumental in the act's 1929 repeal. The American Academy of Pediatrics was born in 1930 from disagreement with AMA's position. During the eight years that it was on the books, this law fostered creation of child health units in 47 states, many of which remained in place after its repeal.

The Social Security Act of 1935 included Title V, again authorizing grants to states, this time to "extend and improve" services. The grants targeted maternal and child health (MCH), children with special needs (then known as "crippled children"), and child welfare services. While the MCH component continued to focus on prevention, the CSHCN component introduced grants for medical care. States were funded by formula to establish service units and were required to submit state plans to obtain funding.

Over the next six decades, special program emphases were added to Title V, as the program adapted to identified needs and to the enactment of other federal health programs. Maternity and Infant Care (MIC) and Children and Youth (C&Y) projects developed under Title V in the 1960s to respond to problems of mental retardation and poverty conditions, respectively. These projects proved to be effective comprehensive care models. Projects for neonatal intensive care, family planning and dental care were added by the 1970s. Later years brought programs on school health, genetic diseases, newborn screening, training and research. All of these made significant contributions in advancing the field of maternal and child health. At the same time, new federal programs, including community health centers and Medicaid, resulted in some loss of influence for the Title V federal and state program.

In 1981, Title V became a block grant but retained key features of the original legislation. These amendments established the groundwork for current aspects of the program, such as the needs assessment. However many critics, including those in Congress, decried the lack of accountability mechanisms and cited initial reductions in funding and decreased federal oversight as weakening programs in some states.

The 1989 amendments brought increased accountability for Title V while retaining flexibility. Although some now dub the Title V Block Grant a "blockagorical," the 1989 amendments were an attempt to retain the historic strength of the program in assessing, planning and responding flexibly to state specific needs, while introducing stronger national accountability. Advocates came together with state MCH programs and AMCHP to urge Congress to seek this balance in the law.

Recent years showed continued tension between flexibility and accountability. Over the course of the 1990s, Congress frequently proposed federal legislation to create more and larger block grants. Some proposals included recommendations to consolidate the MCH Block Grant program with others, such as WIC, family planning, immunizations and other public health programs. Some also proposed turning the Medicaid program into a block grant. As of 2003, Congress hasn't enacted any of these proposals. The State Children's Health Insurance Program (SCHIP) was enacted as a capped entitlement to the states, allowing states more flexibility than they have with Medicaid. At the same time, this decade saw passage of the Government Performance and Results Act (GPRA), which was one of the policy forces that drove development of performance measures under Title V. These policy tensions between block grant and categorical programs and flexibility and accountability are likely to continue.

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

A brief summary of the law's current provisions can be found in Chapter 6 of this guide.

Title V Mission Statements 2003

...in federal statute

The Title V MCH Services Block Grant statute is authorized to improve the health of all mothers and children consistent with national health objectives to enable each state to provide and assure access to quality maternal and child health services, reduce mortality, prevent diseases and disabling conditions, promote health, provide services to children and youth with disabilities, and promote family-centered, community-based, coordinated care.

...for AMCHP

To provide leadership to assure the health and well-being of all women, children, youth and families, including those with special health care needs.

...for MCHB

To provide national leadership and to work in partnership with states, communities, public-private partners and families to strengthen the maternal and child health infrastructure, assure the availability and use of medical homes and build the knowledge and human resources in order to assure continued improvement in the health, safety and well-being of the MCH population. The MCH population includes all America's women, infants, children, adolescents and their families, including fathers and children with special health care needs.

State Title V managers are responsible for:

- Working toward the national mission
- Creating a vision for state systems in improving the health and welfare of families, including children and youth with special health care needs
- Using Title V's limited resources strategically and mobilizing, leveraging and aligning other resources to achieve the mission and vision.

Animal, Vegetable or Mineral

How does Title V fit with public health, health care delivery and financing, and children and family service systems?

Answer: It cuts across all of them, developing strategies that build on, integrate or coordinate services to meet needs and improve outcomes. With roots in child labor protections, child welfare and public health, Title V provides for comprehensive, family-centered policies and programs.

Conceptual Frameworks for Title V

Essential Public Health Services

In 1989, the Institute of Medicine (IOM) published *Toward the Future of Public Health*. Finding the public health system in "disarray," IOM recommended that public health agencies focus on strengthening three core functions: assessment, policy development and assurance. As public health agencies worked to rise to the challenges of this report, federal and state agencies came together to flesh out these core functions. The

result was a set of 10 essential public health services that are used as a framework for a range of public health efforts.

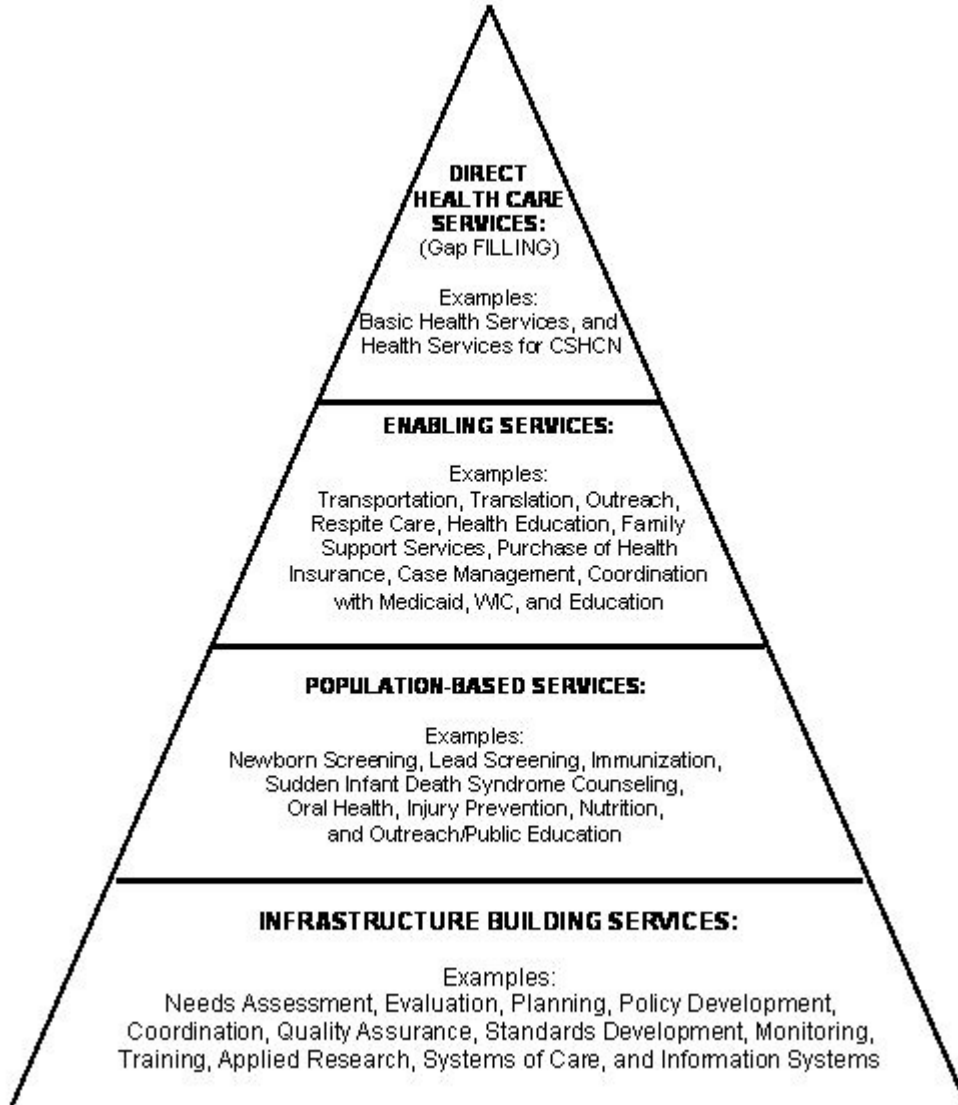
Simultaneous to this work, the Association of Maternal and Child Health Programs (AMCHP), the national organization of state Title V MCH, CSHCN and family health programs, was working with the federal Maternal and Child Health Bureau to articulate and support future directions and roles for state programs. In 1995, AMCHP partnered with the Child and Adolescent Health Policy Center at Johns Hopkins University to produce the *Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America*.

This document, developed by and for state leaders, helped provide a common framework for programs across the country. The content is consistent with broader public health frameworks but is tailored to promoting maternal and child health and serving children with special health care needs. Strong emphasis is placed on assuring availability, access and quality of health services, as well as on linkages with other systems serving women, children, youth and families. **Because the MCH Essential Services are adapted from the 10 essential public health services framework, they offer an important common language and bridge to broader public health efforts.**

Ten Essential Public Health Services to Promote Maternal and Child Health in America

1. Assess and monitor maternal and child health status to identify and address problems.
2. Diagnose and investigate health problems and health hazards affecting women, children, and youth.
3. Inform and educate the public and families about maternal and child health issues.
4. Mobilize community partnerships between policymakers, health care providers, families, the general public, and others to identify and solve maternal and child health problems.
5. Provide leadership for priority-setting, planning and policy development to support community efforts to assure the health of women, children, youth and their families.
6. Promote and enforce legal requirements that protect the health and safety of women, children, and youth, and ensure public accountability for their well-being.
7. Link women, children, and youth to health and other community and family services, and assure access to comprehensive, quality systems of care.
8. Assure the capacity and competency of the public health and personal health work force to effectively address maternal and child health needs.
9. Evaluate the effectiveness, accessibility, and quality of personal health and population-based maternal and child health needs.
10. Support research and demonstrations to gain new insights and innovative solutions to maternal and child health-related problems.

In the 1990s, the federal MCHB developed a framework for Title V that graphically represents the role of the program as the foundation for the family health system.



Now known as the MCH pyramid, this framework is consistent with the essential public health services; they can be mapped onto each other. The MCH pyramid distills core services into four main categories and, through the graphic of the pyramid, illustrates how each set of services rests on the foundation beneath.

- **Infrastructure Building Services** include most of the 10 essential public health services and encompass the functions that indirectly benefit families by laying the foundations for the policies and programs that can improve their health and well-being.
- **Population Based Services** in this framework are largely primary prevention programs, universally reaching everyone that might be affected or in need.
- **Enabling Services** help families access and use health services and are usually targeted to families that have special needs or face specific barriers.
- **Direct Health Care Services** in this framework are directly provided to individuals, by state or local agency staff or by grantees or contractors. Title V programs commonly support prenatal care, well-child and school-based health services, and specialty services for children and youth with special health care needs.

Federal Title V requirements, including applications, annual reports and performance measures, are tied to this framework. It is critical that you be familiar with the pyramid and how your agency's Title V activities are classified within this framework.

The pyramid also illustrates the shift that is occurring in the roles of state Title V programs. If you plugged in Title V federal and state expenditures into the appropriate levels of the pyramid, the pyramid might be up ended. Historically, the largest share of states' MCH/CSHCN funds supported direct provision of health services. As health coverage for women, children and youth expanded, first through Medicaid and later through the State Children's Health Insurance Program (SCHIP), and as many publicly insured families were served through managed care systems, many state Title V programs reduced their roles and expenditures in direct provision of health care.

Title V's role has always been to "assure" services, a role for public health also emphasized in the Institute of Medicine's core public health roles. State leaders can assure services through multiple mechanisms, including needs assessment, planning and recommendations to state policymakers and other agencies to fill gaps. But when no other recourse is available, state leaders use Title V resources to provide access. While this need has not disappeared completely for women, children and youth, it has diminished. States have begun to shift resources down through the pyramid to support enabling, population-based and infrastructure-building services.

Systems of Care

In response to the needs of children and youth with chronic health conditions and disabilities, over the last several decades the federal MCH Bureau has placed strong emphasis on systems development. Congress first added language focusing on this Title V role in 1987 and later in the 1989 amendments. While the focus has been on systems for children and youth with special health care needs, states also address preventive, primary and specialty care services for *all* women, children, youth and families.

State systems development for children and youth with special health care needs is now incorporated into national health objectives, as well as Title V performance measures. The federal MCH Bureau has developed a national agenda focused on:

- Access to coordinated, quality health services through a "medical home"
- Trained providers
- Adequate insurance coverage
- Family involvement and satisfaction
- Early and continuous screening
- Transition to adult systems

Family health programs strive to develop systems of care that are family-centered, comprehensive, coordinated, culturally competent and community-based.

To ensure that all families have access to health care that meets their needs, health systems must be *culturally competent*. Particularly given the health disparities for different racial and ethnic groups, MCH programs must assure that providers and systems are culturally competent to narrow those gaps. Providing guidance and requiring accountability for cultural competence demands that you, your staff, and your policies embody its attributes. Ongoing training in cultural competence is a key element to your programs' success.

Systems should also be *family-centered* and *consumer-oriented*. Families can and should be involved in all of the core functions of state programs - from needs assessment, through planning and program development, to service delivery and evaluation. As with cultural competence, the MCH Bureau has extensive resources on family-centered approaches.

A state MCH leader builds systems on the foundation of Title V's history, mission and key concepts.

Key Concepts for Maternal and Child Health

Systems Building

MCH and CSHCN programs historically have played a strong role in "filling the gaps" or serving as part of a "safety net" for low-income, underserved and special needs populations. Many state programs historically filled this role by directly providing services through state and local clinics. As the nation took action beginning in the late 1980s to improve health care coverage, especially for children and pregnant women, and as Medicaid recipients moved to managed care delivery systems, public health programs re-examined their roles.

The need for a strong safety net remains today, and family health programs continue to play a substantial role in supporting it. However, programs are decreasing their role in "direct service" while focusing more on systems building. Title V programs build systems of care by assessing unmet needs and gaps in services, identifying and developing service provider and funding resources to fill gaps and meet needs, providing training and monitoring to assure quality services, and measuring system performance and population outcomes. Title V promotes a multidisciplinary approach to health care to address interrelated medical, psychosocial and nutritional needs.

Systems building is a concept that encompasses a range of functions included in the many conceptual frameworks discussed above. A key idea of systems building is a focus on the whole and how its parts interact, not just on the parts. **In line with Title V's focus on all women, children, youth and families, and on outcomes for their health, a systems approach is absolutely necessary to achieve results.** This systems approach also explains why MCH programs straddle public health, health care, and child and family service arenas. All of these arenas interact with families and communities to affect conditions that impact health and well-being.

Consider, for example, the problem of childhood asthma. Traditionally public health studied its epidemiology and worked to eliminate or reduce environmental contributors. The health care system also plays a role to medically manage the condition. Child-care centers and schools need help preventing and managing asthma. The Title V systems building role is to assure that all of these components and strategies are identified, carried out in a coordinated and integrated way, and monitored, evaluated and adjusted as necessary. The Title V program leads only some of these components, but it works with the others to assure that the entire picture is addressed and that the components are linked.

Family Involvement

Family involvement is now a guiding principle in state CSHCN programs across the country, and one on which they must measure their performance. Family involvement also is being incorporated into other maternal, child and adolescent health programs. In a 1999 AMCHP survey, 70 percent of state Title V programs said that they involved family members as advisors in policy and program areas other than CSHCN. Family involvement is part of the tangible evidence that the block grant requirement for family-centered, community-based, culturally competent and coordinated care is being met. Family involvement can make a positive difference in program planning, implementation and outcomes. States have used highly individualized approaches in working with family representatives. Some specific approaches and tips for working with families are detailed in Chapter 5.

Population Based

Like public health programs, Title V always has focused on entire populations, unrestricted by categorical eligibility requirements. The program's statutory mission remains *to improve the health of all mothers and children* (emphasis added). However the boundaries of the "MCH population" have been interpreted more broadly recently and are now the subject of discussion and debate.

Although this is not always well understood, adolescents definitely are part of the population of focus. The Title V statute defines children as individuals under age 22. The federal MCH agency turned attention to this population in the 1960s. Today, most state Title V programs have designated adolescent health coordinators, who are organized in the State Adolescent Health Coordinators' Network (SAHCN). SAHCN and AMCHP have partnered to produce guidance for states, including a conceptual framework for adolescent health.

Children and youth with special health care needs have always been a major, specific component of Title V programs. Prior to the block grant, there were separate funding streams for CSHCN ("crippled children" as

they were then known). For many decades, the programs focused on bringing quality specialty medical care to children with specific diagnoses, at times and in places where such care would not otherwise have been available. With advances in medical care and coverage, the need for the public sector to provide such care diminished, while other needs intensified. Increased specialization and sub-specialization of medical care, along with creation of new human service and education programs, created needs for managing or coordinating care. Medical advances also enhanced survival rates and longevity of infants and children with illnesses or disabilities, challenging system capabilities and family resources. Today, the role of Title V programs in directly providing medical services has decreased, as the programs increasingly work to improve systems, enable access and coordinate care, in partnership with families.

CSHCN are children who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally.

Particularly as we have learned more about the importance of preconceptional health for birth outcomes, state leaders and MCHB have turned their attention to women's health. As the 21st century begins, these leaders are working to conceptualize and test models for building women's health systems.

