Health Resources and Services Administration
Maternal and Child Health Bureau

Discretionary Grant Performance Measures

OMB No. 0915-0298
Expires: _____

Attachment B
Part 1- Detail Sheets

OMB Clearance Package

List of Revised Discretionary Grant Performance Measures (PM) For 2012 Office of Management and Budget (OMB) Approval	
PM 3	**The percentage of MCHB-funded projects submitting and publishing findings in peer-reviewed journals**
PM 20	**The percentage of women participating in MCHB-funded programs who have an ongoing source of primary and preventive care services for women.**
PM 21	**The percentage of women participating in MCHB-funded programs who have a completed referral, among those women who receive a referral.**
PM 24	**The degree to which MCHB-funded initiatives contribute to infrastructure development through core public health assessment, policy development and assurance functions which enhance the public's health and decrease health disparities.**
PM 27	**The degree to which grantees have mechanisms in place to ensure quality in the design, development, and dissemination of new information resources that they produce each year.**
PM 33	**The degree to which MCHB-funded initiatives work to promote sustainability of their programs or initiatives beyond the life the MCH funding.**
PM 35	**The degree to which States and communities have implemented comprehensive systems for women's health services**
PM 38	**The percentage of completed referrals among women in MCHB-funded programs**
PM 39	**The percentage of women participating in MCHB-funded programs who smoke in the last three months of pregnancy**
PM 41	**The degree to which grantees have assisted in developing, supporting, and promoting medical homes for MCH populations.**
New Measure	**The percentage of children age 0 to 2 participating in MCHB-funded programs who receive coordinated , ongoing, comprehensive care within a medical home**
NEW FORM – Healthy Start Sites	
MCHB Program Performance Measures Detail Sheets	

01 PERFORMANCE MEASURE **Goal 1: Provide National Leadership for MCH (Create a shared vision and goals for MCH)** **Level: Grantee** **Category: Client Satisfaction**	The percent of MCHB supported programs that are satisfied with the leadership of and services received from MCHB.
GOAL	To increase responsiveness of MCHB services, including leadership, technical assistance, grants processing and training, to the needs of MCHB grantees, i.e., training, etc. to MCHB State and local grantees
MEASURE	The percent of MCHB supported programs that are satisfied with the leadership of and services received from MCHB.
DEFINITION	**Numerator:** Number of unduplicated MCHB supported projects that report being satisfied with the responsiveness of services provided to them by MCHB in a determined time period as measured by customer satisfaction surveys. **Denominator:** The total number of state and local grantees receiving support from MCHB during the time period. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Public Health Infrastructure Goal: To ensure that Federal, State, Tribal, and local health agencies have the necessary infrastructure to effectively provide essential public health services
DATA SOURCE(S) AND ISSUES	• Surveys of customer satisfaction conducted by ACSI at regular intervals for each target audience. There is a blanket OMB approval for these surveys. Survey questions for each target population will be developed in conjunction with ACSI.
SIGNIFICANCE	High quality, accessible, and culturally competent services, provided in a timely fashion, can minimize access barriers and enable people to obtain the health care services they need, reducing morbidity and mortality. The leadership and responsiveness of MCHB to grantees' needs facilitates this increased access and quality.

02 PERFORMANCE MEASURE **Goal 1: Provide National Leadership for MCHB (Create a shared vision and goals for MCH)** **Level: National** **Category: Client Satisfaction**	The percent of MCHB customers (clients) of MCHB programs that are satisfied with services received from MCHB supported programs.
GOAL	To increase responsiveness of MCHB sponsored programs in providing high quality, accessible, and culturally competent services, in a timely fashion, to their target populations.
MEASURE	The percent of MCHB customers (clients) of MCHB programs that are satisfied with services received from MCHB supported programs.
DEFINITION	**Numerator:** Number of unduplicated clients of selected MCHB-funded programs who report being either satisfied or very satisfied with the services received during a given time period. **Denominator:** The total number of programs' clients surveyed who received services during the time period. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Public Health Infrastructure: To ensure that Federal, State, Tribal, and local health agencies have the necessary infrastructure to effectively provide essential public health services
DATA SOURCE(S) AND ISSUES	Surveys of customer satisfaction conducted by ACSI at regular intervals for each target audience. There is a blanket OMB approval for these surveys. Survey questions for each target population will be developed in conjunction with ACSI.
SIGNIFICANCE	High quality, accessible, and culturally competent services, provided in a timely fashion, can minimize access barriers and enable people to obtain the health care services they need, reducing morbidity and mortality. The responsiveness of MCHB funded projects to those needs improves access and care.

REVISED DETAIL SHEET

03 PERFORMANCE MEASURE **Goal 1: Provide National Leadership for MCHB** **(Strengthen the MCH knowledge base and support scholarship within the MCH community)** **Level: Grantee** **Category: Information Dissemination**	The percentage of MCHB-funded projects submitting and publishing findings in peer-reviewed journals as (a) primary author, and/or (b) contributing author.
GOAL	To increase the number of MCHB-funded research projects that publish in peer-reviewed journals.
MEASURE	The percent of MCHB-funded projects submitting articles and publishing findings in peer-reviewed journals.
DEFINITION	**(a) Numerator:** Number of projects (current and completed within the past three years) that have submitted articles as primary author by peer reviewed journals. **Denominator:** Total number of current projects and projects that have been completed within the past three years. (b) Numerator: Number of projects (current and completed within the past three years) that have submitted articles as contributing author in peer reviewed journals Denominator: Total number of current projects and projects that have been completed within the past three years And **(a) Numerator:** Number of projects (current and completed within the past 3 years) that have published articles as primary author in peer reviewed journals **Denominator:** Number of current projects and projects that have been completed within the past three years (b) Numerator: Number of projects (current and completed within the past three years) that have published articles as contributing author in peer reviewed journals Denominator: Number of current projects and projects that have been completed within the past three years **Denominator:** Total number of current projects and projects that have been completed within the past three years. **Units:** 100 **Text:** Percent

HEALTHY PEOPLE 2020 OBJECTIVE	Related to Access Goal: Improve access to comprehensive, quality health care services (Objectives AHS-1 – AHS-9)
DATA SOURCE(S) AND ISSUES	Attached data collection form will be sent annually to grantees during their funding period and three years after the funding period ends. Some preliminary information may be gathered from mandated project final reports.
SIGNIFICANCE	To be useful, the latest evidence-based, scientific knowledge must reach professionals who are delivering services, developing programs and making policy. Peer reviewed journals are considered one of the best methods for distributing new knowledge because of their wide circulation and rigorous standard of review.

Data Collection Form for Performance Measure #03

Please use the space provided for notes to detail the data source and year of data used.

Number of articles submitted for review by refereed journals but not yet published in this reporting year as primary author _____

Number of articles published in peer-reviewed journals this reporting year as primary author _____

Number of articles submitted for review by refereed journals but not yet published in this reporting year as a contributing author

_____

Number of articles published in peer-reviewed journals this reporting year as primary author

_____

NOTES/COMMENTS:

04 PERFORMANCE MEASURE **Goal 1: Provide National Leadership for MCHB (Strengthen the MCH knowledge base and support scholarship within the MCH community)** **Level: National** **Category: Information Dissemination**	The number of publications, including peer-reviewed manuscripts, authored or co-authored by MCHB staff.
GOAL	To enhance the scientific knowledge base covering the major goals and programs of the Maternal and Child Health Bureau, and disseminate the information to the appropriate audiences.
MEASURE	The number of publications authored or co-authored by MCHB staff.
DEFINITION	The number of monographs, journal articles, books, book or publication chapters, MCHB reports, guidelines, and doctoral dissertations authored by MCHB staff. Publications are defined as monographs, journal articles, books or publication chapters, MCHB reports, guidelines, and doctoral dissertations.
HEALTHY PEOPLE 2020 OBJECTIVE	No related Healthy People 2020 Objective
DATA SOURCE(S) AND ISSUES	• MCHB surveys, data from MCHB programs, and maternal and child health data sources.
SIGNIFICANCE	MCHB leadership role includes contributing to MCH scientific knowledge and policy debate. Part of MCHB's mission is to address the most pressing issues in the maternal and child health area, and disseminate the latest information to policy makers, state and local MCH professionals, and the general public. This performance measure is important because it demonstrates the magnitude of MCHB's investment.