Increased attention is being devoted to family health, including the roles and needs of fathers. In 2003 MCHB defined its population as "*all women, infants, children, adolescents and their families, including fathers and children with special health care needs.*" The future promises increased exploration of the population boundaries for programs historically rooted in the health of children and their mothers.

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CHAPTER 2 The ABCs: Title V at the National and State Levels

An Important Tool for Building State Systems

While more accountability was introduced with the 1989 amendments, the Title V statute today continues to offer significant flexibility to build programs to meet your state's specific needs and to fit with your state's size, systems and cultures. This chapter provides more specific information on the federal and state components of Title V and how they work together.

As a senior manager with responsibility for Title V, it is important that you review the Title V legislation, as well as the current application and report guidance (see Chapter 6 for highlights). All of the requirements for state programs are contained in these documents; there are no regulations specific to Title V. As with every law, there are nuances and aspects that are open to interpretation. In addition to reading the tips included in this guide, talk to your counterparts in other states to learn from their experience. Federal MCH administrators can advise you within the context of the law, the guidance and federal policies.

How are State MCH Programs Organized?

Given the flexibility of Title V, there is great variation among MCH programs across the country. One (mostly) common denominator is that programs by law must be administered by the "state health agency." The exception to this rule is that a small number of CSHCN programs are located in other state agencies, usually universities, because the Title V legislation "grandfathered" existing programs.

Even with this common location there is great variety in the structure and hierarchy for state Title V programs. State executive branch agencies vary widely across the country, and their structure and responsibilities can change, especially with new administrations.

As the nation and states experienced great political shifts starting in the mid 1990s, a trend toward major reorganizations and consolidations occurred. The implications of these reorganizations on Title V and public health programs remain unclear. In larger agencies, some Title V programs, such as in Illinois and Michigan, underwent major restructuring, while others retained most of their previous structure and functions.

Today, MCH leaders usually work within larger public health agencies that include traditional areas such as epidemiology and health statistics, chronic disease prevention, and health promotion. The agency also may include environmental health, substance abuse prevention and treatment, mental health, developmental disabilities, health facilities management or regulation, and Medicaid. Whether Title V operates within or outside of the same agency, these programs can make a big difference in the ease of communication and coordination of efforts.

The units with direct responsibility for Title V programs may be called MCH, CSHCN or similar terms or may have a broader scope in family or community health. *A fairly common structure is a bureau of family health (aka "big MCH") overseeing MCH preventive and primary services for women or pregnant women, children and youth (aka "little MCH"), as well as CSHCN.* Related programs may be administered under or alongside these units. A 1999 AMCHP survey found that over two-thirds of state health agencies had a "family health" organizational unit, and over half of these states considered that to be the Title V unit. MCH or family health agencies commonly administer family planning programs and the supplemental food program for Women, Infants and Children (WIC). MCH or CSHCN may administer the federal early intervention program (Part C) or Medicaid waivers for home- and community-based services. Related state-funded programs, foundation initiatives and CDC programs - such as lead poisoning prevention, breast and cervical cancer screening, birth defects and developmental disabilities prevention - also often fall under the Title V unit's purview.

In some states, the scope of Title V programs may be even broader, reaching to adult-oriented programs, primary care or chronic disease prevention. *States with broad units often organize, plan and link the programs in a lifespan framework.* This approach can assure specific attention to children's and youths' needs, while maximizing opportunities for prevention and intervention at appropriate points across the lifespan.

What Do State Title V Programs Actually Do?

Within the broad and flexible scope of Title V, the mix of agency functions and community services varies considerably. Each agency has a unique history in the context of the state'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.

Southern 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. Northern states, especially on the coasts, tend to have high concentrations of academic and medical institutions and play a lesser role in public delivery of care. These states tend to play more of a role in financing and regulating health care. States in the middle of the country tend to have a mix of these roles.

Historically, MCH programs have played a significant role in delivering clinical preventive and primary care services to women, children and youth with state or local health agency staff. Many state provide specialty and therapeutic services for children with special health care needs in medical centers and mobile units. Other states rely on contracting with providers such as community health centers. *Historically Title V programs were involved where services were not available or not accessible due to barriers such as lack of coverage.*

As public insurance has expanded in recent decades, it has met more of the fundamental health needs of women, children and youth. In turn, the variation in the roles of MCH programs seems to have increased. Without universal coverage, there are still families who lack insurance, particularly among immigrants. Even with insurance, providers may not be available or accessible, and barriers such as culture, language or transportation may impede access. **Title V programs still are charged with assuring access to preventive, primary and specialty care.** But how programs do this is shifting in most states.

With the shift to managed care systems in the 1990s, many states decreased considerably their roles in delivering care directly with state or local health agency staff. Where gaps in coverage, availability or access persist, more state Title V programs have moved toward grants or contracts to support local agency services. State programs also have looked to influence policy and to leverage other resources to close the gaps. Drawing on assessment and evaluation data, and on population and program expertise, MCH leaders are seeking to work with Medicaid, SCHIP, managed care organizations, state policymakers and families to identify solutions for gaps in coverage and access.

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

Additionally, state Title V 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:

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

State Title V 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, Title V programs determine strategies to meet identified goals and objectives. These strategies may or may not entail extensive use of Title V resources. 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 may result in a new intervention with other funding sources. *Title V programs can be leaders and catalysts for systems change.*

Although the trend toward major, multi-agency restructuring may have accelerated recently, reorganization is a constant in public agencies, and something for which you should be prepared. While there is not one model for organizational structure and placement, some things to consider include:

- The agency's mission should support Title V's emphases on prevention, population-based and comprehensive approaches, special needs, and systems development.
- Children, youth and women, especially those with special health needs, each have unique needs that should be explicitly addressed in organizational structure.
- The agency must be competent in data collection and analysis for needs assessment, planning and evaluation, as well as program development for target populations.

MCH leaders agree that it is critical for all states to have a division responsible for assuring the health of women, children, youth and families.

As with organizational structures, there is considerable variation in the education and experience of your colleagues across the country. MCH programs historically have promoted multidisciplinary teams, at the management as well as the local service level. Previous federal requirements for physicians to lead state programs were eliminated, but many states retain physicians on their senior leadership teams. These doctors, most commonly pediatricians, bring critical expertise, along with an ability to forge relationships with state physician groups that may be more difficult for non-physicians. Nurses, social workers and nutritionists also are commonly found in senior leadership positions. Clinical backgrounds are helpful in policy and program development and evaluation and offer a value often sought after by other agencies. Many clinicians in leadership positions have advanced degrees in public health or other relevant fields. With the growth of MCHB training programs, increasing numbers of Title V leaders have earned graduate degrees in MCH.

Increasingly, people with experience administering other public programs are bringing that experience to bear on family health. Community-based providers from both the public and private sectors are bringing their important ground-level knowledge to the state level.

You have the flexibility and opportunity under Title V to form a multidisciplinary team to reach your mission and goals.

State programs also play a leadership role in workforce development. One of the essential health services - assuring the capacity and competency of the public health and personal health work force - has become an urgent necessity. Shortages in key areas, particularly nursing, have been well documented. State senior managers can partner with schools of public health, other academic partners, and state and national public health associations to assure the availability of health workers. It is also important to train your staff in new areas, such as systems development and information technology.

What Is the Role of the Federal MCH Bureau?

As we saw earlier, federal leadership for maternal and child health dates back before Title V to the Children's Bureau. A reorganization in 1969 moved Title V to the Public Health Service. After a number of reorganizations and in response to advocacy led by the American Academy of Pediatrics (AAP), the modern day MCH Bureau was established in 1990. As of the early 21st century, MCHB was one of four bureaus within the Health Resources and Services Administration (HRSA).

The federal-state partnership for maternal and child health also predates Title V. The nuances of that relationship, and particularly the amount of federal oversight, have varied over the past century. The philosophy of the federal administration has a strong influence on the relationship, particularly since Title V became a block grant in 1981. In the 1980s, the Title V statute had very limited accountability provisions and the administration strongly emphasized state flexibility; accordingly there was limited direction from the federal MCH agency. Following the 1989 Title V amendments and with new federal leaders, more emphasis was placed on accountability and on assisting states to develop capacities. *The strength of the federal-state MCH partnership over the past decade is evidenced in the collaborative effort of states and MCHB to develop and implement performance measures into the Title V program.*

State Title V programs, through AMCHP, urged that the 1989 amendments address the federal as well as the state role in the Title V program. The result was legislation requiring the secretary to "designate an identifiable administrative unit with expertise in maternal and child health within the Department of Health and Human Services, which unit shall be responsible for:"

- Special Projects of Regional and National Significance (SPRANS) in Title V
- Federal-level coordination of Title V, Medicaid (especially EPSDT), related agriculture and education programs, health block grants, and categorical health programs, such as immunizations
- Information in areas such as preventive services and advances in care and treatment
- Technical assistance, on request, to states in areas such as program planning, establishment of goals and objectives, standards of care, evaluation, and consistent and accurate data collection
- In cooperation (and avoiding duplication with) the National Center for Health Statistics, collection, maintenance and dissemination of information on the health status and needs of mothers and children in the U.S.
- Preparation of reports to Congress on state Title V activities, accomplishments and information
- Assistance to states for developing care coordination services
- A directory of toll-free information lines established in states under Title V.

Like its state counterparts, the federal MCH agency has a broad mission based in Title V but extending beyond the specific provisions of Title V. Over the past decades, the federal agency has taken on a number of related programs including:

- Emergency medical services for children (EMSC)
- Traumatic Brain Injury (TBI) service programs
- Healthy Start, which is focused on community based infant mortality prevention
- Abstinence education, both Section 509 grants to state programs, as well as federal special project (SPRANS) funds
- Newborn hearing screening
- Poison control centers
- Women's Health Office.

AMCHP and MCHB are among the best sources for Title V information, best practices and models.

The Federal-State Partnership in the 21st Century

As a result of the new accountability measures incorporated into Title V in the 1990s, one important aspect of the federal-state relationship now revolves around annual applications and reports. The review of block grant plans and performance measures provides an opportunity for feedback and identification of state needs. In the last decade, the review has broadened to include consumers, incorporating the Title V goal of being family-centered.

The federal MCH agency responds to needs identified in the block grant process and provides assistance to state programs. This assistance comes in many forms, and like many aspects of this program, has varied over time.

State Title V programs and AMCHP have played a critical role in advising the federal agency on

state needs, with many specific initiatives developed in response.

Some of the ways MCHB provides assistance to state programs include:

- **Directly from MCHB central or regional offices.** Assistance is limited by numbers of staff, but funds are sometimes available to help states purchase technical assistance.
- **National partnership conferences** that include orientation for new leaders, information on priority issues, and opportunities to meet federal leaders.
- **Policy, information and resource centers** funded under the Title V grants for "Special Projects of Regional and National Significance" (SPRANS). Over time, the federal agency has funded many such centers with a range of programs, which may or may not have state Title V programs as a primary audience.
- **SPRANS grants focused on state identified needs.** The federal agency has flexibility in setting SPRANS priorities, although Congress has come to have strong influence. In response to states and AMCHP's identification of needs, the federal agency often has developed specific SPRANS projects, such as women's health systems.
- **SPRANS grants to assist states at national or regional levels.** The federal MCH agency has supported much of AMCHP's work in assisting states, specifically through conferences, workshops, publications, consultation and other tools. Other grantees, often university-based, have assisted states in specific regions.
- **Continuing education institutes**, also funded by SPRANS, for senior Title V leaders. These institutes focus on skill development in the context of Title V programs.
- **CISS grants** to assist all states in key program or system areas. Community Integrated Service Systems (CISS) grants are another Title V "set-aside" added in 1989. Developed in partnership with the federal Administration for Children and Families, the initiative helped build state interagency partnerships supporting family preservation goals in child welfare. For example, a national CISS initiative helped all states develop home visiting programs.

Resources

[Association of Maternal and Child Health Programs](#)

[Health Resources and Services Administration, Maternal and Child Health Bureau](#)

[Maternal and Child Health Leadership Skills Training Institute](#)

CHAPTER 3 The Big Picture: Leading Through Influence to Achieve Change

You have power and influence!

MCH leaders vary in the degree of power they have by virtue of their positions within state bureaucracies and the magnitude of their budgets and programs. This chapter discusses tools that are available to you, including sources of potential power, statutory leverage, vision, partnerships, advocacy and marketing. Certainly Title V leaders do not have the same kind of power and influence that comes with leading a large state agency or directing a budget as large as Medicaid. But managers responsible for Title V programs have both formal and personal sources of power and influence. *The greatest power comes from recognizing potential sources you have and using them strategically and judiciously.*

As a Title V leader, you have a number of *sources of potential power and influence*, including:

- A rich legacy of MCH leadership
- Your knowledge, skills, expertise and passion
- Your staff's knowledge, skills, expertise and passion
- Stature, visibility and direct means of control related to your position
- Budget resources, including the ability to fund agencies and organizations that may be supporters or detractors
- Legislative and regulatory requirements governing your programs that can be used strategically to back up your course of action or requests of others
- Control or influence over contracts, regulations or other legal requirements
- Ability to develop voluntary standards and guidelines, backed by the power of your office and the influence of the stakeholders involved in development
- Data, information and reports needed by others or which can influence others
- Access to other state leaders and managers in your agency, other agencies, the governor's office and the state legislature
- Individuals, organizations and agencies with direct, vested interests in your programs, and those with more indirect investments in your mission, at both state and national levels
- A network of colleagues in other states, accessible via AMCHP

My years of experience in state government have shown me that sometimes people in the highest positions do not see themselves as having power and influence while 'true leaders' at lower levels of the hierarchy assume the leadership role and end up moving mountains. It's up to you!

Joan Wightkin, Director, MCH Program, Louisiana

What Kind of Leverage Does Title V Provide?

While statutory requirements for Title V are fairly limited, there are some important tools to exert influence and lead change.

Within Title V

- Needs assessment and performance data can draw public and policy attention to unmet needs and insufficient progress. You can use this data to compare your state to the nation, other states or across political jurisdictions within the state.
- Legal requirements to address identified needs can help protect against changing political priorities.
- So called "30/30 earmarks" designate minimum funding for preventive and primary services for children and youth. These earmarks can help assure continued attention to children's needs and counteract mistaken assumptions that Medicaid and SCHIP can or will meet all needs.
- Requirements that Title V services be provided free of charge to those below the poverty line, and using a sliding scale for those above, can help assure that financial barriers are not erected to block access to services.

- Requirements for interagency coordination can be used internally and externally to place priority on interagency efforts and to help gain a "seat at the table." Requirements for Medicaid coordination are the most detailed and support roles in policy development for EPSDT, outreach and information, including toll-free phone lines.

Language referencing Title V in other programs' statutes

- The **Medicaid** statute was amended in 1967 to require that states provide for agreements with Title V agencies to deliver Medicaid services. This language has been interpreted to place Title V in the position of payor of last resort, after Medicaid. The language also assures that Title V services can be billed to Medicaid for Medicaid-eligible children and offered free of charge to others. This provision, which is contrary to general Medicaid policy requiring payment for all services, has been used in Title-V-supported, school-based health programs. Finally, some have used the language to argue that Title V programs should receive cost-based Medicaid reimbursement. Federal Medicaid regulations provide additional requirements for Medicaid agreements with Title V.
- **Amendments to Medicaid** to address managed care made special provisions for children with special health care needs, citing Title V as one category in defining special needs children exempt from mandatory enrollment.
- The federal **State Children's Health Insurance Program** legislation requires states to coordinate with maternal and child health programs. Although Title V is not specifically cited, this was the intent behind the language.
- In the **Supplemental Security Income (SSI)** for disabled children program, reference to Title V has provided the basis for state CSHCN programs to receive lists of all children enrolled in SSI. These lists have facilitated Title V outreach and follow-up to assure these children are linked with needed services. This policy also helped support a Title V role in outreach and recertification efforts following changes in federal eligibility rules in the 1990s.
- The authorization for the federal **Healthy Start** program requires grantees to coordinate their services and activities with state Title V agencies.

Congress enacted most of these provisions in response to recommendations from MCH leaders through AMCHP and its partner organizations. AMCHP continues to seek opportunities to strengthen the statutory basis for effective program coordination.

Use the "vision thing"!

One of the most, if not the most, important roles of a leader is to develop, communicate and mobilize others around a vision for the future. If the Title V program previously developed a vision statement, review it and renew or revise it with your internal and external stakeholders. Taking a look at vision statements from AMCHP, MCHB and other states, as well as your agency's, can be useful in this process.

AMCHP's vision is to build a society that values healthy families as the foundation of vital communities.

MCHB's vision is, a future America in which the right to grow to one's full potential is universally assured through attention to the comprehensive physical, psychological and social needs of the maternal and child health population. We strive for a society where children are wanted and born with optimal health, receive quality care and are nurtured lovingly and sensitively as they mature into healthy, productive adults. MCHB seeks a nation where there is equal access for all to quality health care in a supportive, culturally competent, family and community setting.

Knowing and passionately communicating your vision can inspire others to work with you. With a vision to work toward, you can align strategies, plans and budgets to support it.

Communicate your vision frequently. Be able to articulate it in 30-second sound bites that your audience will hear and remember. Your passion can be contagious.

Know your key stakeholders

Stakeholders - those who have or could have a direct interest in your programs - include a wide range of groups, such as:

- Your staff
- Consumers of services your programs directly support
- Providers of services funded by your programs
- Clinical and health professionals and their organizations
- Other state programs and agencies, especially those with overlapping missions, functions or target populations
- Local health agencies
- Community-based organizations
- Your agency's leaders
- Governor, including key staff
- State legislature, especially key committees
- Congressional delegation
- Advocacy and voluntary agencies
- Business community
- Faith community
- Health care providers, including hospitals and community health centers
- Academic institutions, especially schools of public health
- Women, children, youth and families who benefit from population-wide functions

A fundamental part of your job as a state leader is to forge relationships with stakeholders, especially those with strategic importance to achieving your vision, mission and goals.

Tips for building partnerships

- Learn about and actively practice family-centered policies and programs
- Learn about and actively practice cultural competence
- Identify effective committees, associations and other groups with similar missions and contribute to their work
- Identify and cultivate potential champions in key stakeholder groups to help carry your vision
- Learn about the mission, goals and agendas of key stakeholders and help them within the context of your mission
- Learn who your program's detractors are and why; develop strategies to respond to their concerns
- Form task forces, advisory groups and coalitions when appropriate to achieve specific strategic aims

Pearls of wisdom from your colleagues...

- The more difficult the relationship, the more important it is to meet face-to-face
- Assess what you might do differently, but do not take all difficulties personally
- Some responses may be to past history or the legacy of your predecessor. Find out your key stakeholders' views of your programs and learn from that past history and legacy
- Never, ever burn your bridges!

Be a good listener, always be willing to meet people halfway, do not be afraid to help someone get their needs met first, and build your reputation as someone who is trustworthy and who honors their commitments.

Donna Petersen, University of Alabama at Birmingham, former CSHCN and family health director

Understand Your Advocacy Role

As we saw earlier, public sector advocacy for maternal and child health has roots dating back to the beginning of the 20th century. A dictionary definition of advocacy is "an act of pleading for a cause." The dictionary definition of the verb to advocate "is to support or urge by argument." Leaders of Title V programs generally have a commitment to the cause of improving health and well-being. MCH leaders need to lay out a vision and support its achievement, using data and evidence to make the argument for specific programs. So, you are an advocate!

Agency culture. The possibilities for advocacy are numerous. It's important to know the limitations, but often you are not as limited as you may assume. There are several parameters for advocacy as a state employee. First is the extent to which your agency fosters or discourages open discussion and diversity of views. All agencies need their senior staff to support the agency's mission and goals, but there are degrees to which agencies seek total adherence to the "party line." This political culture affects the degree to which you may be able to argue or discuss disagreements publicly. Observe and ask colleagues about your agency's culture.

External communications. Another parameter affecting advocacy is agency policy on communications with the state legislature, the governor's office, congressional delegation or the media. Many times, public employees assume that such communications are not possible, when they may be. Sometimes you need advance approval, which seems like a barrier. Learn what your agency's policies are, in statute, written policy and in practice. You can then determine if and how you may use direct communications.

In some states, direct communications with legislators, the governor's office and media may be centralized in the agency. If this is the case in your state, one of your advocacy roles is to educate the individuals in these central offices about your areas of expertise and the MCH programs. If you become a helpful resource to these offices, they are more likely to represent your programs in their communications or even direct questions to you. In some states, it may be routine for such communications to be routed to you, although you may not be allowed to initiate such contacts. Some states allow both response and initiation of contacts by certain senior managers. In these cases, you can build a reputation as a helpful resource with these key external players.

Education versus lobbying. It's useful to bear in mind the distinctions among education, advocacy and lobbying.

Education, or the provision of information and science-based evidence, is an essential public health service. Education coupled with a call to action is advocacy. This role is also consistent with a core public health service: leadership for priority-setting, planning and policy development. Only when advocacy focuses on specific legislation does it become lobbying.

There is no blanket prohibition on lobbying by public employees. Again, if you seek to lobby, to affect specific legislation, it is important to know if you are within permissible parameters for your agency. You must also be sure that any time spent lobbying is not charged to federal funding that prohibits use of those funds for that purpose, such as Title V. Finally, you can lobby as a private citizen on your own time.

There may be some real barriers to lobbying, so how else can you advocate for action? Lots of ways!

Public health tools for advocacy

- Sharing newsletters, fact sheets and reports with key stakeholders like advocates and policymakers
- Informational briefings and conferences for advocates and policymakers
- Inviting policymakers to visit programs
- Convening task forces and advisory committees to review information and develop recommendations
- Facilitating or participating in coalitions to stimulate specific action

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Understand the Policy Process

A former German chancellor noted, "*People who love the law or good sausage should never watch either being made.*" However, if you want to educate, advocate or even lobby to influence policy, it's critical to know how public policy is made, both formally through legislation and informally through policymakers.

The governor. The state's chief executive is clearly in a position of power and influence. Gubernatorial priorities are in turn influenced by a number of factors, including not only party and ideology but personal background and experiences. Find out as much as you can about these and their potential link to MCH issues. Does the governor have children? Do the governor or his contributors have any strong ties to health groups? What are the governor's spouse's interests? Spouses often take on campaigns and initiatives relevant to family health. Find out how the governor's office is structured, whether there are advisors on health or families, and what their backgrounds and interests are. Be sure to provide them with information relevant to their interests, if appropriate. The governor's office usually will initiate the state budget, introduce legislation in priority areas and can dictate many aspects of state agency operations.

The state legislature. State legislatures vary tremendously in their make up and operations. Know whether yours is part-time or full-time, paid or volunteer, staffed or not. These characteristics can make a big difference in the timing and information needed to enact legislation. Know which committees in both branches have jurisdiction over budget and policy matters related to health, children and families, and other areas of importance to you. Committees are the next step after introduction of legislation, and committees have the power to stop or significantly alter legislation before it goes to each branch for a vote and, if passed, to the governor for action. Know the chairs and most influential members of the committees, along with those who are most interested in your issues. Attend committee hearings if possible to learn their styles and interests; observe how others before the committees present testimony and respond to questions. Get to know legislative staff, establishing yourself as a helpful expert resource - they will remember!

Congressional delegations. Do not forget the federal policy process! While significant power has been devolved to the state level, Congress still exerts strong influence on what states can do. Congress makes decisions on the federal budget and appropriations for specific programs, including Title V. The Labor, HHS and Education appropriations committees in both the House and Senate are key to Title V and other programs benefiting women, children, youth and families. Authorized under the Social Security Act, Title V is under a different Senate committee than programs authorized under the Public Health Service Act. As with your state legislature, knowing the process and the key players in Congress is important to your ability to assist them with information and recommendations. You also need to know your state's senators and representatives to Congress and their committees that are relevant to your programs. As with state-level policymakers, it is important to develop relationships with these federal staffs, making yourself known as a good source of information.

Influential people in your state. Regardless of the degree of latitude you have to interact directly with policymakers, it's important to know who has influence with them and whether anyone has a connection with your programs. Often, a personal connection to an issue has a strong influence on policies.

Use Communications and Marketing Strategies

Once a dirty word in health and human service circles, marketing has come to be recognized as an important tool in public and nonprofit arenas. At a very basic level, this means thinking beyond the programs to *how* they are presented and to *whom*.

Some simple tips for marketing

- Write simply, using plain English and short sentences
- Use easy-to-understand state maps, graphs and pie charts to depict data
- If you can, budget for professional printing of documents that will be disseminated broadly, using colors and plenty of space
- Make your website a priority; keep it up-to-date, interesting and complete with key data, reports, contact information and links, including a link to AMCHP
- Tell stories about your data and programs or, better yet, have families tell stories about the impact of programs

Working with the media. Knowing how to work with the media can do a lot to help you get the word out on your vision, your programs' accomplishments and resources that are needed to achieve goals. Your state agency's public information office can be a resource, and it's well worth your time to inform them about your programs and areas of expertise. That office will be more likely to forward media calls to you or represent your perspectives with the media. Working with this office, you can develop proactive media strategies, using tools like letters to the editor, op-ed columns, press releases and press briefing kits, and human interest pieces profiling local programs and family stories. These tools can get your messages across more powerfully than written reports. As with policymakers, making yourself known as a credible source of information for the media can help assure balanced coverage of issues concerning the health of women, children, youth and families. Consider training for yourself and key colleagues if your senior team doesn't have this expertise.

Resources

[Association of Maternal and Child Health Programs](#), including the Legislative Center

[Connecticut Health Policy Project](#) has a web based toolbox for state level advocacy

[MCH Leadership Skills Training Institute](#)

[New England SERVE](#)

[Women and Children's Health Policy Center, Johns Hopkins University](#) - including compendium of MCH related legislation

CHAPTER 4 The ABCs: Key Players at National and State Levels

Ya Gotta Have Friends!

It is a truism that no one can succeed alone. MCH leaders have learned this lesson well over the years. Chapter 4 provides more specific information about the legislative process (federal and state), as well as some of the Title V partners that share similar concerns and viewpoints with MCH and CSHCN programs. Some are federal agency partners and others are advocacy organizations that offer services that you may find useful.

Public Policy at National and State Levels

The federal government is a key national partner for the Title V program, particularly because the program exists as a result of federal legislation and annual appropriations. For those of you who need a quick reminder, a review of the three branches of government and the federal and state legislative processes may be helpful. If you are already familiar with this information, feel free to skip ahead to the sections on national and state agencies.

The Legislative Process

The business of Congress is to make laws; their work begins with the introduction of a proposal that can take the form of a bill, a joint resolution, a concurrent resolution or a simple resolution. A **bill** is the form used for most legislation and can originate either in the House of Representatives or the Senate. The letters "H.R." designate a bill originating in the House of Representatives ("S." is used for bills originating in the Senate), followed by a number that the bill retains throughout its parliamentary stages. Bills are given to the president for action when approved in identical form by both the House and the Senate.

Joint resolutions may originate either in the House or the Senate; there is little practical difference between a bill and a joint resolution as both become law in the same manner (except for a joint resolution proposing an amendment to the Constitution).

Concurrent resolutions are used for matters affecting the operations of both the House and the Senate. On approval by both bodies, they are signed by the clerk of the House and the secretary of the Senate and are not presented to the president for action. A matter concerning the operation of either the House or Senate alone is initiated by a *simple resolution* that is not presented to the President for action.

Any member of the House or Senate may introduce a bill. An important phase of the legislative process is the action taken by committees that function similarly in both bodies. It is during committee action that the most intense consideration is given to the proposed measures. Each bill is referred to the committee that has jurisdiction over the area affected by the measure. Usually the first step in the process is a public hearing where committee members hear witnesses representing various viewpoints. After hearings are completed, the bill is considered in a session that is commonly known as the "markup" session where amendments may be offered to the bill, and the committee members vote to accept or reject these changes. Markup can happen in either the subcommittee, full committee or both. At the conclusion, a vote of the committee or subcommittee members decides what action to take. It can be reported, with or without amendment, or tabled. If the committee approved extensive amendments, they may decide to report a new bill incorporating all the amendments, known as a "clean bill" which is also given a new number. If the committee votes to report a bill, the Committee Report is written to describe the purpose and scope for the measure and the reasons for recommended approval. After the committee has reported a bill, it is generally ready for action by the full House or Senate where debate time is provided to proponents and opponents, and a final vote is held. Once a measure passes the House or Senate, it is sent to the other body for consideration. A bill must pass both bodies in the same form before it can be presented to the president for signature into law. If there are any changes, differences must be resolved, usually by a conference committee appointed with both House and Senate members. This group will resolve differences and report an identical measure back to both bodies for a vote. Final votes may be taken by the electronic voting system that registers each individual member's response (although votes in the House may be by voice vote without a record of individual responses). After a bill has passed both the House and the Senate, it is considered "enrolled" and is sent to the president, who may sign it into law, veto it and return it to Congress, let it become law without signature, or, at the end of a session, pocket-veto it.

The state legislative process. The legislative process used in most states mirrors that of Congress although there can be some unique differences. Besides understanding the federal legislative process, it is important that the Title V leader be completely familiar with the legislative process for his own state or jurisdiction and to know the relevant committees and their members. Usually the state legislature will print a limited number of legislative directories. If you are unable to obtain a copy of that directory, some advocacy or professional organizations print and distribute free copies of state legislative rosters, committee assignments, maps of districts, etc. If the state agency has a legislative liaison, meet with that person to establish your interest in all bills and public hearings concerning MCH, CSHCN and family health issues. There may also be a daily publication or website that provides information about bills introduced, committee assignment for bills, hearing schedules, reports of testimony, and other information. You should scan these publications frequently while your legislature is in session to ensure that you are aware of any proposed bills that impact the Title V program and alert your agency's legislative liaison or chain of command about the need for possible agency positions, testimony or behind-the-scenes conversations with the sponsors or friendly legislators.

Tips for success

- Stay well informed about current legislative activity at both the federal and state level.

Keep one-page, "thumbnail" descriptions of your programs handy as background information to use during bill drafting, hearings, etc.

The Judicial Branch

The U.S. Supreme Court is the highest court in the country and is vested with the judicial powers of the government. There are lower federal courts that have been established by Congress using the power granted from the Constitution. Courts decide arguments about the meaning of laws, how they are applied and whether they violate the Constitution. The judiciary uses its power of judicial review to provide checks and balances on the legislative and executive branches of government.

The Executive Branch

The executive branch of government is responsible for enforcing laws. It is recognized that one person, the president, cannot carry out the duties of the office without advice and assistance. The vice president, department heads (Cabinet members) and heads of independent agencies assist in this capacity; however, their powers are not defined in the Constitution although each has specific powers and functions that have been spelled out in law. Department heads advise the president on policy issues and help to carry out those policies. You will relate most to the agencies and programs within the U.S. Department of Health and Human Services (DHHS).

The Federal Budget. The president submits a budget to Congress by February 1 each year. The budget contains estimates of federal government income and spending for the upcoming fiscal year (obtained from the Office of Management and Budget - OMB) and also recommends funding levels for the federal government. The president's budget is jointly developed and negotiated through the programs and departments, OMB and White House advisors before the president reviews and approves it for submission to Congress. Congress then must pass all appropriations bills based on the president's recommendations and congressional priorities.

There is a congressional budget plan, separate from the president's budget. The Senate Committee on the Budget, along with the House Budget Committee, is responsible for drafting Congress's annual budget plan and monitoring action on the budget for the federal government. The annual budget resolution is an agreement between the House and Senate on a budget plan for the upcoming fiscal year and at least the following four fiscal years. The budget resolution is in the form of a concurrent resolution, so it is not sent to the president for his signature and thus does not become law, but it does provide a framework for subsequent legislative action on the appropriations bills. Additionally, the budget committees have jurisdiction over the Congressional Budget Office (CBO). The CBO provides Congress with objective, timely, nonpartisan analyses needed for economic and budget decisions.

There is a timetable for the consideration of budgetary legislation:

- May 15, annual appropriation bills may be considered in the House
- June 10, House Appropriations Committee reports the last appropriation bill
- June 30, House completes action on annual appropriation bills
- October 1, federal fiscal year begins and all appropriations actions should be completed

June 10 and June 30 serve as target dates. If Congress does not pass all appropriations measures by the start of the fiscal year, it has to enact a continuing resolution to keep the government running. In recent years, Congress has not been able to complete its work on all of the appropriations bills by the deadline. As a result, there have been multiple continuing resolutions adopted to keep federal agencies open and functioning at the same (i.e., continuing) level of funding.

You should be prepared for the management issues that arise in your agency when your federal funding is dependent upon a continuing resolution.

In one recent fiscal year, three continuing resolutions over nearly two quarters were necessary before the appropriations bill was finally adopted. If the final appropriations bill results in a cut to the previous funding level, it is more difficult for the state to adjust its spending in a fiscal year already underway with a higher level of spending. It's important to keep an eye on the federal budget process and to alert your agency's leadership about any anticipated problems you may have in meeting fiscal obligations.

Remember that the congressional budget process involves two separate and distinct parts. First is legislation that sets a ceiling for future spending for a specific program, known as the authorization level. Besides setting a funding ceiling, authorization legislation also lays out the overall policy framework for programs. Currently, the authorization level for the Title V-MCH Block Grant is \$850 million. Once a program is authorized, Congress can choose to fund the program (or not) in the separate appropriations act process already described above.

Federal Spending. Spending by the federal government is a multi-step process in which budget authority is enacted and obligated, and outlays are generated. Budget authority is enacted into law and gives federal agencies the legal basis to incur obligations. Obligations establish the financial liabilities of the federal government and reflect such activities as employing staff and contracting. Outlays are the payments (expenditures) made to honor the obligations.