DATA COLLECTION FORM FOR DETAIL SHEET #04

Publications, Including Peer-Reviewed Manuscripts, Authored Or Co-Authored By MCHB Staff

TITLE: _____

AUTHOR: _____

PUBLICATION:_____

If Journal:

Peer Reviewed [ ] Yes [ ] No

VOLUME:_____ NUMBER:_____ SUPPLEMENT:_____YEAR:_____PAGE(S):_____

If Book or chapter,

Publisher _____ Location _____ Year _____

Other:

_____ Year _____
(i.e., Monograph, Report, Guidelines, doctoral dissertations)

05 PERFORMANCE MEASURE	The percent of MCHB supported projects that are sustained in the community after the federal grant project period is completed.
Goal 1: Provide National Leadership for MCHB **(Forge strong collaborative, sustainable MCH partnerships both within and beyond the health sector)** **Level: Grantee** **Category: Sustainability**	
GOAL	To increase the sustainability of MCHB funded projects after their federal grant project period is completed.
MEASURE	The percent of MCHB funded projects that are sustained in the community after the federal grant project period is completed.
DEFINITION	**Numerator:** Number of designated MCHB funded projects that are sustained after the federal MCHB project period. **Denominator:** Total number of designated MCHB funded projects that have completed the federal MCHB project period during the reporting year. **Units:** 100 **Text:** Percent The relevant MCHB supported projects are defined as projects that attempt to foster community partnerships and build capacity and/or program resources that continue as needed in that community after federal funds discontinue. These projects include but are not limited to Healthy Tomorrows, Healthy Child Care America Campaign, CISS, Integrated Services projects, etc. A "sustained" project refers to a project that demonstrates the continuation of key elements of program/service components started under the MCHB supported project.
HEALTHY PEOPLE 2020 OBJECTIVE	No related Healthy People 2020 Objective
DATA SOURCE(S) AND ISSUES	• The final project report (submitted after the grant period ends) for each MCHB supported project will provide the necessary data. • One potential source of difficulty is the variable submission rate of required final project reports by grantees and the narrative nature of final project reports.
SIGNIFICANCE	A major strategy of MCHB is to strengthen public health infrastructure at the state and local level by providing small "start up" grants which communities are encouraged to use to leverage other community resources. These grants are meant to foster community partnerships, and build capacity and program services that continue in the community after the federal grant period ends. Measuring sustainability gauges the effectiveness of Bureau resources in generating longer-term community investments through its initial funding.

07 PERFORMANCE MEASURE **Goal 1: Provide National Leadership for MCHB (Promote family participation in care)** **Level: Grantee** **Category: Family/Youth/Consumer Participation**	The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities.
GOAL	To increase family/youth/consumer participation in MCHB programs.
MEASURE	The degree to which MCHB-funded programs ensure family/youth/consumer participation in program and policy activities.
DEFINITION	Attached is a checklist of eight elements that demonstrate family participation, including an emphasis on family-professional partnerships and building leadership opportunities for families and consumers in MCHB programs. Please check the degree to which the elements have been implemented.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: MICH-30: Increase the proportion of children, including those with special health care needs who have access to a medical home MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems
DATA SOURCE(S) AND ISSUES	Attached data collection form is to be completed by grantees.
SIGNIFICANCE	Over the last decade, policy makers and program administrators have emphasized the central role of families and other consumers as advisors and participants in policy-making activities. In accordance with this philosophy, MCHB is facilitating such partnerships at the local, State and national levels. Family/professional partnerships have been: incorporated into the MCHB Block Grant Application, the MCHB strategic plan. Family/professional partnerships are a requirement in the Omnibus Budget Reconciliation Act of 1989 (OBRA ’89) and part of the legislative mandate that health programs supported by Maternal and Child Health Bureau (MCHB) Children with Special Health Care Needs (CSHCN) provide and promote family centered, community-based, coordinated care.

DATA COLLECTION FORM FOR DETAIL SHEET #07

Using a scale of 0-3, please rate the degree to which the grant program has included families, youth, and consumers into their program and planning activities. Please use the space provided for notes to describe activities related to each element and clarify reasons for score.

0	1	2	3	Element
				1. Family members/youth/consumers participate in the planning, implementation and evaluation of the program's activities at all levels, including strategic planning, program planning, materials development, program activities, and performance measure reporting.
				2. Culturally diverse family members/youth/consumers facilitate the program's ability to meet the needs of the populations served.
				3. Family members/youth/consumers are offered training, mentoring, and opportunities to lead advisory committees or task forces.
				4. Family members/youth/consumers who participate in the program are compensated for their time and expenses.
				5. Family members/youth/consumers participate on advisory committees or task forces to guide program activities.
				6. Feedback on policies and programs is obtained from families/youth/consumers through focus groups, feedback surveys, and other mechanisms as part of the project's continuous quality improvement efforts.
				7. Family members/youth/consumers work with their professional partners to provide training (pre-service, in-service and professional development) to MCH/CSHCN staff and providers.
				8. Family /youth/consumers provide their perspective to the program as paid staff or consultants.

0=Not Met
1=Partially Met
2=Mostly Met
3=Completely Met

Total the numbers in the boxes (possible 0-24 score) _____

NOTES/COMMENTS:

08 PERFORMANCE MEASURE **Goal 1: Provide National Leadership for Maternal and Child Health (Provide both graduate level and continuing education training to assure interdisciplinary MCH public health leadership nationwide)** **Level: Grantee** **Category: Training**	The percentage of graduates of MCHB long-term training programs that demonstrate field leadership after graduation.
GOAL	To increase the percentage of graduates of long-term training programs that demonstrate field leadership five years after graduation.
MEASURE	The percentage of graduates of MCHB long-term training programs that demonstrate field leadership after graduation.
DEFINITION	Attached is a checklist of four elements that demonstrate field leadership. For each element, identify the number of graduates of MCHB long-term training programs that demonstrate field leadership five years after graduation. Please keep the completed checklist attached. "Field leadership" refers to but is not limited to providing MCH leadership within the clinical, advocacy, academic, research, public health, public policy or governmental realms. Refer to attachment for complete definition. Cohort is defined as those who graduate in a certain project period. Data form for each cohort year will be collected five years following graduation.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: PHI-1: Increase the proportion of Federal, Tribal, State and local public health agencies that incorporate Core Competencies for Public Health Professionals into job descriptions and performance evaluations PHI-3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs and schools of nursing (with public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula
DATA SOURCE(S) AND ISSUES	Attached data collection form to be completed by grantees.
SIGNIFICANCE	An MCHB trained workforce is a vital participant in clinical, administrative, policy, public health and various other arenas. MCHB long-term training programs assist in developing a public health workforce that addresses MCH

concerns and fosters field leadership in the MCH arena.

DATA COLLECTION FORM FOR DETAIL SHEET #08

A. The total number of graduates, five years following completion of program _____

B. The total number of graduates lost to followup _____

C. The total number of respondents (A-B) _____

D. Number of respondents demonstrating MCH leadership in **at least one** of the following areas below: _____

E. Percent of respondents demonstrating MCH leadership in at least one of the following areas below: _____

Please use the notes field to detail data sources and year of data used.

(Individual respondents may have leadership activities in multiple areas below)

1. Number of trainees that have participated in **academic** leadership activities _____
   - Disseminated information on MCH Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
   - Conducted research or quality improvement on MCH issues
   - Provided consultation or technical assistance in MCH areas
   - Taught/mentored in my discipline or other MCH related field
   - Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
   - Procured grant and other funding in MCH areas
   - Conducted strategic planning or program evaluation

2. Number of trainees that have participated in **clinical** leadership activities _____
   - Participated as a group leader, initiator, key contributor or in a position of influence/authority on any of the following: committees of State, national, or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
   - Served in a clinical position of influence (e.g. director, senior therapist, team leader, etc
   - Taught/mentored in my discipline or other MCH related field
   - Conducted research or quality improvement on MCH issues
   - Disseminated information on MCH Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
   - Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)

3. Number of trainees that have participated in **public health practice** leadership activities _____

- Provided consultation, technical assistance, or training in MCH areas
- Procured grant and other funding in MCH areas
- Conducted strategic planning or program evaluation
- Conducted research or quality improvement on MCH issues
- Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
- Participated in public policy development activities (e.g., Participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation (provided testimony, educated legislators, etc)

4. Number of trainees that have participated in **public policy & advocacy** leadership activities _____

- Participated in public policy development activities (e.g., participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation, provided testimony, educated legislators)
- Participated on any of the following as a group leader, initiator, key contributor, or in a position of influence/authority: committees of State, national, or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
- Disseminated information on MCH public policy Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)

NOTES/COMMENTS:

09 PERFORMANCE MEASURE **Goal 2: Eliminate Health Barriers and Disparities (Train an MCH Workforce that is culturally competent and reflects an increasingly diverse population)** **Level: Grantee** **Category: Training**	The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups.
GOAL	To increase the percentage of trainees participating in MCHB long-term training programs who are from underrepresented racial and ethnic groups.
MEASURE	The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups.
DEFINITION	**Numerator:** Total number of long-term trainees (≥ 300 contact hours) participating in MCHB training programs reported to be from underrepresented racial and ethnic groups. (Include MCHB-supported and non-supported trainees.) **Denominator:** Total number of long-term trainees (≥ 300 contact hours) participating in MCHB training programs. (Include MCHB-supported and non-supported trainees.) **Units:** 100 **Text:** Percentage The definition of "underrepresented racial and ethnic groups" is based on the categories from the U.S. Census.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: AHS-4: Increase the number of practicing primary care providers ECBP-11: (Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs
DATA SOURCE(S) AND ISSUES	Data will be collected annually from grantees about their trainees. MCHB does not maintain a master list of all trainees who are supported by MCHB long-term training programs. References supporting Workforce Diversity: ● In the Nation's Compelling Interest: Ensuring Diversity in the Healthcare Workforce (2004). Institute of Medicine. ● Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2002). Institute of Medicine.

SIGNIFICANCE

HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. Training a diverse group of professionals is necessary in order to provide a diverse public health workforce to meet the needs of the changing demographics of the U.S. and to ensure access to culturally competent and effective services. This performance measure provides the necessary data to report on HRSA's initiatives to reduce health disparities.

Data Collection Form For Detail Sheet #09

Report on the percentage of long-term trainees (≥300 contact hours) who are from any underrepresented racial/ethnic group (i.e., Hispanic or Latino, American Indian or Alaskan Native, Asian, Black or African-American, Native Hawaiian or Pacific Islander, two or more race (OMB). Please use the space provided for notes to detail the data source and year of data used.

Report on all long-term trainees (≥ 300 contact hours) including MCHB-funded and non MCHB-funded trainees

Report race and ethnicity separately

Trainees who select multiple ethnicities should be counted once

Grantee reported numerators and denominator will be used to calculate percentages

Total number of long-term trainees (≥ 300 contact hours) participating in the training program. (Include MCHB-supported and non-supported trainees.) _____

Ethnic Categories

Number of long-term training participants who are Hispanic or Latino (Ethnicity) _____

Racial Categories

Number of long-term trainees who are American Indian or Alaskan Native _____

Number of long-term trainees who are of Asian descent _____

Number of long-term trainees who are Black or African-American _____

Number of long-term trainees who are Native Hawaiian or Pacific Islanders _____

Number of long-term trainees who are two or more races _____

Notes/Comments:

10 PERFORMANCE MEASURE **Goal 2: Eliminate Health Barriers & Disparities** **(Develop and promote health services and systems of care designed to eliminate disparities and barriers across MCH populations)** **Level: Grantee** **Category: Cultural Competence**	The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts and training.
GOAL	To increase the number of MCHB-funded programs that have integrated cultural and linguistic competence into their policies, guidelines, contracts and training.
MEASURE	The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts and training.
DEFINITION	Attached is a checklist of 15 elements that demonstrate cultural and linguistic competency. Please check the degree to which the elements have been implemented. The answer scale for the entire measure is 0-45. Please keep the completed checklist attached. Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989; sited from DHHS Office of Minority Health--http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlid=11) Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. (Goode, T. and W. Jones, 2004. National Center for Cultural Competence; http://www.nccccurricula.info/linguisticcompetence.html) Cultural and linguistic competency is a process that occurs along a developmental continuum. A culturally and linguistically competent program is characterized by elements including the following: written strategies for advancing cultural competence;

	cultural and linguistic competency policies and practices; cultural and linguistic competence knowledge and skills building efforts; research data on populations served according to racial, ethnic, and linguistic groupings; participation of community and family members of diverse cultures in all aspects of the program; faculty and other instructors are racially and ethnically diverse; faculty and staff participate in professional development activities related to cultural and linguistic competence; and periodic assessment of trainees' progress in developing cultural and linguistic competence.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to the following HP2020 Objectives: PHI-1: Increase the proportion of Federal, Tribal, State and local public health agencies that incorporate Core Competencies for Public Health Professionals into job descriptions and performance evaluation PHI -3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs, and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula PH-5: (Developmental) Increase the proportion of 4-year colleges and universities that offer public health or related majors and/or minors which are consistent with the core competencies for undergraduate public health education MICH-31:Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems
DATA SOURCE(S) AND ISSUES	Attached data collection form is to be completed by grantees. There is no existing national data source to measure the extent to which MCHB supported programs have incorporated cultural competence elements into their policies, guidelines, contracts and training.
SIGNIFICANCE	Over the last decade, researchers and policymakers have emphasized the central influence of cultural values and cultural/linguistic barriers: health seeking behavior, access to care, and racial and ethnic disparities. In accordance with these concerns, cultural competence objectives have been: (1) incorporated into the MCHB strategic plan; and (2) in guidance materials related to the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), which is the legislative mandate that health programs supported by MCHB Children with Special Health Care Needs (CSHCN) provide and promote family centered, community-based, coordinated care.

DATA COLLECTION FORM FOR DETAIL SHEET #10

Using a scale of 0-3, please rate the degree to which your grant program has incorporated the following cultural/linguistic competence elements into your policies, guidelines, contracts and training.

Please use the space provided for notes to describe activities related to each element, detail data sources and year of data used to develop score, clarify any reasons for score, and or explain the applicability of elements to program.

0	1	2	3	Element
				1. Strategies for advancing cultural and linguistic competency are integrated into your program's written plan(s) (e.g., grant application, recruiting plan, placement procedures, monitoring and evaluation plan, human resources, formal agreements, etc.).
				2. There are structures, resources, and practices within your program to advance and sustain cultural and linguistic competency.
				3. Cultural and linguistic competence knowledge and skills building are included in training aspects of your program.
				4. Research or program information gathering includes the collection and analysis of data on populations served according to racial, ethnic, and linguistic groupings, where appropriate.
				5. Community and family members from diverse cultural groups are partners in planning your program.
				6. Community and family members from diverse cultural groups are partners in the delivery of your program.
				7. Community and family members from diverse cultural groups are partners in evaluation of your program.
				8. Staff and faculty reflect cultural and linguistic diversity of the significant populations served.
				9. Staff and faculty participate in professional development activities to promote their cultural and linguistic competence.
				10. A process is in place to assess the progress of your program participants in developing cultural and linguistic competence.

0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Total the numbers in the boxes (possible 0-30 score) _____

NOTES/COMMENTS:

12 PERFORMANCE MEASURE **Goal 2: Eliminate Health Barriers & Disparities (Develop and promote health services and systems of care designed to eliminate disparities and barriers across MCH population)** **Level: National** **Category: Dental**	The percent of children under age 21 enrolled in Medicaid for at least 6 months continuously during the year who receive any preventive or treatment dental service.
GOAL	To increase the percent of children under age 21 that receive preventive and treatment dental services under State Medicaid programs.
MEASURE	The percent of children under age 21 enrolled in Medicaid for at least 6 months continuously during the year who receive any preventive or treatment dental service.
DEFINITION	**Numerator:** The number of children under age 21 enrolled in Medicaid who receive any preventive or treatment Medicaid dental health service. **Denominator:** The number of children under age 21 enrolled in Medicaid during the reporting period. **Units:** 100 **Text:** Percent *Children under Medicaid* is defined as children enrolled continuously during the year.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objective OH-8: Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year.
DATA SOURCE(S) AND ISSUES	• CMS (formerly HCFA) Form 416. All states are required by statue to annually submit to HCFA on this form a summary of Medicaid health activities within a state. The CMS Form 416 has recently been revised to track annually the number of children who receive any dental service, any preventive dental service and any oral health treatment service.
SIGNIFICANCE	A 1996 Office of Inspector General (OIG) Report, a 2000 General Accounting Office (GAO) Report and a very recent Surgeon General's Report on Oral Health all attested that access to dental services for our Nation's poor children has reached critical levels. Data show that currently only one in five children are able to access dental health services under Medicaid. HRSA and CMS have entered into a collaborative initiative to address this problem. This collaboration has initially demonstrated that some increased access to oral health services in states can occur if the service delivery and

financing components of the health system mutually address the access problem. Additionally, at the national level MCHB, CMS and states are actively addressing oral health access issues through the MCH/Medicaid TAG.