Budget authority is the specific dollar amount made available for obligation and is provided in appropriations and direct spending legislation. For some programs, however, budget authority is indefinite, providing "such sums as may be necessary" to achieve certain purposes. Budget authority may be enacted for one year, several years or no-year periods. Annual budget authority is available for obligation only during a specific fiscal year, and any unobligated authority expires at the end of that fiscal year. Multi-year authority is available for a period of time longer than one year (the Title V block grant has two-year budget authority, which allows funds appropriated in one year's budget to be spent over a two-year period), and no-year budget authority is available indefinitely. Federal agencies are prohibited by law from obligating more budget authority than was provided by the appropriations act. Adjustments such as a rescission (cut) may be made to cancel or reduce budget authority after it was enacted into law.

The State Budget. The state budget process generally involves only the legislative process for a budget appropriations bill. Usually this is done annually, although some states have a biannual budget process. Before the governor's budget is introduced in the state legislature, however, there is a great deal of work that goes into the preparation of that budget. As a Title V leader, you will be involved in the budget preparation process to a greater or lesser degree for the programs under your supervision. Generally, the state's office of budget and management (OBM or comparable title) provides budget preparation guidance and a proposed funding ceiling by line item to the agency director and fiscal/budget officer. The programs must then develop justifications for maintaining current funding levels, justifications for increased funding, or adverse impact statements for reduced or eliminated funding. Once the agency responds to the initial proposal from the state's budget office, an opportunity might be provided to negotiate and resolve differences between what OBM suggested and the state agency requests.

You should try to participate in meetings with OBM if possible to present strong justification for your program needs. If that is not permitted, be certain that you thoroughly brief the staff who do attend the OBM meeting.

It is common that all of the steps of the budget preparation process are kept confidential until the governor has approved the budget and it has been introduced into the state legislature as a bill. Once the budget bill has been introduced, your agency will likely be expected to support the governor's budget request. If the budget request is inadequate to meet the program needs, you are in a difficult situation because you cannot publicly criticize your governor's budget. You will find that program advocates and families are in the best position to press the legislators for additional funds during budget hearings. They may request information from your programs in order to be effective in their advocacy.

Be sure that you completely understand the budget development and adoption process for your specific jurisdiction. In some states, the legislature plays a more prominent role than the governor in making funding decisions. While the nuances may vary depending on your locale, the role you play as the MCH senior manager will remain largely unchanged. Be prepared to respond quickly, efficiently and effectively to information requests when the legislature is giving consideration to the budget. Anything can happen!

Selected Federal Partners

The following is a very limited listing of some of the major federal partners providing direction and funding to Title V programs. This is meant to be only a handy reference for you to use in identifying those agencies and programs within your state that share your interest and concern in family health. You should become familiar with these and other federal programs in your state.

Maternal and Child Health Bureau (MCHB)

The Maternal and Child Health Bureau (MCHB) is located in Rockville, Maryland, and administers the MCH-Title V Block Grant. More detailed information about MCHB is found in Chapter 2. Within the MCHB, the Division of State and Community Health (DSCH) is the federal government's primary liaison with each of the 59 states' and jurisdictions' MCH programs. New state Title V leaders and senior managers should meet with their assigned DSCH project officer for an orientation, technical assistance and federal insights into your program's areas of strength, as well as those areas needing attention.

The Centers for Disease Control and Prevention

The CDC, part of DHHS, but located in Atlanta, is another federal partner important to the Title V program. It is recognized as the lead federal agency for protecting the health and safety of people - at home and abroad. CDC is composed of the following organizations:

- National Center on Birth Defects and Developmental Disabilities
- National Center for Chronic Disease Prevention and Health Promotion
- National Center for Environmental Health
 - Office of Genomics and Disease Prevention
- National Center for Health Statistics
- National Center for HIV, STD and TB Prevention
- National Center for Infectious Diseases
- National Center for Injury Prevention and Control
- National Immunization Program
- National Institute for Occupational Safety and Health
- Epidemiology Program Office
- Public Health Practice Program Office

New Title V leaders may want to develop a relationship with several of the CDC organizations because they tie closely to MCH and CSHCN programs and are potential sources of information (data), technical assistance and funding. For example, the National Center on Birth Defects and Developmental Disabilities'

funding opportunities include support for expanded surveillance and epidemiology in autism and Duchenne and Becker muscular dystrophy, fetal alcohol syndrome prevention, early hearing detection and intervention programs, and a national spina bifida program. The National Immunization Program provides ongoing leadership to reduce disability and death resulting from vaccine-preventable diseases. The National Center for Injury Prevention and Control administers the Traumatic Brain Injury (TBI) prevention program. These CDC programs should all relate to and enhance state Title V programs. If CDC funding for these programs is not under your direct span of control, you need to develop a relationship with the manager in your agency responsible for these programs and identify how to enhance coordination.

Centers for Medicare and Medicaid Services (CMS)

On July 1, 2001, the Health Care Financing Administration in Department of Health and Human Services was reorganized into the Centers for Medicare & Medicaid Services (CMS). Three new business centers were established as part of the reform: the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations. The latter is the center of most interest to Title V programs; detailed information about the three business centers and their programs is available on the CMS website. There are five major CMS programs with which you should be familiar. You need to develop a working relationship with the state personnel responsible for their implementation, because they have major impact on Title V services and our clients.

- **Medicaid**

Title XIX of the Social Security Act, passed in 1965, established Medicaid, a federal/state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program is a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the territories) to assist states in furnishing medical assistance to eligible needy persons.

Medicaid is the largest source of funding for medical and health-related services for America's poorest people, and the state share of funding to participate in Medicaid is generally the largest item (or close to it) in the state budgets.

Within broad national guidelines established by federal statutes, regulations and policies, each state

(1) establishes its own eligibility standards (but limited to individuals who fall into any of 25 specified categories);

(2) determines the type, amount, duration and scope of services;

(3) sets the rate of payment for services; and

(4) administers its own program.

Medicaid policies for eligibility, services and payment are complex and vary considerably, even among states of similar size or geographic proximity. A person eligible for Medicaid in one state may not be eligible in another, and the services provided by one state may differ in amount, duration or scope from services provided in a similar or neighboring state. Certain services must be covered by the states and other services are optional.

Because the Medicaid program is individualized by each state, the relationship between Medicaid and the Title V programs is also highly individualistic. A new Title V leader should meet with the Medicaid director regularly to ensure coordination between the programs for seamless services to clients, timely reimbursement to providers and development of an agenda of mutual concerns, such as oral health services for children.

- **State Child Health Insurance Program (SCHIP)**

The Balanced Budget Act of 1997 amended the Social Security Act to add Title XXI, the State Children's Health Insurance Program.

This legislation enables states to initiate and expand health assistance to uninsured, low-income children. The assistance can be provided primarily through two methods:

(1) a program to obtain health insurance coverage that meets certain requirements relating to the amount, duration and scope of benefits; or

(2) expanded eligibility for children under the state's Medicaid program.

This program allows each state to offer health insurance plans for children up to age 19 who are not already insured. Families who earn too much to qualify for Medicaid may be able to qualify for SCHIP, a capped entitlement for states. To be eligible for funds, states must submit a State Child Health Plan, including a description of the coordination with Title V programs.

A new Title V leader should meet regularly with the state's SCHIP director, because this program has greatly impacted the service delivery system for children. For example, in some states, the children with special health care needs (CSHCN) population was carved out of the general SCHIP population and the Title V program was assigned to provide their services. In other states, the CSHCN population was retained in SCHIP and the Title V program sets standards for the services they receive.

Like Medicaid, implementation of SCHIP is highly individualistic in each state, territory and jurisdiction; in some states it may be part of Medicaid. The Title V leader must be on good footing with the SCHIP leader and develop an agenda of mutual interest to assure high quality services for all children in the state.

- **EPSDT**

The Early Periodic Screening, Diagnosis and Treatment (EPSDT) program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21.

EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental and hearing services. In addition, EPSDT requires that any medically necessary health care service listed in the law be provided to an EPSDT recipient even if the service is not available to the rest of the state's Medicaid population.

The EPSDT program has two components:

(1) assuring the availability and accessibility of required health care resources; and

(2) helping Medicaid recipients and their parents or guardians effectively use these resources.

The state Medicaid agencies are supposed to manage a comprehensive child health program of prevention and treatment, seek out those who are eligible and inform them of the benefits of prevention and the health services available to them, and help them and their families use health resources effectively. The state Medicaid agency is also supposed to assess the child's health needs through initial and periodic examinations and assure that health problems are diagnosed and treated early. With the recent intense focus on Medicaid managed care and the SCHIP program, the EPSDT program has faded into the background somewhat. However, the state Medicaid agencies must still provide annual reports to CMS about the EPSDT activities in the state, so the state is still responsible for carrying out the EPSDT program. The Title V leader needs to be knowledgeable about the coordination between the SCHIP and EPSDT programs and identify ways Title V may be helpful to the clients served by both programs.

- **HIPAA**

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. CMS is responsible for implementing various unrelated provisions of HIPAA, which may mean different things to

different people. Title I protects health insurance coverage for workers and their families when they change or lose their jobs. It lowers the chance of losing existing coverage, eases the ability to switch health plans and helps people buy coverage if they lose an employer's plan and have no other coverage available.

Title II requires the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans and employers. It also addresses the security and privacy of health data. Title II is critically important to the administration of all health care services including Title V programs.

MCH leaders must ensure that the electronic data systems for patient records, billing and more are in compliance. The Title V leader will need to meet with the Medicaid leadership to discuss the program implications created by compliance in the Medicaid billing system. For example, state specific "dummy" codes have been eliminated. You'll need to discuss adequate reimbursement for Title V services with Medicaid leaders.

- **CLIA**

CMS regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). In total CLIA covers about 175,000 laboratories.

The Division of Laboratory Services, within the Survey and Certification Group under the Center for Medicaid and State Operations, has the responsibility for implementing the CLIA program to ensure quality laboratory testing. Laboratories in clinics and physician offices are generally required to be CLIA-approved to qualify for Medicaid payments.

U.S. Department of Education, Office of Special Education and Rehabilitation Services (OSERS)

OSERS is comprised of the Office of the Assistant Secretary and three program components: the Office of Special Education Programs (OSEP), the National Institute on Disability and Rehabilitation Research and the Rehabilitation Services Administration. OSERS supports programs that help educate children and youth with disabilities, provides for the rehabilitation of youth and adults with disabilities, and supports research to improve the lives of individuals with disabilities.

- **IDEA '97**

OSEP administers the Individuals with Disabilities Education Act (IDEA) including early intervention and preschool programs. OSEP develops and disseminates federal policy and information on early intervention and the education of infants, toddlers, children and youth with disabilities. It also monitors and reports on the implementation of federal early intervention policies and coordinates with other federal agencies, state agencies and others. The IDEA Amendments of 1997 (IDEA '97) represent the first major revision to the act in more than 23 years (since the enactment of P.L. 94-142, the Education of all Handicapped Children Act of 1975). IDEA '97 retains and strengthens the basic rights and protections under IDEA - including the right to a free appropriate public education (FAPE) for all children with disabilities (including children suspended or expelled from school) and the procedural safeguard rights for these children and their parents. The early intervention program authorized under IDEA '97 is administered by a variety of agencies in the states, typically health (usually the MCH or CSHCN program), education or mental health. A new Title V leader should quickly identify the agency responsible for the IDEA programs and meet to coordinate between the programs. Generally, early intervention programs need help to complete diagnostic evaluations and arrange health care services for the children in the program.

Head Start

Head Start and Early Head Start are comprehensive child development programs that serve children from birth to age 5, pregnant women and their families. Their goal is to increase the school-readiness of young children in low-income families. The Head Start Bureau, the Administration on Children, Youth and Families (ACYF), Administration for Children and Families (ACF) in the DHHS administers the Head Start program. The ACF Regional Offices and the Head Start Bureau's American Indian - Alaska Native and Migrant and Seasonal Program branches award grants directly to local public agencies, private organizations, Indian Tribes and school systems for operating Head Start programs at the community level. Participation in Head Start programs requires income eligibility. All Head Start programs must adhere to program performance standards and define the services that they provide to the children and families in accordance with the expectations, requirements, goals and objectives of Head Start. Because Head Start grants are funded directly to local agencies, a new Title V leader will want to meet with the Head Start Directors Association president for your area to identify areas for coordination between the programs. Typically, Head Start programs are interested in health care services, particularly evaluations and immunizations, for enrolled children. Title V programs may be able to provide for health, dental, disabilities and nutrition consultation services to local Head Start programs.

Office on Women's Health

The Office on Women's Health (OWH) in the Department of Health and Human Services was established in 1991 to improve the health of American women through health care prevention and service delivery, research, public and health care professional education, and career advancement for women in the health professions and in scientific careers. The office also works with numerous government agencies, nonprofit organizations, consumer groups and associations of health care professionals. Since 1998, OWH has operated a website, the National Women's Health Information Center (NWHIC), for the public, health care professionals, medical researchers, educators and the media.

Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA, an agency of the Department of Health and Human Services, was established in 1992 to improve the lives of people with or at risk for mental and substance abuse disorders. SAMHSA offers discretionary grants and communications initiatives on co-occurring mental and substance abuse disorders, criminal justice, children and families, aging, substance abuse treatment capacity, prevention and early intervention, the New Freedom Initiative, homelessness, disaster response, seclusion and restraint, and HIV/AIDS. SAMHSA supports formula grant programs, primarily the Mental Health and Substance Abuse Prevention and Treatment block grant programs. Under both programs, SAMHSA encourages states and territories to address substance abuse prevention, addiction treatment and mental health, both by supporting service programs and by assessing progress, needs and ongoing activities. Because Title V provides comprehensive health care services to families, it is important to coordinate between these two programs. Title V programs can benefit from learning more about mental health screening in child and adolescent health services and in perinatal care to high-risk women (including those with addictions and substance abuse), appropriate locations for referrals, and data for the Title V needs assessment.

National and State Organizations

Following is a very limited listing of some of the key partners for Title V, especially in the policy arena. Brief descriptions of the organizations, their location and services are included for your information. Some of these organizations have state offices; others have a national presence only but their policy activity frequently affects Title V. This listing is not exhaustive and is meant to be only a beginning point for you to use in identifying organizations in your state that share your interest in family health. You will want to create your own list of organizations that are critical to the success of Title V in your state.

Association of Maternal and Child Health Programs (AMCHP)

AMCHP is *your* association - the national nonprofit organization representing state public health leaders and others working to improve the health and well-being of women, children, youth and families, including those with special health care needs. It is an affiliate organization of the Association of State and Territorial Health Officials (ASTHO) and maintains its offices in Washington, D.C. AMCHP accomplishes its mission through

the active participation of its members and vital partnerships with government agencies, families and advocates, health care purchasers and providers, academic and research professionals, and others at the national, state and local levels. AMCHP offers many opportunities for you to formulate health policy at the national level and learn more about the field, such as:

- Participating in the AMCHP mentoring program for new Title V directors or the data training for epidemiologists
- Attending annual meetings that attract more than 800 attendees to educational sessions on cutting-edge topics
- Participating on AMCHP committees or task forces that:
 - Develop policy documents such as [A Conceptual Framework for Adolescent Health](#) or fact sheets such as [MCH Role in Bioterrorism Planning](#)
 - Develop tools useful to Title V administrators such as [CAST-5: Capacity Assessment for State Title V](#), an assessment approach to linking the 10 essential MCH services with related organizational resources
 - Confer with key federal officials from MCHB and CDC
- Supporting national advocacy efforts such as congressional briefings on Title V topics or congressional hearings on proposed legislation or the federal budget
- Running for AMCHP board officer or regional councillor
AMCHP gives voice to your interests!

Tips for success

- Meet with your AMCHP regional councillor early in your new job. You will be welcomed, provided with resources helpful to your job performance and informed about current AMCHP activities.
- Talk with your state health agency's member(s) of the following national associations about their organization's activities relevant to Title V programs.

Association of State and Territorial Health Officials (ASTHO)

ASTHO is the national nonprofit organization for the states, territories and the District of Columbia public health agencies. ASTHO's members are the chief health officials of these jurisdictions. ASTHO has 17 affiliate organizations, including AMCHP. ASTHO's mission is to formulate and influence sound national public health policy, to assist state health departments in the development and implementation of programs and policies to promote health and prevent disease, and to assure excellence in state-based public health practice. ASTHO maintains its headquarters in Washington, D.C. and has public policy information related to *access to care, environmental health, infectious diseases, prevention, public health informatics and public health preparedness*.

Association of Public Health Laboratories (APHL)

APHL is headquartered in Washington, D.C., and represents national, state, city and local public health, environmental and international laboratories. It is an affiliate organization of ASTHO. APHL's mission is to promote the role of public health laboratories and policies and programs that assure continuous improvement in the quality of laboratory practices. The association links public health laboratories in 50 states and six territories with federal partners, such as the Centers for Disease Control and Prevention, the Environmental Protection Agency, the Department of Homeland Security and the Federal Bureau of Investigation.