13 PERFORMANCE MEASURE	The percent of States that have MCH staff who perform specific epidemiological activities and other MCH evaluations and analyses.
Goal 3: Assure Quality of Care (Build analytic capacity to assess and assure quality of care) **Level: State** **Category: Data and Evaluation**	
GOAL	To increase the percent of State MCH staff performing specific MCH evaluations and analyses.
MEASURE	The percent of States that have MCH staff who perform specific epidemiological activities and other MCH evaluations and analyses.
DEFINITION	**Numerator:** Number of States that have MCH staff performing specific MCH evaluations and analyses. **Denominator:** 59 States **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective PHI-13: Increase the proportion of Tribal, State, and local public health agencies that provide or assure comprehensive epidemiology services to support essential public health services.
DATA SOURCE(S) AND ISSUES	• MCHIP Annual Survey of State data contracts • MCH Block Grant Annual Report
SIGNIFICANCE	To carry out essential public health services and to enhance State data capacity, CDC/HRSA currently place MCH epidemiologists in State MCH programs. This MCH field component was established to increase the number of State-trained MCH epidemiologists while providing critically needed services to State and local Health Departments. Traditional capacity-building efforts in States have focused on using epidemiologist to conduct infectious disease surveillance and investigation of disease outbreaks. State MCH epidemiologists also perform other functions including analyzing epidemiologic data bases, evaluating surveillance systems, designing and analyze State survey data and producing reports with which State policies and programs can be established. Increased capacity for MCH epidemiologist, therefore, improves assessment of population health status, surveillance of risk in MCH populations and systematic reporting of MCH health indicators.

14 PERFORMANCE MEASURE **Goal 3: Assure Quality of Care (Build analytic capacity to assess and assure quality of care)** **Level: State and Local** **Category: Data and Evaluation**	The degree to which States and communities use "morbidity/mortality" review processes in MCH needs assessment, quality improvement, and/or data capacity building.
GOAL	To increase the number of MCHB programs that incorporate the findings and recommendations from Mortality/Morbidity Review processes in their planning and program development (e.g., needs assessment, quality improvement, and/or capacity building).
MEASURE	The degree to which States and communities use "morbidity/mortality" review processes in MCH needs assessment, quality improvement, and/or data capacity building.
DEFINITION	Attached is a scale to measure 1) the presence of the mortality/morbidity review, 2) coordination with other mortality/morbidity reviews, 3) utilization of the mortality/morbidity review process in MCH planning.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: MICH-1: Reduce the rate of fetal and infant deaths. MICH-5: Reduce the rate of maternal mortality
DATA SOURCE(S) AND ISSUES	Attached data collection form to be completed by MCHB Program Directors.
SIGNIFICANCE	Mortality/morbidity reviews are processes aimed at guiding States and communities to identify and solve problems contributing to poor reproductive outcomes and maternal and child health. The ultimate goal is to enhance assessment capacity, policy development, and quality improvement efforts. These processes provide a means to systematically examine the factors that play a role in mortality and morbidity, integrating information about the health of individuals with other information about medical care, community resources, and health and social services systems. This process should lead to system improvements to decrease preventable mortality/morbidity.

DATA COLLECTION FORM FOR DETAIL SHEET #14

Using a scale of 0-1, please rate the degree to which your program utilizes the mortality/morbidity review processes in a coordinated and integrated way in the following categories.

Please use the space provided for notes to describe activities related to each type of review, clarify any reasons for score, and explain the applicability of elements to program.

Review Processes	In Place	Coordination	Used in State or Local MCH Planning
Fetal/Infant Mortality Review			
Child Fatality Review			
Maternal Mortality Review			

In Place: 0 = Not in place
1 = In place

Coordination: 0 = No Coordination
1 = Coordination between at least 2 mortality/morbidity review processes

Used in State or Local MCH Planning:
0 = Findings not used in State or Local MCH planning
1 = Findings used in State or Local MCH planning

NOTES/COMMENTS:

15 PERFORMANCE MEASURE **Goal 3: Assure Quality of Care (Develop and promote health services and systems designed to improve quality of care)** **Level: National** **Category: CSHN/Health Insurance**	The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for needed services.
GOAL	To increase the percent of children with special health care needs, age 0 through 18, with adequate insurance coverage for primary care, specialty care, inpatient, and enabling services.
MEASURE	The percent of children with special health care needs age 0 through 18 whose families perceive that they have adequate insurance coverage.
DEFINITION	**Numerator:** Number of children with special health care needs age 0 through 18 whose families perceive that they have adequate insurance coverage. **Denominator:** Number of children with special health care needs age 0 through 18 during the reporting period. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: AHS-1: Increase the proportion of persons with health insurance MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems
DATA SOURCE(S) AND ISSUES	The National CSHCN Survey will provide state and national data on the percent of parents of children with special health care needs reporting: • having current health insurance with no gaps in coverage over past 12 months; • no delays or failure to get needed care due to costs; • no access problems due to health plans; and • satisfaction with health plan. The National CSHCN Survey will provide a national estimate in 2002 and periodically thereafter.

SIGNIFICANCE

Children with special health care needs often require an amount and type of care beyond that required by typically developing children and are more likely to incur catastrophic expenses. This population of children and families often have disproportionately low incomes and, therefore, are at higher risk of being uninsured. Since children are more likely to obtain health care if they are insured, insurance coverage and the content of that coverage is an important indicator of access to care. Because children with special health care needs often require more and different services than typically developing children, under-insurance is a major factor in determining adequacy of coverage.

16 PERFORMANCE MEASURE **Goal 2: Eliminate Health Barriers & Disparities** **(Develop and promote health services and systems of care designed to eliminate disparities and barriers across MCH populations)** **And** **Goal 3: Assure Quality of Care** **(Develop and promote health services and systems designed to improve quality of care)** **Level: Grantee** **Category: Health Insurance/CSHN**	The degree to which grantees have assisted in increasing the percentage of pregnant women and percentage of children whose families have continuous and adequate private and/or public insurance, or other financing to pay for needed services.
GOAL	To increase the percentage of children and pregnant women with adequate insurance coverage or other financing for primary care, specialty care, inpatient, and enabling services.
MEASURE	The degree to which grantees have worked to increase the percentage of pregnant women, children and youth who have continuous and adequate health insurance and other financing to pay for needed services.
DEFINITION	Attached is a checklist of six elements that demonstrate how a grantee has worked to improve access to adequate health insurance or other financing for health services for children and pregnant women. Please check the degree to which each element has been implemented.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People Objectives: AHS-1: Increase the proportion of persons with health insurance MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems
DATA SOURCE(S) AND ISSUES	Attached data collection form to be completed by grantees. The data collection form represents a menu of strategies by which grantees may improve access to adequate health insurance and financing for children, youth, and pregnant women.

SIGNIFICANCE

There is strong evidence that children are more likely to obtain health care and have a medical home if they are insured. Uninsured children including those with discontinuous coverage are more likely to report unmet needs for preventive and specialty care. National surveys indicate that the majority of children who are uninsured are eligible for public programs such as Medicaid or the Children's Health Insurance Program (CHIP), but due to a number of reasons, are not enrolled. Like their counterparts, it is critical for children and youth with special health care needs to have continuous, adequate insurance. While most CYSCHN have private or public coverage, they are more likely to be underinsured and incur catastrophic expenses. In many instances, other sources of supplemental financing are needed to assure children have access to services that are not adequately covered by insurance

Data Collection Form For Detail Sheet #16

Using the scale below, indicate the degree to which your grant program has worked toward or accomplished improvements in adequate health insurance and/or financing of care for children, youth, and pregnant women. This includes a focus on decreasing uninsurance, increasing continuity of coverage, improving access to adequate health insurance coverage, and/ or improving the financing of and reimbursement for primary care, specialty care, inpatient and enabling services for children, youth, and pregnant women.

Population Focus (please check all that apply):

All Children and youth Children and youth with Special Health Care Needs _____
Pregnant Women _____

Please use the space provided for notes to describe activities related to each element and clarify reasons for score.

0	1	2	3	Element
				1. **Activities to decrease uninsurance.** The grantee was engaged in local, State, or national-level work to decrease the number of uninsured children and youth, and/or pregnant women.
				2. **Activities to increase the number of children and youth whose insurance coverage is adequate.** The grantee was engaged in local, State, or national-level work to decrease the number of children and youth, and/or pregnant women whose insurance coverage is adequate to meet their health care needs.
				3. **Activities to improve continuity of insurance for children and youth.** The grantee was engaged in local, State, or national-level work to prevent gaps in health insurance coverage for children and youth, and thus promote continuity of coverage for children.
				4. **Activities to improve financing or reimbursement of services.** The grantee was engaged in local, State, or national-level work to improve the financing and reimbursement of health and related services needed by children and youth, and/or pregnant women.
				5. **State or local implementation.** The grantee was able to improve access to adequate health insurance or financing for health care for children and youth, and/or pregnant women at the individual, family, local, State, or national level.
				6. **Collaboration.** The grantee was directly engaged in or assisted the State in developing partnerships and collaborating with key stakeholders, such as State agencies (e.g., Medicaid agencies, State insurance commissioners), health insurance companies/managed care organizations, provider organizations (e.g., hospitals, physician groups); health purchasers (e.g. employers, unions, and other employee-related organizations); families; and consumer groups to improve adequate and continuous health insurance coverage and/or financing of care for children and youth, and /or pregnant women..

0	1	2	3	Element
				7. **Dissemination:** The grantee participated in activities to disseminate the project's results, products, and materials related to improving access to adequate health insurance coverage or financing and reimbursement of needed services for children and youth, and/or pregnant women to local, State, or national audiences.
				8. **Monitoring:** The grantee monitored the rate of uninsurance and/or underinsurance among children and youth and/or pregnant women, using available local, state and national data.

0=Not Met

1=Partially Met

2=Mostly Met

3=Completely Met

Total the numbers in the boxes (possible 0–24 score): _____

NOTES/COMMENTS:

17 PERFORMANCE MEASURE **Goal 3: Assure Quality of Care (Develop and promote health services and systems designed to improve quality of care)** **Level: National** **Category: Child Health/Medical Home**	The percentage of children age 0 to 18 participating in MCHB-funded programs who receive coordinated, ongoing, comprehensive care within a medical home.
GOAL	To increase the number of children in the State who have a medical home.
MEASURE	The percentage of all children age 0 to 18 participating in MCHB-funded programs who receive coordinated, ongoing, comprehensive care within a medical home.
DEFINITION	**Numerator:** The number of children participating in MCHB funded projects age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home during the reporting period. **Denominator:** Te number of children participating in MCHB funded projects age 0 to 18 during the reporting period. **Units:** 100 **Text:** Percentage The MCHB uses the American Academy of Pediatrics (AAP) definition of "medical home." The definition establishes that the medical care of infants, children and adolescents should be accessible, continuous, comprehensive, family centered, coordinated and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them. These characteristics define the "medical home" and describe the care that has traditionally been provided in an office setting by pediatricians. (AAP, Volume 90, No. 5, 11/92). Please use the space provided for notes to detail the data source and year of data used.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objective MICH-30: Increase the proportion of children, including those with special health care needs who have access to a medical home
DATA SOURCE(S) AND ISSUES	Provider and MCHB program patient records.
SIGNIFICANCE	Providing primary care to children in a "medical

home" is the standard of practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. Data collected for this measure would help to ensure that children have access to a medical home and help to document the performance of several programs including EPSDT, Immunization, and IDEA in reaching that goal.

18 PERFORMANCE MEASURE **Goal 3: Assure Quality of Care (Develop and promote health services and systems designed to improve quality of care)** **Level: National** **Category: CSHN/Medical Home**	The percent of children with special health care needs age 0 through 18 who receive coordinated, ongoing, comprehensive care within a medical home.
GOAL	To increase the number of children with special health care needs who have a medical home.
MEASURE	The percent of children with special health care needs age 0 through 18 who have a medical home.
DEFINITION	**Numerator:** The percent of children with special health care needs age 0 through 18 who have a medical home during the reporting period. **Denominator:** The number of children with special health care needs in the State age 0 through 18 during the reporting period. **Units:** 100 **Text:** Percent The MCHB uses the AAP definition of "medical home." The definition establishes that the medical care of infants, children and adolescents should be accessible, continuous, comprehensive, family centered, coordinated and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them. (AAP, Volume 90, No. 5, 11/92).
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective MICH-30: Increase the proportion of children, including children with special health care needs who have access to a medical home
DATA SOURCE(S) AND ISSUES	• The National CSHCN Survey will provide state and national level data on the extent to which families perceive that their child with a special health care need has access to a medical home. Indicators include having a regular doctor for routine and sick care; access to care that is coordinated with specialty care and community services; ease in obtaining referrals; and receipt of respectful and culturally competent care.
SIGNIFICANCE	Providing primary care to children in a "medical home" is the standard of practice. Research

indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The MCHB uses the AAP definition of “medical home.” The definition establishes that the medical care of infants, children and adolescents should be accessible, continuous, comprehensive, family centered, coordinated and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them. (AAP, 1992)

REVISED DETAIL SHEET

20 PERFORMANCE MEASURE **Goal 3: Assure Quality of Care (Develop and promote health services and systems designed to improve quality of care)** **Level: Grantee** **Category: Women's Health**	The percentage of women participating in MCHB-funded programs who have an ongoing source of primary and preventive care services for women.
GOAL	To increase the percentage of women participating in MCHB-funded projects who have an ongoing source of primary and preventive care services for women.
MEASURE	The percentage of women participating in MCHB-funded programs who have an ongoing source of primary and preventive care services for women.
DEFINITION	**Numerator:** The number of women participating in MCHB-funded projects who have received an ongoing source of primary and preventive care services during the reporting period. **Denominator:** The number of women participating in MCHB-funded projects during the reporting period. **Units:** 100 **Text:** Percentage "Ongoing source of care" is defined as the provider(s) who deliver ongoing primary and preventive health care. Women commonly use more than one provider for routine care (e.g., internist/FP and obstetrician-gynecologist). Ongoing source of care providers for women should offer services that ideally are accessible, continuous, comprehensive, coordinated and appropriately linked to specialty services, linguistically and culturally relevant and focused on the full context of women's lives. Please use the space provided for notes to detail the data source and year of data used.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective AHS-5: Increase the proportion of persons who have a specific source of ongoing care.
DATA SOURCE(S) AND ISSUES	Provider and MCHB program patient records. In the grant application, designated MCHB-funded projects will need to indicate how they will identify and document that program participants have an ongoing relationship with a provider(s) of primary and preventive services.

SIGNIFICANCE

Women across the life span often receive fragmented health care from non-coordinated sources or enter care only for ob/gyn services or to secure services for family dependents. Women need a comprehensive array of integrated services from an ongoing provider of primary and preventive health care services. Research indicates that women with a stable and continuous source of health care are more likely to receive appropriate preventive care and are less likely to have unmet needs for basic health care.

REVISED DETAIL SHEET

21 PERFORMANCE MEASURE **Goal 3: Assure Quality of Care (Develop and promote health services and systems that assure appropriate follow-up services)** **Level: Grantee** **Category: Women's Health**	The percentage of women participating in MCHB-funded programs who have a completed referral, among those women who receive a referral.
GOAL	Increase the percentage of completed referrals for women participating in MCHB-funded programs in need of services.
MEASURE	The percentage of women participating in MCHB-funded programs who have a completed referral among those that receive a referral.
DEFINITION	**Numerator:** Unduplicated number of women program participants who have at least one completed health or supportive service referral **Denominator:** Unduplicated number of women program participants who receive at least one referral for health and other supportive services **Units:** 100 **Text:** Percentage A "completed service referral" is defined as a client (who received a referral) attending one or more sessions with the provider to whom she was referred. The provider may be within or outside of the MCHB program/agency. The purpose of these referrals can be either treatment-related (e.g., AIDS or substance abuse treatment, domestic violence counseling), preventive (e.g., family planning, WIC, depression screening/ referral, early intervention services), or supportive services (e.g., housing, job training, transportation). Please use the space provided for notes to detail the data source and year of data used.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: MICH-6: Reduce maternal illness and complications due to pregnancy (complications during hospitalized labor and delivery) MICH-10: Increase the proportion of pregnant women who receive early and adequate prenatal

	care MICH-11: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women
DATA SOURCE(S) AND ISSUES	Provider and MCHB program patient records. Projects will need to have a process to verify a completed referral.
SIGNIFICANCE	In order to be effective, health services must ensure that a client's risks are identified, and clients receive services that address their identified needs and are referred appropriately. There is no impact if the referral is not completed/services not obtained.