Association of State and Territorial Dental Directors (ASTDD)

ASTDD is a national non-profit organization representing the directors and staff of state public health agency programs for oral health and is headquartered in Jefferson City, Mo. ASTDD formulates and promotes the establishment of sound national dental public health policy and assists state dental programs in the development and implementation of programs and policies for the prevention of oral diseases. It is an affiliate organization of ASTHO.

Council of State and Territorial Epidemiologists (CSTE)

CSTE is a professional organization of public health epidemiologists. Headquartered in Atlanta, CSTE is concerned with the surveillance and epidemiology of infectious diseases, chronic diseases and conditions, and environmental health concerns. It is an affiliate organization of ASTHO. CSTE promotes the effective use of epidemiologic data to guide public health practice and improve health through effective public health surveillance, good epidemiologic practice, standards for practice and advocacy.

National Association of Public Health Statistics and Information Systems (NAPHSIS)

NAPHSIS is a national association of state vital records and public health statistics offices and is based in Washington, D.C. It is an affiliate organization of ASTHO. The association develops and markets innovative programs and services to promote collaboration among vital records, health statistics and health information systems professionals in providing health information to policymakers and the public.

National WIC Association (NWA)

NWA is a national association for state and local directors of WIC programs and maintains headquarters in Washington, D.C. It provides leadership in promoting quality nutrition services; advocating for services for all eligible women, infants and children; and assuring sound, responsive management of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

State and Territorial Injury Prevention Directors Association (STIPDA)

STIPDA is a national nonprofit organization of public health injury prevention professionals in state and territorial public health departments. It is an affiliate organization of ASTHO with headquarters in Atlanta. The association produces *Safe States 2003* and other publications about injury prevention programs.

Family Voices

Family Voices is a national grassroots network of almost 40,000 families, friends, professionals and advocates for health care services that are family-centered, community-based, comprehensive, coordinated and culturally competent for all children and youth with special health care needs. Family Voices is also a clearinghouse for information concerning the health care of children with special health needs.

Family Voices is based in Albuquerque, N.M., and is represented in every state, Washington, D.C., Puerto Rico and the Virgin Islands. Many state organizations are operated on a volunteer basis, while some are funded. Title V leaders and senior managers should be very familiar with the Family Voices leaders in their area. See Chapter 6 for a further discussion on the importance of family involvement in Title V programs.

The following list of organizations may not have programs linked directly to your agency, but all are important to Title V programs.

American Academy of Pediatrics (AAP)

AAP is a national and state-level membership organization for pediatricians. It maintains an office in Washington, D.C., to ensure that children's health needs are taken into consideration as national legislation and public policy are developed, but headquarters are located in Evanston, Ill. AAP interests include access to care for low-income children, injury and poison prevention, disabled children, sports medicine, nutrition, child health financing, child safety legislation and Medicaid policies.

Title V leaders should establish a close relationship with the AAP state chapter president. Members of the state chapter are a wonderful resource for draft policy review, consultation about program standards of care, strategic planning, educational programs and other advisory functions. Their testimony and other advocacy activities are usually very helpful during budget hearings, as well as hearings on other bills impacting Title V programs.

American College of Obstetricians and Gynecologists (ACOG)

ACOG is a membership organization dedicated to advancing women's health through education, practice, research and advocacy. ACOG has over 45,000 member physicians who are specialists in obstetrics and gynecology. Based in Washington, D.C., it is a private, voluntary, nonprofit membership organization that also has state chapters. *Title V leaders should cultivate a relationship with ACOG for advice on women's health policies, program care standards, strategic planning, educational programs and advocacy.*

American Public Health Association

APHA members represent more than 50 occupations of public health. Its headquarters are located in Washington, D.C., but there is an affiliated chapter in each state, New York City, five territories and the District of Columbia. Its mission is to improve public health for everyone. The basic organizational unit of APHA's membership is the 25 discipline-based sections and seven Special Primary Interest Groups (SPIGs) that enable members to share knowledge and experience with their peers, develop new techniques and contribute to the growing body of scientific knowledge within their respective fields. APHA sections of particular interest to Title V include maternal and child health, food and nutrition, HIV/AIDS, injury control and emergency health services, and statistics. The *American Journal of Public Health* is a publication of APHA.

American Public Human Services Association (APHSA)

APHSA is a nonprofit, bipartisan organization of individuals and agencies concerned with human services. Members include all state and many territorial human service agencies, more than 1,200 local agencies, and several thousand individuals who have an interest in human service programs. APHSA educates members of Congress, the media and the broader public on what is happening in the states around welfare, child welfare, health care reform, and other issues involving families and the elderly. The headquarters is located in Washington, D.C., and APHSA has 12 affiliate organizations including the National Association of State Medicaid Directors, National Association of State Child Care Administrators and the National Association of Public Child Welfare Administrators.

The Arc of the United States

The Arc is the national organization of and for people with mental retardation and related developmental disabilities. It seeks to improve supports, services, research and education for people with mental retardation and their families. The Arc is a grassroots organization with 140,000 members who are affiliated through approximately 1,000 state and local chapters across the nation; national headquarters are located in Silver Spring, Md.

Children's Defense Fund (CDF)

CDF began in 1973 and is a private, nonprofit organization that lobbies for all American children. Headquarters are in Washington, D.C., although a few states also have state CDF organizations. CDF has high quality publications, issue briefs, initiatives and other activities of interest to Title V.

Families USA

Families USA is a national, nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health care for all Americans. Working at the national, state and community levels, it is an effective lobbying group for health care consumers. Its headquarters are found in Washington, D.C. Families USA produces health policy reports, conducts public information campaigns about the concerns of health care consumers, operates a consumer information clearinghouse, provides training and technical assistance, and collaborates with a wide range of organizations interested in health care.

National Association of Children's Hospitals and Related Institutions (NACHRI)

NACHRI is a not-for-profit membership organization of children's hospitals, large pediatric units of medical centers and related health systems, including those that specialize in rehabilitative care of children with serious chronic or congenital illnesses. NACHRI has 161 members, associates and supporters in over 190 hospitals and clinics to ensure children's access to health care and the continuing ability of children's hospitals to provide services needed by children. NACHRI's headquarters are located in Alexandria, Va.

National Association of County and City Health Officials (NACCHO)

NACCHO is the national nonprofit organization representing local public health agencies (including city, county, metro, district and tribal agencies). NACCHO provides education, information, research and technical assistance to local health departments and facilitates partnerships among local, state and federal agencies to promote and strengthen public health.

National Alliance for Hispanic Health

The National Alliance for Hispanic Health (the Alliance) is the nation's oldest and largest network of Hispanic health and human service providers and is located in Washington, D.C. Alliance members deliver services to over 12 million people annually. As an action forum for Hispanic health and well-being, the programs of the Alliance inform and mobilize consumers, promote appropriate use of technology, improve the science base for accurate decision-making, and promote philanthropy.

National Conference of State Legislatures (NCSL)

NCSL is a bipartisan organization serving the lawmakers and staffs of the nation's 50 states, commonwealths and territories. It has offices located both in Washington, D.C., and Denver. It provides a bipartisan, national forum for lawmakers to communicate with one another and share ideas. NCSL represents state lawmakers' interests before Congress, the administration and federal agencies. Each state has an NCSL staff liaison to assist the organization's membership and meet with legislators and staff. While Title V leaders will not be able to access NCSL materials directly, AMCHP is often able to obtain materials and discuss policies with NCSL.

National Family Planning and Reproductive Health Association (NFPRHA)

NFPRHA is a national nonprofit membership organization established to assure access to voluntary, comprehensive and culturally sensitive family planning and reproductive health care services and to support reproductive freedom for all. NFPRHA represents clinicians, administrators, researchers, educators, advocates and consumers. Members include private nonprofit clinics; state, county and local health departments; Planned Parenthood Federation of America affiliates; family planning councils and hospital-based clinics, along with international family planning agencies. NFPRHA members provide reproductive health care at more than 4200 clinics nationwide, to nearly five million low-income women each year. The headquarters is located in Washington, D.C. NFPRHA is an advocacy organization and develops a variety of publications, reports and clinically based fact sheets that are helpful to Title V leaders.

National Governors' Association (NGA)

NGA is a national public policy organization representing the nation's governors and is located in Washington, D.C. NGA represents states on Capitol Hill and before the administration, develops policy reports on innovative state programs and hosts seminars for state executive branch officials. The NGA Center for Best Practices helps governors and their staff learn about emerging issues and develop innovative solutions to governance and policy challenges in their states. The NGA Center tracks, evaluates and disseminates information on issues such as education, health, technology, welfare reform, the environment, energy, social services, trade, transportation, workforce development and homeland security. While Title V directors cannot access NGA materials directly, AMCHP is often able to discuss policy issues affecting Title V programs with NGA staff.

National Urban League

The National Urban League is the nation's oldest and largest community-based organization empowering African-Americans to enter the economic and social mainstream. The Urban League is headquartered in New York City and is a nonprofit, nonpartisan, community-based movement. The heart of the movement is the staffed affiliates located in more than 100 cities in 34 states and the District of Columbia. The mission of the Urban League movement is to enable African Americans to secure economic self-reliance, parity and power, and civil rights.

New England SERVE

New England SERVE is a health policy, research and planning organization that promotes quality systems of care for children with special health care needs and their families. Headquarters are located in Boston, Mass. This organization produces very high quality publications for programs serving children with special health care needs and also provides technical assistance, needs assessments and other consultative services.

March of Dimes

The March of Dimes is headquartered in White Plains, N.Y., and has state chapters. The organization's public affairs agenda focuses on advocacy for public policies and programs that relate to the foundation's mission - improving the health of babies by preventing birth defects and infant mortality - and on issues that pertain to nonprofit organizations. Public affairs efforts are organized into four general categories: access to health care for women of childbearing age, infants and children; research to prevent birth defects and infant mortality; prevention and treatment programs to improve maternal, infant, and child health; and institutional concerns for nonprofit organizations.

Tip for success

- Look at these organizations websites and note their activities related to MCH populations. You'll find many helpful publications!
- Make a list of the key agencies and organizations with interest in family health in your state, territory or jurisdiction. Schedule appointments to meet the key representative of each group to identify and discuss mutual concerns.
- There are many other associations sharing common interests with the Title V program or its "family," such as adolescent health coordinators, genetics coordinators, state family planning directors, Council of Churches, etc. What additional groups can you identify for your jurisdiction?

Resources

[Council for Exceptional Children](#)

[Department of Health and Human Services/Health Resources and Services Administration](#)

[NHeLP publications](#)

[Selected Federal Programs for Children and Families](#). Women's and Children's Health Policy Center, The Johns Hopkins University website.

[Thomas Legislative Information on the Internet](#). Information on executive branch agencies and the legislative process.

[Urban Institute](#) publications

CHAPTER 5 The Big Picture: Planning and Managing Resources for Results

If You Don't Know Where You Are Going, You Will End Up Somewhere Else!

In *The Wizard of Oz*, Dorothy lamented her fears, "Lions! And tigers! And bears! Oh, my!" Planning and managing resources may seem fearsome, but they don't have to be so overwhelming. This chapter offers basic information about family involvement, the strategic planning process, leadership, budget administration and strategies for managing scarce resources

Family Involvement

As raised in the first chapter of this guide, CSHCN programs provide leadership for promoting family involvement in Title V programs. Family involvement in the planning, development and evaluation of all aspects of maternal and child health programs is important to assuring program effectiveness and accountability. National surveys have shown that, increasingly over the last decade, programs are hiring family representatives on staff. Most serve their organizations in more than one area, but nationally there continue to be fewer family representatives in MCH programs, particularly immunization and prenatal care.

One approach to securing family involvement is to develop a parent advisory committee. Staff and parents should mutually set meeting agendas and hold meetings on a regular basis. During meetings, families can help review new policies, brochures and literature to be used by families, and annual report accomplishments. The council may discuss policies that parents find problematic, help develop the strategic plan, participate in the needs assessment, help develop the block grant application and provide advice on the budget. Besides policy making, families can participate in outreach work and training activities for both professionals and families.

For parents to be effective in their role as advisors to Title V programs, they must be provided with education about the block grant and their role. Take the time to ensure they are oriented completely so they feel comfortable and able to participate fully. They should receive information about the work of the advisory committee, the culture of the organization, and the "dos and don'ts" of their new role. A mentor program where seasoned parent advisors and professional staff provide training to new parent advisors is an excellent approach. It might be especially effective to use the experienced parents of CSHCN to assist in engaging families from other Title V programs. Listen to what parents say about the importance of their input. They need to feel welcomed at meetings, including understanding any jargon or acronyms. More than anything, parents want to feel that they are truly making a difference. When you hear someone make a great comment at a meeting, tell her so.

When the chair of a policy level group of professionals invited the new parent representative to offer her views and perspectives on issues under discussion at her first advisory meeting in the 1980s, she said, His behavior demonstrated respect for my opinion, made me feel welcomed and supported, and specifically created the opportunity for my comments.

Betsy Anderson, director, National Parent Resource Center,
Boston, Mass.

Figure out how to pay for parents to be involved in Title V programs. In some states, you may be able to use the agency contracting process to reimburse parents for their expenses. In others, you may need to secure an administrative rule or even special legislative approval to pay parents for their participation in an advisory capacity. Explore avenues within your system that might be used, develop a proposal and get clearance from agency leadership.

Including families from the beginning of program planning is the right thing to do! Smart businesses have known for decades that consumer input is invaluable to develop goods and services that the public will buy. Health care can put those same marketing principles to use in planning services and allocating scarce resources. We can ensure that our services are targeted to best meet family needs without wasting funds on unnecessary frills or errors in judgment about what we think families want and will use. Families can be our programs' target marketers who know where and how to reach under-served families. Remember that families are better able to use services if they are educated and aware of their options.

Expand your definition of parent involvement. Parents can be members of task forces, advisory board members, program evaluators, co-trainers of pre-service or in-service training sessions, paid program staff, paid program or policy consultants, mentors for other families and professionals, grant reviewers, participants in the needs assessment process, reviewers of the block grant application, and much more. The unspoken value of parents familiar with the Title V programs is their ability to strongly advocate for programs that serve them well. Parents who know how to interact with legislators should be your new best friends. The old adage "make your friends before you need them" definitely applies here! Once families understand the impact of budgetary decisions upon their families, they can be eloquent and powerful.

Tips for Successful Family Involvement

- Identify current programs that involve parents and how they are represented, whether as salaried or contract employees or as volunteers. Meet with these parents to discuss their role and identify opportunities for expanding family representation throughout the Title V programs.
- Make it your business to find out what parent groups exist in your state and invite all of them to meet with you to discuss their needs and suggestions for increasing family representation.
- Identify and address barriers to family involvement, such as transportation, travel reimbursement, cost of child care, long distance phone calls, lost wages for time spent attending meetings, etc.
- Plan how to secure or expand family involvement, ensuring cultural diversity and outreach to all groups.
- Identify and address barriers to achieving cultural diversity in family representation.
- Know your state's statutes, regulations and policies that govern travel and expense reimbursement, as well as contracts, because these are the methods you will most likely use to support parental participation.
- Confer with your agency's legal counsel and fiscal personnel to discuss proposed methods to pay for parent involvement.
- Hold regional meetings with parents, because it is easier for staff to travel to families, especially if your state is large geographically.

Frameworks for Strategic Planning and Management

The primary reason to plan is to have a clear purpose and direction for your program; decide how to use available resources; identify the resources that need to be developed; and translate the plan's priorities, goals and performance measures into work assignments for staff. Planning intends to answer these questions:

- (1) Where is the organization now?
- (2) Where does it want to go?
- (3) What does it have to do to get to where it wants to go?

Performing the activities needed to answer these questions is a continuous and cyclical process.

There are many types of plans and a host of planning methods. The annual MCH Block Grant application can, and should, be the annual strategic plan for the program, but even that needs translation to a more functional work plan for each program and staff member.

A quick review of one type of planning process may be useful to a new Title V leader. There are numerous references available for a more in-depth look at planning strategies. If you are unfamiliar with planning, or your skills are rusty, you may want to spend time refreshing your knowledge in this area. You may also find that your state has designated employees to help guide managers through a strategic planning process.

Be tolerant of ambiguity, but organize, prioritize and closure(ize).

John Hurley, section manager, Children with Special Health Needs, Minnesota

The primary tasks of strategic management are to understand the environment, define organizational goals, identify options, make and implement decisions, and evaluate actual performance. Strategic planning aims to take advantage of new opportunities as yet unknown. This differs from traditional long-range planning that begins with a thorough analysis of the current situation. As time passes, the process of keeping this status report current is known as monitoring. Monitoring produces the kind of information contained in annual reports - numbers of people served, expenditures, number of staff members, number of diagnoses made or immunizations given, and so on. It provides a history of the program's key features up to the current moment. The focus of long-range planning is to project information about the current situation into the future.