22 PERFORMANCE MEASURE	The degree to which MCHB-funded programs facilitate health providers' screening of women participants for risk factors.
Goal 3: Assure Quality of Care (Develop and promote health services and systems that assure appropriate follow-up services) **Level: Grantee**	

Category: Women's Health

GOAL	To improve health providers' appropriate screening for risk factors of women participants in MCHB-funded programs.
MEASURE	The degree to which MCHB-funded programs facilitate health providers' screening of women participants for risk factors.
DEFINITION	Attached is a checklist of four activities that demonstrate the degree to which grantees have facilitated the screening of women participants for risk factors. Please indicate the degree to which the activities have been implemented. Please keep the completed checklist attached.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to various goals and objectives related to women's health, including the following: Access Goal: Improve access to comprehensive health care services C-3: Reduce the female breast cancer death rate C-15: Increase the proportion of women who receive a cervical cancer screening based on most recent guidelines C-17: Increase the proportion of women who receive a breast cancer screening based on the most recent guidelines FP-7.1: Increase the proportion of sexually experienced females aged 15-44 years who received reproductive health services in the past 123 months (Leading Health Indicator) HDS-14: Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high MICH Goal: Improve the health and well-being of women, infants, children and families OA-2: Increase the proportion of older adults who are up to date on a core set of clinical preventive services
DATA SOURCE(S) AND ISSUES	Provider and program patient records

SIGNIFICANCE

Screening of women for behavioral risk factors has proven to be beneficial in improving maternal outcomes, which highlights the importance of women being screened appropriately for risk factors. For example: intimate partner violence during pregnancy has been reported to be as high as 20.1 percent among pregnant women; adverse effects such as spontaneous abortion, LBW, and preterm delivery have been associated with prenatal use of licit and illicit drugs (including alcohol, tobacco, cocaine, and marijuana); screening in the area of mental health can promote early detection and intervention for mental health problems; and while there is insufficient evidence to support a recommendation concerning routine screening of pregnant females for STDs, the benefits of early intervention in HIV and, detection and treatment of asymptomatic Chlamydia have been demonstrated.

DATA COLLECTION FORM FOR DETAIL SHEET #22

Using a scale of 0-2, indicate the degree to which your grant has performed each activity to facilitate screening for each risk factor by health providers in your program.

Please use the space provided for notes to describe activities related to each risk factor, any risk factors included in "other," and supply performance objectives.

Risk Factor	Conduct activities that effectively motivate providers to systematically screen for risk factors, e.g., simple chart tools that identify when provider should screen, a sign off for the provider upon screening completion	Develop and/or enhance a system of care that ensures linkages between health care providers and appropriate intervention programs	Provide training to providers on effective and emerging screening tools.
Smoking			
Alcohol			
Illicit Drugs			
Eating Disorders			
Depression			
Hypertension			
Diabetes			
Domestic Violence			
Other			

0 = Grantee does not provide this function or assure that this function is completed.
1 = Grantee sometimes provides or assures the provision of this function but not on a consistent basis.
2 = Grantee regularly provides or assures the provision of this function.

NOTES/COMMENTS:

REVISED DETAIL SHEET

24 – PERFORMANCE MEASURE **Goal 4: Improve the Health Infrastructure and Systems of Care** **(Assist States and communities to plan and develop comprehensive, integrated health service systems)** **Level: State, Community, or Grantee** **Category: Infrastructure**	The degree to which MCHB-funded initiatives contribute to infrastructure development through core public health assessment, policy development and assurance functions which enhance the public's health and decrease health disparities
GOAL	To develop infrastructure that supports comprehensive and integrated services.
MEASURE	The degree to which MCHB-supported initiatives contribute to the implementation of the 10 MCH Essential Services and Core Public Health Program Functions of assessment, policy development and assurance.
DEFINITION	Attached is a checklist of 10 elements that comprise infrastructure development services for maternal and child health populations. Please score the degree to which each your program contributes to the implementation of each of these elements Each element should be scored 0-2, with a maximum total score of 20 across all elements.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objective PHI-15: Increase the proportion of Tribal, State, and local public health agencies that have implemented a health improvement plan and increase the proportion of local health jurisdictions that have implemented a health improvement plan linked with their State plan
DATA SOURCE(S) AND ISSUES	Attached data collection form to be completed by grantees based on activities they are directly engaged in or that they contribute to the implementation of by other MCH grantees or programs.
SIGNIFICANCE	Improving the health infrastructure and systems of care is one of the five goals of MCHB. There are five strategies under this goal, all of which are addressed in a number of MCHB initiatives which focus on system-building and infrastructure development. These five strategies follow: 1. Build analytic capacity for assessment, planning, and evaluation. 2. Using the best available evidence, develop and promote guidelines and practices that improve services and systems of care. 3. Assist States and communities to plan and develop comprehensive, integrated health service systems. 4. Work with States and communities to assure that services and systems of care reach targeted populations.

5. Work with States and communities to address selected issues within targeted populations.

The ten elements in this measure are comparable to the 10 Essential Public Health Services outlined in Grason H, Guyer B, 1995. *Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America.* Baltimore, MD: The Women's and Children's Health Policy Center, The Johns Hopkins University.

Data Collection Form for Detail Sheet # 24

Use the scale below to describe the extent to which your program or initiative has contributed to the implementation of each of the following Public MCH Program core function activities at the local, State, or national level. Please use the space provided for notes to clarify reasons for score.

0	1	2	Element
			Assessment Function Activities
			1. Assessment and monitoring of maternal and child health status to indentify and address problems, including a focus on addressing health disparities [Examples of activities include: developing frameworks, methodologies, and tools for standardized MCH data in public and private sectors; implementing population-specific accountability for MCH components of data systems, and analysis, preparation and reporting on trends of MCH data and health disparities among subgroups.]
			2. Diagnosis and investigation health problems and health hazards affecting maternal and child health populations [Examples of activities include conduct of population surveys and reports on risk conditions and behaviors, identification of environmental hazards and preparation of reports on risk conditions and behaviors.]
			3. Informing and educating the public and families about MCH issues.
			Policy Development Function Activities
			4. Mobilization of community collaborations and partnerships to identify and solve MCH problems. [Examples of stakeholders to be involved in these partnerships include: policymakers, health care providers, health care insurers and purchasers, families, and other MCH care consumers.]
			5. Provision of leadership for priority setting, planning and policy development to support community efforts to assure the health of maternal and child health populations.
			6. Promotion and enforcement of legal requirements that protect the health and safety of maternal and child health populations.
			Assurance Function Activities
			7. Linkage of maternal and child health populations to health and other community and family services, and assuring access to comprehensive quality systems of care
			8. Assuring the capacity and competency of the public health and personal health workforce to effectively and efficiently address MCH needs.
			9. Evaluate the effectiveness, accessibility and quality of direct, enabling and population-based preventive MCH services
		\	10. Research and demonstrations to gain new insights and innovative solutions to MCH-related issues and problems

0 = Grantee does not provide or contribute to the provision of this activity.
1 = Grantee sometimes provides or contributes to the provision of this activity.
2 = Grantee regularly provides or contributes to the provision of this activity

Total the numbers in the boxes (possible 0–20 score): _____

NOTES/COMMENTS:

25 PERFORMANCE MEASURE **Goal 4: Improve the Health Infrastructure and Systems of Care** **(Build analytic capacity for assessment, planning, and evaluation)** **Level: State** **Category: Data and Evaluation**	The degree to which States electronically link vital statistics data sets, Medicaid, and other health information systems data sets.
GOAL	To increase the number and degree to which States electronically link different maternal and child health databases for the purpose of assessing program performance and health status indicators for MCH populations.
MEASURE	The degree to which States electronically link vital statistics data sets, Medicaid, and other health information systems data sets.
DEFINITION	Attached is a checklist of four elements that demonstrate linkage. Please check the degree to which data sets have been linked. The answer scale is 0-8 for each linkage and 0-32 across all four elements. Please keep the completed checklist attached.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective PHI-10: Increase the number of states that record vital events by using the latest U.S. standard certificates and report
DATA SOURCE(S) AND ISSUES	• Attached data collection form to be completed by State MCH Directors.
SIGNIFICANCE	It is important to find new ways to examine information in order to improve evaluations of public health programs, conduct needs assessment, or address persistent problems such as racial and ethnic disparities. Data linkages provide a relatively cost-effective method for States to examine problems that they could not ordinarily address. Linking specific data sets such as Medicaid with WIC and birth records with death records can assist in providing information on high-risk groups and health outcomes for populations receiving Medicaid.

DATA COLLECTION FORM FOR DETAIL SHEET #25

Indicate the degree to which your State MCH program links the following databases using the following values:

0= The State or MCH agency does not provide this function or assure that this function is completed.
1= The State or MCH agency sometimes provides or assures the provision of this function but not on a consistent basis.
2= The State or MCH agency regularly provides or assures the provision of this function.

DATABASES	**QUESTIONS**				
	Does your state perform this function?	Does your MCH program have direct access to reports?	Does your MCH program have the ability to obtain timely analyses for programmatic or policy purposes?	Does your MCH program have direct access to the electronic database for analysis?	TOTAL (0-8)
ANNUAL DATA LINKAGES					
Annual linkage of infant birth and infant death certificates					
Annual linkage of birth certificates and MEDICAID paid claims or eligibility files.					
Annual linkage of birth records and WIC eligibility files.					
Annual linkage of birth records and newborn screening (metabolic and hearing) files.					
TOTAL (0-32)					

26 – PERFORMANCE MEASURE **Goal 1: Provide National Leadership for Maternal and Child Health (Strengthen the MCH knowledge base in the MCH community)** **Level: Grantee** **Category: Training**	The extent of training and technical assistance (TA) provided and the degree to which grantees have mechanisms in place to ensure quality in their training and TA activities.
GOAL	To increase the number of MCHB grantees that are using needs assessments, evaluation tools, and applying the results of the evaluation for quality improvement in their training and technical assistance (TA) efforts.
MEASURE	This measure has two components: A. The number of individuals who were provided training and TA by types of target audiences. B. The degree to which grantees have put in place key elements to improve the quality of their short- and long-term training and TA activities designed to promote professional and leadership development for the MCH community.
DEFINITION	The training and TA efforts that fall under this measure are short- and medium-term technical assistance and training, not graduate-level and continuing education training provided by MCHB long-term training programs. The target audiences include various populations in the MCH community, including families and other consumers, professionals and providers, State MCH agencies, community-based organizations, and other MCH stakeholders. The eight elements listed in the attached form contribute to promoting quality in the training and TA provided to the MCH community. Please check the degree to which each of the eight elements have been planned and implemented. The answer scale is 0–3 for each activity or element and 0–24 total across all elements.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective PHI-16: (Developmental) Increase the proportion of Tribal, State, and local public health agencies that have implemented an agency-wide quality improvement plan
DATA SOURCE(S) AND ISSUES	Attached is a data collection form to be completed by grantees.
SIGNIFICANCE	National Resource Centers, Policy Centers, leadership training institutes and other MCHB discretionary grantees provide technical assistance and training to various target audiences, including grantees, health care providers, program beneficiaries, and the public as a way of improving skills, increasing the MCH knowledge base, and thus improving capacity to adequately serve the needs of MCH populations and improve their outcomes. To provide these training and TA services most effectively, MCHB has identified performance recommendations, categorized into three categories: 1) activities to promote quality in the content and format of TA

and training activities, and prevent duplication of effort ; 2) outreach and promotion to ensure target audiences are aware of the services available to meet their needs, and 3) routine mechanisms to obtain trainee satisfaction and outcomes data and apply what is learned to improve the design and delivery of these services.

Data Collection Form – Detail Sheet # 26
Quality of Training and Technical Assistance

PART A

Numbers of individual recipients of training and technical assistance, by categories of target audiences: (drop down box for respondents to check and report on the numbers trained/served)

(For each individual training or technical assistance activity, individual recipients or attendees should be, counted only once, in one audience category. Trainees who attended more than one training or received more than one type of TA activity should be counted once for each activity they received).

1. Families trained/provided TA	___(check = yes) ___# of individuals
2. Other Consumers trained/provided TA	___(check = yes) ___# of individuals
3. Health Providers/Professionals trained/provided TA	___(check = yes) ___# of individuals
4. Education Providers/Professionals trained/provided TA	___(check = yes) ___# of individuals
5. State MCH Agency Staff trained/provided TA	___(check = yes) ___# of individuals
6. Community-Based/Local Organization Staff trained/provided TA	___(check = yes) ___# of individuals
7. Other (specify _____) trained/provided TA	___(check = yes) ___# of individuals

Total number of individuals trained/provided TA from all audience types _____

PART B

Use the scale described below to indicate the degree to which your grant has incorporated each of the design, evaluation, and continuous quality improvement activities into your training and TA work. Please use the space provided for notes to describe activities related to each element and clarify reasons for the score.

0	1	2	3	Element
Mechanisms in Place to Ensure Quality in Design of Training and TA Activities				
				1. **Build on Existing Information Resources and Expertise, and Ensure Up-to-Date Content.** As part of the development of training and technical assistance services, the grantee conducts activities (such as reviewing existing bibliographies, information resources, or other materials) to ensure that the information provided in newly developed training curricula and technical assistance materials and services is up to date with standard practice; based on research, evidence, and best practice-based literature or materials in the MCH field; and is aligned with local, State, and/or Federal initiatives. Grantee uses these mechanisms to ensure that information resource content does not duplicate existing training and technical assistance available to the same audience. Also include in the design and development expert review panels (experts may include target audience members).
				2. **Link to Other MCH Grantees Training and TA Activities.** The training and TA provided by this grantee is linked to the content and timing of training offered by other MCH grantees (e.g., Family-to-Family Health Information Centers, other national resource and training centers, State and local CSHCN/MCH programs).
				3. **Obtain Input from the Target Audience to Ensure Relevancy to their Needs.** The grantee routinely obtains input from the audience targeted for each training or TA activity before finalizing the curriculum or materials. This could include a determination of whether the content and language of the materials are relevant to the audience's current needs and are understandable. Training and TA should also be relevant with respect to timeliness, ensuring that they reach trainees when needed.
				4. **Ensure Cultural and Linguistic Appropriateness.** The grantee employs mechanisms to ensure that training and TA materials, methods, and content are culturally and linguistically appropriate.
Mechanisms in Place to Promote Grantee's Training and Technical Assistance Services				
				5. **Conduct Outreach and Promotion to Ensure Target Audience is Aware of TA and Training Services.** The grantee routinely uses mechanisms to reach out to MCHB grantees and other target audiences such as provider or family organizations, consumers of MCH services, and the public, to make sure that target audiences know the services are available. (Examples of outreach methods include promotion of services through list servs, exhibits at meetings, and targeted outreach to representatives of individual organizations or MCHB grantees.)

0	1	2	3	Element
Mechanisms in Place to Evaluate Training and TA Activities and Use the Data for Quality Improvement				
				6. **Collect Satisfaction Data.** The grantee routinely uses mechanisms, such as evaluation forms, to collect satisfaction data from recipients of training or TA.
				7. **Collect Outcome Data.** The grantee routinely collects data to assess whether recipients have increased their knowledge, leadership skills, and ability to apply new knowledge and skills to their family, health care practice, or other MCH program situation.
				8. **Use Feedback for Quality Improvement.** The degree to which the grantee has used the results of assessments or other feedback mechanisms to improve the content, reach and effectiveness of the training or TA activities.

0=Not Met

1=Partially Met

2=Mostly Met

3=Completely Met

Total the numbers in the boxes (maximum possible 0–24): _____

NOTES/COMMENTS:

REVISED DETAIL SHEET

27 – PEFORMANC MEASURE **Goal 4: Improve the Health Infrastructure and Systems of Care by Improving MCH Knowledge and Available Resources** **Level: Grantee** **Category: Infrastructure**	The degree to which grantees have mechanisms in place to ensure quality in the (a) design, development, and (b) dissemination of new information resources that they produce each year.
GOAL	To improve the dissemination of new knowledge to the MCH field by increasing the quality of informational resources produced, including articles, chapters, books, and other materials produced by grantees, and by addressing the quality in design and development. This includes consumer education materials, conference presentations, and electronically available materials.
MEASURE	The degree to which grantees have mechanisms in place to ensure quality in the design, development, and dissemination of new informational resources they produce each year.
DEFINITION	Publications are articles, books, or chapters published during the year being reported. Products include electronic Web-based resources, video training tapes, CD ROMs, DVD, materials created for consumers (parents, children, and community agencies). Products and publications also include outreach and marketing materials (such as presentations, alerts, and HRSA clearinghouse materials). Details on these publications and products are reported on a data collection form. These products are summed by category and the total number of all publications and products are reported on a PM tracking form for a reporting year. This measure can be applicable to any MCHB grantee.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020: ECBP Goal: Increase the quality, availability and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life ECBP-11: (Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs HC/IT Goal: Use health communication strategies and health information technology (IT) to improve population health outcomes and health care quality, and to achieve health equity PHI Goal: To ensure that Federal, State, Tribal, and local health agencies have the necessary infrastructure to effectively provide essential public health services
DATA SOURCE(S) AND ISSUES	Data will be collected by grantees throughout the year and reported in their annual reports and via this measure's data collection form.