The strategic planning process most often consists of six identifiable stages:

- **Environmental scanning** - scan the external environment for driving forces, emerging issues or major influences that might impact the program. This is a "taking stock" phase and helps to answer the question "Where are we now?"
 - **Evaluation of issues** - analyze the current situation, looking for issues that may emerge and assessing their potential impact on the organization. During this stage, planners may use a "SWOT" analysis, an acronym for considering the strengths, weaknesses, opportunities and threats facing the program. This stage ranks the issues according to their importance to operations.
 - **Forecasting** - develop an understanding of the expected future for the most important issues and trends, usually by extrapolating from historical data.
 - **Goal setting** - define the desired future based on the issue analysis and overall mission of the program. Goals answer the question, "Where do we want to go?" and should build on strengths (to take advantage of opportunities). They should devote attention to building up areas of weakness while warding off threats.
 - **Implementation** - implement specific strategies, such as policies and actions, designed to reduce threats and reach the goals. Strategies give consideration to what is practical, affordable and efficient, with a timeframe and leader responsible for implementation. Strategies designate the human and fiscal resources that will be assigned. They answer the question, "What do we have to do to get there?"
 - **Monitoring** - monitor the effects of implementation on the achievement of the goals. This requires that the plan be organized and written into a document that is distributed to all staff and other interested parties.
- Throughout the planning process, it is important that you keep in mind the overall mission of your program and the vision and values of what your program's ideal world will be if you are successful. This will help you to stay focused. If your Title V program does not already have statements of mission, vision and values, then develop them with a group of staff.

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Selected Tools for Planners

Strategic planning literature includes a number of tools to help incorporate accountability into the plan. As the plan evolves, think about how it will be evaluated from the very beginning. What data will be needed to determine the effectiveness and efficiency of the plan and its strategies? Where will you get that data? How will the program be evaluated? Who is responsible for conducting that evaluation? You are responsible for making many of these decisions even though the plan is developed by a larger group. You may find it helpful to use the following decision-making and evaluation models.

The Logic Model

For most evaluations, it is important to have a clear description of the program to be evaluated; it will help you identify the critical questions for the evaluation. All programs share common elements. A logic model is a diagram of these common elements, showing what the program is supposed to do, with whom and why. For evaluation purposes, a logic model will:

- Summarize the key elements of your program (limited to a single piece of paper)
- Explain the rationale behind program activities
- xClarify the difference between the activities and intended outcomes of the program
- Show which activities are expected to lead to which outcomes
- Help you identify the critical questions for your evaluation, and
- Provide the opportunity for program stakeholders to discuss the program and agree upon its description.

You will find that logic models are also useful for communicating the elements of your program to policymakers, staff, external funding agencies, the media and colleagues within your agency.

It is impossible to know with 100 percent accuracy that the decision you have made is "correct," because implementation of that decision happens in the future.

Decision-making

Decision-making is necessary to the smooth functioning of any organization, because activities involve collective action not just individual action. Models of group or individual decision-making can be helpful but can't prevent or cure bad decisions. Trust yourself to make the decision, either with a group process or individually, and don't worry about the decision once you have made it. But be ready to handle any consequences of the decision. Think through how the decision is to be implemented or "played out" before you make the decision. If there are negative aspects to the implementation, think about how you can alter the decision to avert those negatives. Don't let decisions pile up; make them as you go along because a backlog of many little decisions is nearly always more difficult to deal with than a big and complex decision. Consistently being afraid to make a decision or not taking action will also impair the operation of your program and demoralize the staff. Remember that not making a decision is actually a decision to simply not take any action at all on the problem.

Managing Resources - Your Leadership Style

A cartoon recently making the rounds illustrates the power of leadership humorously. Sled dogs are running as a team behind a single lead dog. The caption reads, "Unless you are the lead dog, the view never changes!" That is the thrill of leadership...making the decision about where you will lead the program. Take the time to learn about your own leadership style and encourage your staff to do likewise.

Authority

Your authority is probably governed in your state, territory or jurisdiction by civil service law and regulations, other comparable requirements and federal laws such as the Family Leave Act. For jurisdictions in which employees have unionized, contracts will also provide details about the relationship between "administration" and "line staff."

As a new leader in the Title V program, you must be completely familiar with the basic rules governing your agency's organizational structure, assignment of human resources, work environment and benefits.

Recognize the difference between the authority or span of control that you hold in the agency's organization and the circle of influence that you exert as the state's MCH leader. Actively build coalitions with related programs, helping them to share the vision for Title V programs. A good start in building coalitions is to join and actively participate in groups that share similar missions, such as a Medicaid advisory committee, the state interagency coordinating council for the early intervention program, the state developmental disabilities planning council and program advisory boards to schools of public health, to name just a few. Never miss an opportunity to network and influence others in their work on policy and program development.

Leadership Style

Leadership style combines your education, experience, skills, knowledge and abilities and translates them into a style of directing others that is both unique to you and definable as a leadership model. Notwithstanding the statutes, regulations and union contracts, however, there are some basic techniques of good management. Mastery of these guidelines will help you take charge of the Title V program. It has been said that an inspired leader has the hearts as well as the minds of her subordinates. To win the "minds" of your staff, you should ensure your agency is organized so that:

- Every function needed to accomplish the strategic plan and performance measures are realistic and assigned to a designated team or employee. This workplan is a written document and is reflected in individual job descriptions, performance standards and employee performance evaluations, as well as the policies, procedures and other operational documents describing the collective work of the unit.
- Each employee has only one supervisor to whom he reports.
- Each supervisor has the authority and time to enable employees to fulfill their responsibilities.
- Responsibilities assigned to each team are clearly defined, communicated and understood by everyone - through staff meetings where duties are discussed, orientation of new employees, written manuals and procedures, job descriptions that include specific assignments from the workplan, and a written workplan that is drawn from the strategic plan (e.g., MCH Block Grant).

Tips for Success

- Do not assign overlapping responsibilities to more than one team - it results in confusion, animosity and wasted effort.
- Don't be too anxious to reorganize the staff when you arrive on the scene. Observe what works well currently and what doesn't. Talk with key advisors before you reorganize to get their perspectives and then make your decision.
- Discuss your proposals for a new organization with your superiors, as well as your human resources office to ensure that you comply with existing statutes, regulations and union contracts.

Basic Management Skills

- **Planning**
- **Directing**
- **Organizing**
- **Coordinating**
- **Communicating**
- **Delegating**
- **Evaluating**

To illustrate the above points and the effective management of scarce resources, take a close look at the Incident Command System (ICS) developed by the emergency preparedness system. ICS is a management tool consisting of comprehensive procedures for organizing personnel, facilities, equipment and communications at the scene of an emergency, as well as a model tool for the command, control and coordination of resources. It is based upon the basic skills that managers and leaders already know, use and trust: planning, directing, organizing, coordinating, communicating, delegating and evaluating. Keep in mind that the ICS recommends that a supervisor can manage effectively three to seven subordinates, with the optimum being five. How does that compare to the span of control for supervisors in your program?

The "hearts" of your staff are won by gaining their confidence in your skill as a manager and credibility for your expertise.

Be conscientious in performing your job; respect the talents and knowledge of the "line staff" and

supervisory personnel; demonstrate that you are in your position for the "long haul;" constantly strive to integrate all the program components into a cohesive whole; and provide clarity and consistency to the strategic plan and workplan implementation. You can successfully accomplish your agenda when the enthusiasm, energies and creative ideas of the staff are all directed toward the goals spelled out in the strategic plan. This sense of common purpose is a source of power that you can use to keep staff motivated to work toward improvement in maternal and child health, i.e., the "greater good."

If you work in an agency that has a small staff, it is easier to develop rapport with your staff and to communicate with them regularly, and you should make a conscious effort to do so. If you work in an agency that has a large staff, you may find it easiest to share your views and listen to your staff's perspectives during staff meetings; ask to attend their team meetings or create other such opportunities to "rub elbows" with your staff. Be accessible to them and think creatively about how to be accessible without losing control of your schedule. For example, you may visit them in district offices, or you might advertise your willingness to meet staff over brown bag lunches. Be sure your staff know that you want to know them personally and have an open and honest sharing relationship with them. Your administrative assistant or secretary can help you by making time with your staff a priority in your schedule. You can even schedule time to "manage by walking around." That is a technique that helps you get to know your staff better in their work environment.

Qualities of a Top Administrator

Embrace the qualities of a top administrator. Understand your job thoroughly, as well as your power, authority and control, and know how to exercise them wisely. Think on your feet. Cultivate the role of being spokesperson for your state's women and children. As you hone your spokesperson role, use your personal skills to best advantage but always guard and protect your reputation for honesty and credibility; your ability to influence others depends on these character traits. Practice your networking skills. Be able to field tough questions, identify problems and develop alternate solutions quickly, but be humble enough to seek advice before making informed decisions. It is extremely important for you to be able to articulate clearly and briefly the vision for maternal and child health in your state. In short, become recognized and respected as THE expert on the MCH and CSHCN programs, both within and outside of your agency; be the "go to" person for your agency's leadership and your staff when there is an issue or question about the program, its budget or services and its needs. Being an effective Title V leader means that you have successfully combined the cachet of your position with your own charismatic leadership traits.

Tips for Success

- Keep yourself healthy! Do not overlook the possibility of burnout and how it can affect you.
- Take courses to improve your ability to be a public speaker.
- Use project management software to keep you organized and task oriented.
- Don't be intimidated by directors of other programs that have more money or a higher profile or a more political agenda. In time, they will look to you for advice and expertise for the maternal and child population in the state.
- Be one of the first to "meet and greet" new key stakeholders. Schedule an appointment to describe your programs and coordination opportunities within their first 60 days on the job. If you wait any longer, they will get too busy and might not view your program as a key stakeholder!

New MCH leaders can initially be overwhelmed by the scope of the job and the gravity of the responsibility that you have assumed. While there is a lot to learn, no one expects you to know everything in the first few months on the job. There are some suggestions from "seasoned" Title V leaders that can help you get your feet on the ground, begin to get comfortable with your new job and most importantly to be a success in the position.

- Review the activities listed in "Your First Months as a New Title V Senior Manager" found in the front of this guide. Be sure that you have started to address all of them early in your new position. You can continue to work on them as you begin to include the other activities recommended here.
- Recognize that learning is a lifelong process, so never stop seeking new knowledge and information. Seek training opportunities to enhance your skills as an administrator for the Title V program. Don't forget that your staff needs to have their knowledge and skills refreshed regularly as well. A workforce development program is always a good idea and helps recruit and retain quality personnel.

- Know the statutes, operating policies and rules of your agency and the employees' union contracts if your agency is unionized. If you are unsure of any of them, meet with the appropriate personnel, obtain copies of the policies, rules and contracts, and study them. Ask questions and don't stop until you are sure that you are familiar with these harbingers of your agency's "culture" necessary for your success as an administrator.
- Obtain training on all current union contracts. Contracts are the framework for personnel actions such as hiring, firing, layoffs, disciplinary actions, etc.
- Review your state's ethics and conflict of interest requirements and procedures. Do you need to file disclosure forms? Do you need to register as a lobbyist? Are you allowed to accept token gifts such as pens or coffee mugs? Meet with your agency's legal counsel to be certain that you understand the requirements, both during your employment and after you leave the job.
- Identify the most controversial issues you might face in your new position and become well versed in all sides of the issue. Identify the programs, legislation, budgets, staff, stakeholders and constituents who support or oppose the issue and their rationales. Propose an agency "position" to your director if needed.

Agency Reorganization

Agency reorganization happens sooner or later to everyone in public health. It occurs most often with a major change of state, territorial or jurisdictional administration — usually a new governor or a new state health officer. A new administration typically means that people in key leadership positions will leave *en masse*, usually the agency director, deputy director, chief legal counsel, lobbyist, chief of human resources, chief of staff and others. While it is upsetting for the agency's remaining staff to witness a mass leadership exodus, have confidence that the agency will not be left with a leadership vacuum and prepare for the change in advance.

There will be a new group of leaders who arrive with an agenda to implement, generally built around the governor's campaign platform. They will probably look first and most critically at the organizational structures, internal and external communication methods, and budgets, because these represent the primary resources of any agency. You should anticipate their need for information by preparing program and budget descriptions in advance; put them together into an easy-to-understand briefing document or manual. You can always polish these materials later when the new leadership requests them.

Be confident that you are the expert in the Title V program and remember that your job is to help the leadership integrate their agenda into your program. Maintain a positive outlook and seek opportunities to be involved in the reorganization process. Gaining a seat at the table where agency-wide reorganization is being planned potentially enables you to steer the direction of the reorganization to avoid serious harm to the program. It is possible that you may actually find this to be an opportunity to strengthen the Title V program by realignment of related programs, budgets and staff.

If your position is protected under civil service you will not need to worry about being removed from employment (although you can be reassigned). However, if your position is one that "serves at the pleasure of" the agency director, your continued employment may be in some jeopardy with the change of agency leadership. It is important that you remain calm and keep others on your staff in a "business comes first" mode of operation. You can help yourself best by thinking ahead. Schedule a meeting with your new supervisor or the agency director. Provide a copy of your resume, a listing of people who are part of the new administration and respected public health leaders who will vouch for your work, and a listing of recent program results achieved during your tenure. But always keep in mind that there is an overarching political agenda; be familiar with that agenda and frame your program results accordingly. Generally, this is all that is necessary for you to be recognized as an expert who should be retained in your current position.

If you have been responsible for the administration of certain politically "targeted" programs, however, you may find it necessary to take further action. For example, you may be required to reapply and compete to retain your job. If this does happen, maintain a positive attitude (remember, the requirements are politically based, not personal) but prepare yourself completely for your interview. Read books to motivate yourself for the interview process, like *Knock 'Em Dead*. Garner behind the scenes support from contacts within the new administration and ask them to call your agency director on your behalf. Try to maintain a balance of the calls made on your behalf between those inside the current administration and respected advocates and public health leaders. Don't flood the director with calls; a few well-placed calls are usually more effective

than a huge number of calls that lack specifics. Remember that there is no guarantee that these suggestions will succeed, but give it your best shot.

This is definitely not the time to begin cultivating "political capital" — you should have been developing those networks prior to any change in administration on a daily basis as you carry out the interagency collaboration necessary to implement the Title V program. Change of administration is a time where you will find it useful to have some political capital in your pocket waiting to be spent.

Resources

Family Involvement

[AMCHP. Meeting the Needs of Families: Critical Elements of Comprehensive Care Coordination in Title V Children with Special Health Care Needs Programs. January 2002.](#) (Available for order from HRSA Publications)

[Family Voices Toolbox](#)

Florida Institute for Family Involvement and Institute for Child Health Policy. *Making It Work: When Families that Represent a Service Population Become Employees*. September 2002.

[Institute for Family Centered Care - Essential Allies: Families as Advisors](#)

Planning

[CDC's Six Steps for Evaluating Physical Activity Programs
Step 2: Describe or Plan the Program](#)

[W.K. Kellogg Foundation Logic Model Development Guide \(2001\)](#). Battle Creek, MI: W.K. Kellogg Foundation.

Decision-making

Burke, W. W. (1994). "Diagnostic models for organizational development". In Howard, A., *Diagnosis for organizational change: Methods and models* (pp. 53-84). New York: Guilford Press.

Winch, G. W. (1995). *Developing consensus: Reflections on a model-supported decision process*. *Management Decision*, 33 (6), 22-31.

Administration

Overview of the Incident Command System, April 1992, Emergency Management Institute, Federal Emergency Management Agency

Martin Yate. *Knock 'Em Dead 2003*. Avon, MA: Adams Media Corp. 2003.

[Association of Maternal and Child Health Programs](#)

CHAPTER 6 The ABCs: State and Federal Grants, Budgets and Accountability

This chapter offers basic information about managing the Maternal and Child Health Block Grant, such as the strategic planning process of the Title V application, accountability, performance measures, budgets and helpful tips from Title V leaders who have "been there, done that."

Planning and Title V

State Health Plan

Most state health agencies have a state health plan that is multi-year and agency-wide in nature and was developed through a strategic planning process. This plan identifies the state's health priorities, goals and strategies and is generally based on the core public health functions, essential public health services, Healthy People national health objectives and state health needs. It is used to assign the agency's resources (workforce and fiscal) and may also be used as a public relations document or to develop state budget requests. By virtue of its planning and documentation process, the Title V program is in an excellent position to be a prominent part of the state health plan, and you should welcome opportunities to participate in the development or revision of a state health plan.

Title V Application and Annual Report Guidance

The [Maternal and Child Health Bureau](#) provides guidance, entitled *Title V Maternal and Child Health Block Grant to States Program Application and Annual Report Guidance*, for the block grant application and annual report each year. There are also federally mandated performance and outcome measures and systems capacity indicators, based on the Healthy People national objectives and input from a group of MCH and CSHCN state leaders. The planning process described in the guidance is very similar to the strategic planning process discussed earlier in [Chapter 5](#). A new Title V leader should read and study the federal guidance before embarking on any new planning process for the block grant to ensure that all requirements are included.

Key MCH Block Grant requirements for states

- Annual application and report
- Comprehensive needs assessment every five years, with annual updates
- Annual plan with goals and objectives (consistent with national health objectives) for meeting needs, with service areas, categories and individuals to be served
- National core and state optional performance measures
- "30/30" requirement to spend at least 30 percent of federal Title V funds on preventive and primary care services for children and youth and 30 percent on services for children with special health care needs
- Match of at least 75 cents for every federal \$1.00
- Maintenance of effort for level of state funding in place in 1989
- Funds can be used for health services and related activities including planning, administration, education, evaluation and purchase of technical assistance
- No more than 10 percent of funds can be used for administering the funds
- Funds cannot be used for inpatient services, except for CSHCN, high risk pregnant women, or where approved by the secretary of health and human services (HHS); cash payments to intended service recipients; purchase or improvement of land, construction or purchase of major medical equipment; meeting requirements for other federal programs; research or training from for-profit entities; or paying for services of providers excluded by HHS.
- Coordination with Medicaid, including the Early, Periodic Screening, Diagnosis and Treatment (EPSDT) program, outreach and enrollment
- Toll-free phone lines to help parents find health information and providers
- Coordination with other federal programs, including food and nutrition, education, developmental disability, family planning and other health programs.

The guidance and application forms are available on the [bureau's website](#). States, territories and jurisdictions must submit the combined application / annual report narrative, forms and budget through HRSA's secure, web-based server.

States are required to conduct a comprehensive needs assessment every five years and, through that process, examine their capacity to fully carry out the Title V program, identify and select their priorities for the coming five-year period, set targets and identify activities to accomplish the targets, allocate available resources and monitor the progress over the five-year planning cycle.

[Overview of MCH Needs Assessment, Planning and Monitoring Process](#) [PDF]

Organizing Staff

You must organize staff to write the combined block grant application and annual report months in advance of the deadline. If you are in a state with a small staff, you may be the best (and maybe the only) person to actually write the document. You will probably still need assistance from your agency's budget personnel to complete the financial portions, however, and may want to consider seeking grant writing expertise from other resources, such as schools of public health or private consultants. In those states with large staff, the task may actually become more complex, because you will probably divide up the preparation and writing of the document to different people. In this case it is crucial to appoint a single person with responsibility for the final preparation of the application - a "Block Grant Czar." In Georgia, the Family Health Branch has written its own manual to direct the numerous employees and programs involved in preparing the MCH Block Grant for submission. Their manual breaks the tasks to be completed into steps, assigns responsibility for each section, provides due dates for each task and specifies the agency's internal clearance process. Regardless of how large or how small your staff, there are some ideas that can make this annual task less of a chore and even more useful as a strategic plan.

Have a master plan. Make a list of all the major steps to prepare the application/annual report, using the Guidance, and put the list into a logical sequence. Lay those steps out onto a "block grant" calendar, working backwards from the MCHB deadline. You do need to plan; don't make it an afterthought or put it off until you have time. The reality is, unless you schedule the time for planning, you won't do it until it's too late to do a great job.

Checklist for Preparing the Block Grant
<ul style="list-style-type: none"> • Study the guidance and make a list of tasks
<ul style="list-style-type: none"> • Put one person in charge of preparing the block grant
<ul style="list-style-type: none"> • Make a master plan <ul style="list-style-type: none"> ○ Gather documents (e.g., current application, last annual report, data, budget, forms) ○ Assign every task to someone to complete by deadline ○ Identify need for & obtain technical assistance to complete preparation
<ul style="list-style-type: none"> • Develop a calendar of key assignments and due dates
<ul style="list-style-type: none"> • Adhere to state agency clearance process and timelines
<ul style="list-style-type: none"> • xSchedule time to read entire document from front to back; edit
<ul style="list-style-type: none"> • Obtain public input; insert documentation into application

<ul style="list-style-type: none"> • Double check all forms and tables
<ul style="list-style-type: none"> • Obtain signature of agency director and submit on time to MCHB
<ul style="list-style-type: none"> • Celebrate a job well done!

Spread out the preparation of the application over at least the 6 months (better yet, 9 months!) before it is due to MCHB, so that you ensure adequate time to obtain data, write new sections, write results and provide updates. Try to begin writing the annual report updates in the application by 90 days after the end of the fiscal year upon which you are reporting.

Your agency probably has clearance requirements that must be met. For example, some state health officers will not sign off on grant applications unless they have first been read and approved by the agency's chief fiscal officer and deputy director. Find out your agency's grant clearance requirements and timeframes and build that time into the calendar. You will win friends throughout the agency if you strictly adhere to their timeframes.

Identify those portions of the document that don't change much from one year to the next and complete them first. Read these parts yourself and make note of what updates are needed. Choose the best staff member to prepare the update (it might be you!). For example, the State Overview section (agency capacity, organizational structure, other MCH capacity, state agency coordination) will probably need very little editing each year if it was comprehensive and well prepared initially, and the agency organizational structure remained relatively unchanged. Get the easy parts done first and spend more time on the more difficult sections.

If you have assigned the work to staff, be clear about the deadlines. If the materials are not submitted to you by the expected date, immediately remind the staff member that the material is overdue and assign a revised date. Determine if you need to adjust the overall block grant calendar.

Once all portions of the application are complete, make time in your own schedule to read the entire document from beginning to end. You have the "big picture" perspective of the Title V program for your state and only you can identify errors or gaps in information. Edit the document before allowing it to proceed to your agency's clearance process or out to the public for comment.

Double-check the budget forms to be certain that they reflect the true picture of funding for your program and that you understand and are able to answer questions about the budget figures.

Public Input

Public input into the block grant application/annual report is required. Think about the best ways to obtain public input for your jurisdiction and build time for public comment into your calendar. You may find it useful to talk with your assigned MCHB project officer about how to achieve public input effectively, and your AMCHP peers in other states may also be helpful. Remember the idea here is to share the plan widely.

If you have an advisory committee for the MCH Block Grant, allow them to comment on the draft application. You might have a one-day committee meeting to review your program results (i.e., annual report) and proposed activities (i.e., annual plan). You could use the MCH pyramid as a review tool. Summarize the comments you receive from the committee and include them in the application, along with a description of your response to the input.

Provide notice on your agency's website about the availability of the draft application. You could post a copy on the website or require them to contact you for a hard copy to track the number of requests. Give a deadline date for comments to be submitted on the draft document. Report a list of comments received and any actions taken in the application.

Post the final version of the application on the agency's website and encourage public input throughout the year. Again, maintain a list of the input received and any action in response. Provide copies

(printed or electronic) of the application/annual report to your state government library each year. This will ensure that legislators and other state agencies have access to the latest version of the document. In some states, your agency's legislative liaison may want to personally deliver a copy of the document to key legislators. Another way to make the application available to the public is to provide copies to the library system throughout the state, including contact information for public comments. If you use this method, be sure to send the new application/annual report every year.

You may want to hold public hearings in various locations throughout your state on the block grant application. Generally, however, such hearings are not well attended unless there is a controversial item in the application or there have been major shifts in policies, funding or budget cuts. Public hearings of this nature work best when they are well advertised in advance, copies of the draft document are easily available to the public and adequate advance notice has been provided to key stakeholders.

Provide key "sister" agencies with an annual courtesy copy of the application. You should think about sending the document in printed and electronic form to Medicaid, SCHIP, early intervention and other key programs that you coordinate with throughout the year. Also share a copy with key programs within your own agency.

Comprehensive Needs Assessment

A comprehensive needs assessment is recognized as a good public health practice and is a common feature of programs throughout the field. For the MCH Block Grant, it is required every five years although it is actually best thought of as a continuous and on-going activity. This process gives you an opportunity to take a fresh look at the needs as well as the accomplishments of the block grant, including program evaluation results, data, measures of health status for MCH populations, priorities and collaborations with other key programs. It also documents the basis for selecting the state negotiated performance measures that are designed to address the new priorities.

Because it takes time to conduct a comprehensive needs assessment, do not wait until the year it is due to start the process. Obtain a copy of the *Maternal and Child Health Services Title V Block Grant Program Guidance and Forms for the Title V Application/Annual Report*. Study the chapter that describes the needs assessment process before initiating any planning activities. It provides an excellent overview of strategic planning and spells out the steps in the process. You can look to other literature and resources to elaborate on any of the steps in the planning process. The needs assessment should serve to inform the MCH Block Grant plan development. One good source is the book, *Needs Assessment in Public Health: A Practical Guide for Students and Professionals*, authored by two MCH veterans, Donna Petersen and Greg Alexander.

If you don't know where you are, you won't know where to go next...a needs assessment is a great starting point.

Joan Wightkin, administrator, MCH Program, Louisiana

Make a master plan for conducting a comprehensive needs assessment. Begin by reading the Guidance and make a list of the major steps you will have to complete. Make a listing of the workforce and fiscal resources you have available to complete this task. Start well in advance — preferably two years before the needs assessment is due. Make a master calendar for completing the needs assessment. Start with the date the needs assessment is due to MCHB and work backward until you have all steps in the process assigned both a deadline and a responsible staff member(s). If you have a staff member with expertise in conducting needs assessment, either designate that person as being "in charge" of the entire process, or ask for her guidance. Look at what work has been done in the past and all comments from the federal block grant reviewers about the strengths and weaknesses of the previous assessment. Talk with your assigned MCHB project officer to obtain further information about comparable states that can serve as examples of how to carry out a comprehensive needs assessment. Talk with your AMCHP peers for additional tips on how they overcame problems or obstacles.

Checklist for Conducting Needs Assessment

<ul style="list-style-type: none"> • Study the guidance and make a list of tasks to be completed
<ul style="list-style-type: none"> • Put one person in charge of the needs assessment
<ul style="list-style-type: none"> • Make a master plan
<ul style="list-style-type: none"> ○ Discuss with MCHB project officer; obtain technical assistance if needed
<ul style="list-style-type: none"> ○ Gather existing documents (e.g., last needs assessment, data updates, studies, reports, program evaluations, SLAITS data, etc.)
<ul style="list-style-type: none"> ○ Assign every task to someone to complete by deadline
<ul style="list-style-type: none"> • Develop a calendar of key assignments and due dates
<ul style="list-style-type: none"> • Hold a stakeholders meeting for all interested parties to review master plan; periodic meetings thereafter for steering needs assessment activities
<ul style="list-style-type: none"> • Conduct environmental scan
<ul style="list-style-type: none"> • Use CAST-5
<ul style="list-style-type: none"> • Obtain new data and analyses
<ul style="list-style-type: none"> • Use consultants as needed
<ul style="list-style-type: none"> • Read draft report from front to back; edit
<ul style="list-style-type: none"> • Share draft with stakeholders; conduct process to develop list of needs and priorities based on needs assessment findings
<ul style="list-style-type: none"> • Share final needs assessment report, including listing of needs and priorities, widely - with state agency leadership, "sister" agencies, advocacy groups, legislature, governor's office, etc.
<ul style="list-style-type: none"> • Celebrate a job well done!

Convene a meeting of all staff, family advisors and coordinating programs (both within and outside your agency). Review the master plan with this ad hoc committee and use their advice in refining the plan for the needs assessment. This group can become a "steering committee" for the needs assessment and be convened periodically to provide status updates and problem solve. In some states, the MCH Block Grant advisory committee could serve this function. In other states, the steering committee may actually assume some of the responsibilities for carrying out the needs assessment. Remember that the more you decentralize the needs assessment process, the more you are going to need a single person to be on top of the process, someone to know who is doing what and when assignments are due.

Always do an environmental scan early in the process to determine what data, program evaluations and other information you have readily available. Identify what information will be more difficult to secure and determine the best method to obtain the information. For example, the data you need might be available from another program such as Medicaid or Vital Statistics. Or perhaps you will need to identify outside consultants to obtain the information you need. Consultants may bring skills such as forecasting or social marketing that are not already available on your staff. The "steering committee" members should be helpful here. If you are not knowledgeable about statistical analyses, ensure that you have someone with expertise

to help you identify trends, determine significant changes over time, and deal with hard data issues, such as small incidence or small populations.

Build adequate time into the needs assessment calendar for an advisory group to review the resulting data, trends and other information. You may use a process such as the Delphi Method or the Nominal Group Process to generate a listing of key MCH issues and some version of voting for the top priorities. Consider sending out the list of key MCH issues to all major stakeholders (local health commissioners, families, clinic personnel, human service agency directors) throughout the state and ask them to prioritize the issues. The results can be the Title V priorities for the next five years. Use the new priorities to direct resources toward the block grant efforts by selecting 7-10 state negotiated performance measures. Recognize that political realities may demand that the block grant priorities be amended to reflect current political leadership or campaign promises. However, having prepared the priorities without considering political perspectives may enable you to "take the high road" and offer a persuasive argument for keeping the priorities because they were determined through a fair and inclusive process.

Combine all of the data and results obtained during the needs assessment process into a written summary that describes the findings, the methodology used, who was involved in the process (stakeholders and other partners), and what the results mean in terms of Title V services and the levels of the [MCH pyramid](#). The guidance provides detailed information about what should be included in the needs assessment summary report. While the needs assessment summary is a document that is submitted to MCHB, it can also be useful to advocacy organizations, advisory committees and other agencies in your state. You may want to use it as a marketing tool for the Title V program.

CAST-5

The [Capacity Assessment for State Title V \(CAST-5\)](#) is a set of assessment and planning tools designed to examine state program's capacity to carry out core maternal and child health functions. They are very helpful tools to use during the needs assessment process and fit well into the second stage in the needs assessment process as described in the guidance. The tools can be used collectively for a comprehensive assessment of the Title V capacity needs, including opportunities for capacity development. Or they can be used individually to assess the specific, narrower scope of the programs.

CAST-5 is meant to answer the strategic planning questions, "What do we have?" and "What do we need to get the job done?" It helps state Title V programs determine what organizational, programmatic and management resources must be developed or enhanced to achieve the program's goals.

Use of CAST-5 is not required by MCHB, but it is recommended by AMCHP because it assures that the needs assessment takes into consideration resources currently available and those needing development. In addition, CAST-5 provides broad guidance on prioritizing program capacity needs and developing strategies for capacity development. CAST-5 is an initiative of AMCHP and the [Johns Hopkins University Women's and Children's Health Policy Center](#), in partnership with the federal MCHB.

Obtaining Data

Obtaining data is critical to the success of the needs assessment and MCH Block Grant plan. Some states have comprehensive structures in place to collect and analyze public health data, while other states have not invested in a data infrastructure of this nature. Because of this wide variability across the states, MCHB has invested significant resources in data capabilities in recent years, such as the State Systems Development Initiative (SSDI) grants to improve specific data sources. Additionally, MCHB funded a national telephone survey database for the health status of children with special health care needs known as SLAITS (conducted by the National Center for Health Statistics). MCHB plans an expansion of SLAITS to secure information about the preventive and primary care health status of all children.

As you begin the needs assessment process, determine what data sources are available within the state, from MCHB or from other national resources, as well as the limitations of these data. Determine what you can do to improve the quality of data sources with available fiscal and human resources. For example, SLAITS undersamples certain populations by design, so you may want to purchase additional sampling for

your jurisdiction to target undersampled groups. You should also identify what basic MCH data exists in your state from sources such as Vital Statistics (from birth and death certificates); research that identifies trends specific to your state or its subpopulations; service data from Title V, WIC, early intervention, public schools, Medicaid, mental health and others; national MCH data from MCHB's Title V Information System (TVIS); and program evaluations. The block grant requires that reliable data be used for the national performance and outcome measures.

Performance and Outcome Measures

Performance and outcome measures were introduced in 1999 by the MCHB in response to the Government Performance and Results Act (GPRA) of 1993. The purpose of GPRA is "to improve federal program effectiveness and public accountability by promoting a focus on results, service quality and customer satisfaction." Performance measures are tied to a performance-based program budget, and the states are accountable for meeting the performance measures and evaluating their results in all federally funded programs. Use of performance measures is a good public health practice and was also recommended by the Institute of Medicine in its two studies of the status of public health in America. GPRA also requires comprehensive strategic plans, annual performance plans with measurable goals and objectives, and annual reports on actual performance compared to performance goals. The MCHB guidance fulfills all of the requirements of GPRA and assures that the states meet those requirements through the MCH Block Grant application and annual report. However, the performance and outcome measures are not a comprehensive representation of the entire scope of the Title V program within any given state. The national performance and outcome measures were selected because they are common to all Title V programs, they relate to existing data sources, and the program results can be quantified or measured. The state negotiated performance and outcome measures allow the state to address its unique needs that surface as a result of the needs assessment. A priority in one state may not be a priority in another state; allowing states to negotiate additional performance and outcome measures ensures flexibility. There are a number of systems building activities that the block grant conducts that are difficult to measure - the quality and extent of interagency collaboration, for example. Because the application limits the number of performance and outcome measures that can be submitted, there will always be state programs that will not be identified in the application. It is important that you include descriptions of these programs in the application narrative to demonstrate the full range of the Title V program.

States ensure public accountability in the block grant in three ways: by annually measuring progress toward performance measures, by budgeting and reporting funds according to the levels of the [MCH pyramid](#), and by improving MCH outcome measures. The guidance requires reporting on the MCH populations served and the activities provided by level of the MCH pyramid for each of the 18 national performance measures, as well as the 7-10 state negotiated performance measures. The outcome measures should improve over time if the performance measures and the activities to accomplish the measures were adequate. Providing this information publicly demands that the state collect dependable service-level data. For public accountability, you must describe your accomplishments, current activities, plans for the coming year and the populations you served. Specifying by level of the MCH pyramid exactly what fiscal resources have been budgeted and expended is also a form of accountability to ensure that the state target funds toward improving the performance measures, health status indicators and health capacity indicators. It is your job as Title V leader to ensure that your state's data, budget and fiscal systems are able to meet these demands.

[Title V Block Grant Performance Measurement System](#) [PDF]

Securing Additional Funds

Securing additional funds from the state budget, other state and federal agencies, SPRANS, CISS (Community Integrated Service Systems grants from MCHB), foundations and philanthropic groups may be easier once you have a comprehensive needs assessment and priorities listing. You can "shop" some of the priority needs separately from the block grant funding. For example, if your priority listing shows that preschool children are not adequately screened for vision problems, you should talk with the Lions clubs or other vision conservation groups about this issue. The result may well be an invitation to submit a grant application for funding a special project. The application should be easier to develop since you have the background information on what services are currently available, the need for new services, a measurable goal (performance measure), and some strategies on how to positively impact the situation. In this way, the MCH Block Grant application, annual plan and annual report are tools you can use to leverage additional funding sources to help you target and impact the state's priorities.

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Other Thoughts About Successful Planning

The Maternal and Child Health Services Block Grant provides the opportunity to direct resources (human, fiscal and technical) to significantly improve the health of the target populations. The critical importance of having a thoroughly researched needs assessment and a strategic plan cannot be overemphasized. Without a well-documented plan and assignment of all resources to fulfill that plan, you will be unable to ward off inappropriate demands and requests for funding unrelated activities. Block grant funds are flexible but only within the parameters previously described in this guide. Because the funds are flexible, they can be targeted to "cover" budget shortfalls in other program areas that are unrelated to the MCH plan. Your best defense against inappropriate use of these funds is to update your strategic plan annually.

The best thing about the block grant is its flexibility. The worst thing about the block grant is its flexibility.

Jeanette Shea-Ramirez, chief, Office of Women's & Children's Health, Arizona

- Develop a strong management team to work closely with you in all aspects of block grant administration. An outstanding leader recognizes his shortcomings and recruits team members with expertise in those areas. Spend time developing strong working relationships and teamwork, preferably in off-site retreats. Meet with the management team regularly and listen to their recommendations before making final decisions.
- Visit local health agencies and providers of MCH/CSHCN services to see the programs in operation and become familiar with their issues.
- Include all stakeholders (staff, advocates, families, other agencies) in the block grant application, needs assessment and strategic planning process from the very beginning. It ensures their buy-in and improves the chances that the block grant will actually become a working document that staff use to guide their daily work.
- Build support for the Title V programs within your home agency as well as with other key stakeholder agencies and organizations. This means that you need to personally meet with and develop close working relationships with the leaders of key programs (e.g., SCHIP, Medicaid, early intervention, bioterrorism and emergency preparedness, prevention and primary care programs). Be sure you understand what other agencies do, and what they expect from Title V programs. Be an effective collaborator.
- Anticipate what the "hot" issues will be and secure the support of your agency's leadership before the plan is released to the public. State health officers do not like to be blind-sided. Respect their leadership position and give them the opportunity in advance to have their say about a controversial issue that may surface. Be proactive.
- Distribute the block grant widely. Remember that others don't know what your program does, and this is one way to share that information. It also helps to remind everyone of their assignments in carrying out the strategies in the plan.
- Be sure that you have built accountability into the plan. Program activities, performance measures and capacity indicators should have timeframes. Be certain that someone is assigned to each activity as well as to conduct a regular review of the plan's status.

- Allow for occasional deviation from the annual plan. Make note of the deviations for use in future annual reports.
- Evaluate the planning process by regularly getting feedback from those involved in the block grant application. Was the process adequate? What could be improved? Are enough resources being directed toward a performance measure or priority issue? These are all questions that will help you improve the next cycle of planning.
- Celebrate completion of the application and celebrate achievements. It may seem like a simple idea, but ignoring accomplishments can encourage staff apathy, skepticism or cynicism. Don't skip this step - make it fun!

Management of Budget Resources

Mastering the budget may not seem very interesting; however, it is one of the most important aspects of your job. You must master your budget to be a successful MCH Block Grant leader, administrator and manager. That means that you must be aware of how much funds you have remaining to be spent at all times and make adjustments in your spending as necessary throughout the budget year to ensure that you are doing everything possible to meet the MCH/CSHCN priorities. You will find it helpful to require the budget staff to notify you when programs are either significantly over or under spending on a line item.

If your budget and expenditures don't reflect the needs assessment data and subsequent priorities, then they have not really been made a priority. This is truly a time when you are expected to "put your money where your mouth is." Your number one priority should be reflected in the budget. The rank order of all data-driven priorities should be obvious when looking at the budget and expenditures.

It may take you a year or more to plan and carry out the realignment of budget items to reflect the newest needs assessment data and priorities. If you find that priorities have changed and you need to shift fiscal resources accordingly, you should make those changes only after providing adequate notice to those who will be impacted directly. Most people will more easily accept a funding cut if given enough time to adjust their services or spending levels so that they can avert their own fiscal crisis. In your job, surprise cuts in funding will nearly always result in major complaints to the agency director, legislators, governor and the media, as well as affected families - in short, a public relations nightmare. When budget realignments are necessary, don't forget to keep the state agency's chain of command informed about your plans and obtain approvals if appropriate. Often there is political "fallout" from budget shifts that can be softened with advanced preparation of state agency leaders, legislators, the governor's office and advocacy groups.

It's a good idea to keep some "rainy day" funds for unexpected demands each budget cycle. You can do this by adding an extra cushion of funding to general line items such as consultant services, travel or the like. The amount you keep set aside for this purpose will vary based on your past experience and the total amount of funds available. Having unbudgeted funds can avert or soften mid-year program cuts when you have no choice but to meet unplanned demands on your budget caused by emergencies or unforeseen circumstances. Keep in mind that having a cushion of funds has a down side and may work against you when the agency experiences a fiscal crisis and "sweeps up" all unexpended funds. Your duty is to ensure that fulfilling agency demands does not compromise the purpose and intent of the block grant. Keep in mind that the block grant is flexible funding within broad parameters, but there are limitations to the use of these funds that must be maintained and assured. The state's leadership has a right to expect, and will respect, your honest attempts to justify use of block grant funds to meet their special budget demand. But if the funding demand is an inappropriate use of these federal funds, it is your responsibility to share that information with the chain of command. NEVER agree to the inappropriate use of funds regardless of who issues the order. To be certain that you have interpreted the block grant requirements correctly, discuss the proposed use of funds with your federal MCHB project officer first. If you cannot prevent inappropriate use of Title V funds, then at least keep a detailed paper trail in a safe location documenting your efforts to inform the state leadership that the desired use of funds is inappropriate.

As you gain knowledge and experience with the budget processes for your state or jurisdiction, you will become an expert in planning for expected budget cuts, quickly dealing with an unexpected influx of funds needing to be encumbered or expended on a short timeframe, or other fiscal challenges tossed your way. For example, it is possible, albeit complicated, to plan the interplay of your state and federal budgets to soften cuts in either source. Because state and federal funds are normally on different fiscal years, using one fund to shore up the other will only be a temporary "fix" for one budget cycle. And this "fix" will only work if there is either no restriction on the use of the funds or you have carefully selected the program area to

ensure that it is an appropriate expenditure. Simultaneous mid-year cuts in both state and federal funding will wreak havoc with all budget plans. In coping with fiscal crises, ask for help from your staff managers, fiscal officers, agency leaders and even your Title V peers in other states who may have faced similar budget problems. They can help you analyze the impact and various options. Giving careful thought before making your final decision is time well spent. Remember that you are not alone when it comes to managing the fiscal resources of the Title V programs.

Tips for Successful Budget Management

- Meet with the MCH/CSHCN financial officer and the state health agency budget director. Learn about funding sources, available discretionary funds, and current budget initiatives for MCH programs and the state health agency.
- Meet with the state health agency director. Learn where MCH programs fit into overall agency budget priorities and how they support the agency's initiatives.
- Understand the budget process and the budget calendar(s). Learn the key state laws and regulations governing budgeting and expenditures, as well as the state health agency's policies and procedures.
- Learn your agency's financial monitoring system.
- Understand your responsibility for managing the MCH budget from all funding sources throughout the year. You are accountable for implementation of program budgets. Know your state mandated role for budgeting and fiscal management.
- Expect to prepare materials in support of MCH budget requests (including expansions or justification for maintenance of current funding levels, impact of cuts, etc.) for state health agency officials to use in public budget hearings, meetings with state legislative leadership, the governor's office and advocacy groups. Be prepared to attend meetings and offer budget testimony or answer questions if requested.
- Participate in agency meetings where MCH budgets will be discussed with the state health officer, the state budget director, legislative leadership, the governor's office and key advocacy organizations.
- Identify issues that are a high priority to constituencies, the legislature, the governor and the state health agency leaders and address these to the extent possible in budget requests and justifications.
- Identify partners and outside support for the MCH budget from advocacy groups, other state or federally funded programs, other agencies and professional associations.
- Understand the state fiscal situation (i.e., shortfalls or surplus) and its impact on MCH and CSHCN programs.
- Understand the impact and extent of federal funding supporting MCH/CSHCN programs. As the state Title V director, you are responsible for your state's compliance with the block grant requirements. You must be completely familiar with your block grant budget request, any changes to the budget, expenditures and justification for the budget.
- Understand the usefulness of audits.

Resources

[Maternal and Child Health Data](#)

[Maternal and Child Health Bureau](#)

[Preparation of MCH Block Grant - Title V Maternal and Child Health Block Grant to States Program Application and Annual Report Guidance](#) is available for download at the Maternal and Child Health Bureau site, (Adobe Reader is required to use this site).

Needs Assessments

[New England SERVE](#)

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Appendix A The Making of This Guide

AMCHP began developing this guide for new state MCH and CSHCN leaders in March 2003. AMCHP, responding to the increasing turnover of leadership positions in the field, views this guide as complementing other initiatives, such as AMCHP's mentor program for new directors and CAST-5, as well as the federal Maternal and Child Health Bureau's New Leaders orientation meeting and Partnership meeting. To author this guide, AMCHP contracted with two senior consultants with state Title V experience. Kathy Peppe, RN, MS, is former director of Ohio's Division of Family and Community Health Services and past-president of AMCHP. Catherine Hess, MSW, is former AMCHP executive director and previously was policy director for Massachusetts' Division of Family Health Services. A focus group of newer and more seasoned Title V leaders, academic and family representatives also assisted in developing this guide.

As the first step in developing this guide, the authors contacted 25 associations representing public officials or administrators, primarily at the state level, to determine if they had developed similar guides for their members. The associations that we contacted included:

- National Governors' Association (NGA)
- National Conference of State Legislatures (NCSL)
- Association of State and Territorial Health Officials (ASTHO)
- 16 associations of state health agency component programs or disciplines (ASTHO affiliates)
- National Association of County and City Health Officials (NACCHO)
- American Public Human Services Association (APHSA) that includes welfare, child welfare and Medicaid directors
- National Association of State Alcohol and Drug Abuse Directors (NASADAD)
- National WIC Association (NWA)
- State Family Planning Directors' Association (SFPA)
- State Adolescent Health Coordinators' Network (SAHCN)

Additionally, we reviewed some of the materials from the two continuing education institutes funded by MCHB to develop the knowledge and skills of state Title V staff - the CSHCN Continuing Education Institute (that ended a number of years ago) and the MCH Leadership Skills Training Institute. The latter continues to provide two institutes annually, one focused on planning and one on systems. Neither of these institutes has produced formal, written material specifically designed to orient new directors to their positions, but they have produced some very relevant resources.

Finding means to orient new personnel in state leadership positions struck a common chord throughout the 25 organizations that we contacted. In addition to AMCHP, 11 of the 25 organizations responded that they had developed either orientation or mentoring materials or programs for new leaders. Five of these organizations actually have developed formal written materials (ASTHO, SAHCN, NCSL, NGA and the National Association of EMS Directors). One organization (NASADAD) was preparing a written guide for new state substance abuse directors at the time of our contact. Two additional organizations have plans to develop guides in the near future, and two more organizations have prepared informal materials (e.g., case studies) for use during orientation training sessions. Finally, one organization, the Association of State and Territorial Dental Directors, developed a new director mentor program modeled on the AMCHP mentor program. The AMCHP program looks to the mentor and new director to shape specific learning objectives for a two-day site visit using the MCH core functions as a framework.

The scan we made of other similar organizations' efforts to orient new state leaders was extremely useful to us in informing the content for this guide. The findings from the half dozen associations that shared written material with us fell into six main categories:

- Understanding the position and what is the same and what varies across states
- Tips on key challenges and issues that arise
- Skills needed for positions
- Content knowledge needed for positions
- Key players and how to work with them
- Resources for further assistance

Generally, materials designed for higher level elected and appointed officials tended to focus on tips, addressing skills and key players at very general levels. Materials for program managers tended to provide more skill and content knowledge and were more specific about key players and resources.

The information gleaned from the first step in the process of developing this guide was shared with a focus group that we invited to participate. Eleven persons agreed to be members of the group, representing a mix of Title V leaders with less than 3 years experience in the job, Title V leaders with 5 or more years experience in the job, a family representative and two academic representatives with previous state Title V experience and AMCHP leadership experience. Besides the 11 able to participate in a meeting, three new Title V leaders agreed to provide feedback through electronic communication. The final list of participants provided a nice mix of representation from MCH, CSCHN, many of the HHS regions, and the AMCHP Board of Directors. A list of focus group participants is in the appendices of this guide.

We conducted a focus group meeting in Scottsdale, Ariz., on April 29, 2003. All 11 focus group members and a staff member from AMCHP attended the one-day meeting. The purpose of the meeting was to discuss the need for a guide for new state Title V leaders, its possible use and format, and potential content. Prior to the meeting in Scottsdale, we shared a copy of the results of our analysis of all similar guides obtained from other associations. Participants were asked to read this material prior to attending the focus group meeting. We also shared hard copies and presentations of materials from other organizations with focus group participants during the meeting.

During its meeting, the focus group reached consensus on the target audience for the guide, the primary uses of what it decided to call a "toolbox," the major content categories, and related suggestions for the MCH Bureau and AMCHP. The group recommended that:

- The target audience consist of the senior managers responsible for Title V MCH and CSCHN, which will vary state by state
- The material be conceptualized as a "toolbox" that might be part of a "leadership library" that MCHB or AMCHP might consider building
- The material be disseminated and marketed not just at completion of the tool, but on an ongoing basis through existing channels such as MCHB and AMCHP meetings and regional structures
- The content be organized around major leadership roles. Some major leadership roles were suggested with the understanding that we would investigate common categories used in the leadership literature.

The focus group confirmed and validated the perceived need and value of this tool for new leaders in Title V. A number of participants in the group commented that the meeting led them to rethink how they approached their positions and had generated new energy for tackling the challenges at home.

Following the focus group meeting, the authors prepared a draft document that was shared with AMCHP staff and the focus group members. On September 4, 2003, a conference call was conducted to review the draft document and receive suggestions for improving the final product. Additionally, tips and quotes were obtained from focus group members to sprinkle throughout the text of this guide. We have purposefully kept the tone of the document informal and friendly because we wanted to impart to the reader the feeling that this guide is friendly advice from those who have walked the same path. Most of all, we wish the new senior managers of the Maternal and Child Health Block Grant great success in their mission to wisely administer these vital public health programs.

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Kathy Peppe, R.N., M.S.

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Appendix B Focus Group Meeting for Development of a Manual for New Title V Directors

April, 29, 2003 - Scottsdale, Arizona

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Appendix C Glossary of Terms

There are several existing glossaries that the reader is advised to review:

USDHHS/HRSA/MCHB. Title V Maternal and Child Health Block Grant to States Program Application and Annual Report Guidance. Washington, D.C.: 2003 (or any subsequent updates).

The [glossary](#). [PDF] as well as the entire guidance document, is available for download at the Maternal and Child Health Bureau site, Adobe Reader is required to use this site.

Maternal and Child Health Leadership Skills Training Institute Glossary of Terms and Acronyms

This glossary has been compiled by the MCH Leadership Skills Training Institute to support and extend the curriculum that comprises the Institute training sessions.

Diskettes with the document in either MSWord or Word Perfect formats are available from the Institute. Additionally, the glossary is available to download at the project web site, <http://www.soph.uab.edu/mch-leadership> on the Learning Resources page.

The glossary is divided into two sections; terms and acronyms. Each section has its own table of contents and its own references.