SIGNIFICANCE	Advancing the field of MCH based on evidence-based, field-tested quality products. Collection of the types of and dissemination of MCH products and publications is crucial for advancing the field. This PM addresses the production and quality of new informational resources created by grantees for families, professionals, other providers, and the public.

Revised Data Collection Form – Detail Sheet # 27

Quality of Information Resources

Using the 0–3 scale below indicate the degree to which your grant has incorporated each of the design, dissemination, and continuous quality improvement activities into MCH information resources that you have developed within the past year. Please use the space provided for notes to describe activities related to each element and clarify any reasons for the score

Part A				
0	**1**	**2**	**3**	**Element**
Mechanisms in Place to Ensure Quality in Design of Informational Resources				
				1. **Obtain input from the target audience or other experts to ensure relevance.** The grantee conducts activities to ensure the information resource is relevant to the target audience with respect to knowledge, issues, and best practices in the MCH field. [Example: Obtain target audience, user, or expert input in the design of informational resources, the testing or piloting of products with the potential users/audience, and the use of expert reviews of new products.]
				2. **Obtain input from the target audience or other experts to ensure cultural and linguistic appropriateness.** The grantee specifically employs mechanisms to ensure that resources are culturally and linguistically appropriate to meet the needs and level of the target audience(s).
				3. **Build on Existing Information Resources and Expertise, and Ensure Up-to-Date Content.** As part of the development of information resources, the grantee conducts activities (such as reviewing existing bibliographies, information resources, or other materials) to ensure that the information provided in newly developed information resources is up to date with standard practice; based on research-, evidence-, and best practice-based literature or materials in the MCH field; and is aligned with local, State, and/or Federal initiatives. Grantee uses these mechanisms to ensure that information resource content does not duplicate existing resources available to the same audience. Also include in the design and development expert review panels (experts may include target audience members).

Part B				
0	**1**	**2**	**3**	**Element**
Mechanisms in Place to Track Dissemination and Use of Resources or Products				
				4. **The grantee has a system to track, monitor, and analyze the dissemination and reach of products.** The grantee implements a mechanism for tracking and documenting dissemination of products, and uses this information to ensure the target audience(s) is reached. Grantees with a Web site should include mechanisms for tracking newly created resources disseminated through their Web sites and are encouraged to detail Web-related dissemination mechanisms and the use of Web-based products in the Notes section below. Grantee ensures that format is accessible to diverse audiences and conforms to ADA guidelines and to Section 508 of the Rehabilitation Act.
				5. **The grantee has a system in place to track, monitor, and analyze the use of products.** The grantee routinely collects data from the recipients of its products and resources to assess their satisfaction with products, and whether products are useful, share new and relevant information, and enhance MCH knowledge. [An example of data collection is assessments.]
Mechanisms in Place to Promote Grantee's Information Resources				
				6. **Conduct Culturally Appropriate Outreach and Promotion to Ensure Target Audience is Aware of Information Resources** The grantee routinely uses mechanisms to reach out to MCHB grantees and other target audiences such as provider or family organizations, consumers of MCH services, and the public, to make sure that target audiences know the resources are available. [Examples of outreach methods include promotion of services through list servs, exhibits at meetings, and targeted outreach to representatives of individual organizations or MCHB grantees.]
Use of Evaluation Data for Quality Improvement				
				7. **Use of Feedback for Quality Improvement.** The degree to which the grantee has used the results of satisfaction and other feedback mechanisms to improve the content, reach, and effectiveness of their products/information resources.

0=Not Met
1=Partially Met
2=Mostly Met
3=Completely Met

Total the numbers in the boxes (possible 0–21 score): _____

NOTES/COMMENTS:

31 PERFORMANCE MEASURE **Goal 4: Improve the Health Infrastructure and Systems of Care (Assist States and communities to plan and develop comprehensive, integrated service systems for MCH populations)** **Level: Grantee** **Category: Infrastructure**	The degree to which grantees have assisted States and communities in planning and implementing comprehensive, coordinated care for MCH populations.
GOAL	To assure access to integrated community systems of care for MCH populations.
MEASURE	The degree to which grantees have assisted in developing integrated systems of care for MCH populations.
DEFINITION	Attached are checklists of elements that demonstrate the degree to which grantees have assisted in developing integrated systems of care for MCH populations. The first checklist addresses defined activities in the area of collaboration and coordination, and the second allows grantees to identify activities in the area of providing support to communities. Please check the degree to which the elements have been implemented.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems
DATA SOURCE(S) AND ISSUES	Attached data collection forms to be completed by grantees. The National CSHCN Survey will provide national and State estimates on the extent to which families perceive that integrated community systems of care are available to their child with a special health care need.
SIGNIFICANCE	Families and service agencies have identified major challenges confronting families in accessing coordinated health and related services that families need. Differing eligibility criteria, duplication and gaps in services, inflexible funding streams and poor coordination among service agencies are concerns across most States. This effort should provide model strategies for addressing these issues.

DATA COLLECTION FORM FOR DETAIL SHEET #31

Using the scale below, indicate the degree to which your grant has assisted in developing and implementing an integrated system of care for MCH populations. Please use the space provided for notes to describe activities related to each element and clarify reasons for score.

Indicate the population and age group served:

Pregnant Women_____ Children _____ Adolescents ____ All Children _____Children with Special Health Care Needs Only____

0	1	2	3	Element
				1. **Collaboration with Other Public Agencies and Private Organizations on the State Level:** The grantee has assisted in establishing and maintaining an ongoing interagency collaborative process for the assessment of needs and assets and the provision of services within a community-based system of care for MCH populations. The programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services.
				2. Collaboration with Other Public Agencies and Private Organizations on the Local Level: The grantee has assisted in establishing and maintaining an ongoing interagency collaborative process for the assessment of needs and provision of services within a community-based system of care for MCH populations. The grantee facilitates electronic communication, integration of data, and coordination of services on the local level.
				3. **Coordination of Components of Community-Based Systems:** The grantee has assisted in the development of a mechanism in communities across the State for coordination of health and essential services across agencies and organizations. This includes coordination among providers of primary care, habilitative services, other specialty medical treatment services, mental health services, early care and education, parenting education, family support, and home health care.
				4. **Coordination of Health Services with Other Services at the Community Level:** The grantee has assisted in the development of a mechanism in communities across the State for coordination and services integration among programs including early intervention and special education, social services, and family support services.

0=Not Met
1=Partially Met
2=Mostly Met
3=Completely Met

Total the numbers in the boxes (possible 0-12 score)_____

NOTES/COMMENTS:

Support for Communities				
0	**1**	**2**	**3**	**Activity**
				1. Technical assistance and consultation
				2. Education and training
				3. Common data protocols
				4. Financial resources for communities engaged in systems development

0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Total the numbers in the boxes (possible 0-12 score)_____

NOTES/COMMENTS:

REVISED DETAIL SHEET

33 – PERFORAMNCE MEASURE **Goal 4: Improve the Health Infrastructure and Systems of Care (Assist States and communities to plan and develop comprehensive, integrated health service systems)** **Level: Grantee** **Category: Infrastructure**	The degree to which MCHB-funded initiatives work to promote sustainability of their programs or initiatives beyond the life of MCHB funding.
GOAL	To develop infrastructure that supports comprehensive and integrated systems of care for maternal and child health at the local and/or state level.
MEASURE	The degree to which MCHB grantees are planning and implementing strategies to sustain their programs once initial MCHB funding ends.
DEFINITION	Attached is a checklist of nine actions or strategies that build toward program sustainability. Please check the degree to which each of the elements is being planned or carried out by your program, using the three-point scale. The maximum total score for this measure would be 45 across all elements.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 202 Objective PHI-15: Increase the proportion of Tribal, State, and local public health agencies that have implemented a health improvement plan and increase the proportion of local health jurisdictions that have implemented a health improvement plan linked with their State plan
DATA SOURCE(S) AND ISSUES	Attached is a data collection form to be completed by grantees. Since these actions and their outcomes are necessarily progressive over time from the beginning to the end of a program funding period, grantees' ratings on each element are expected to begin lower in the first year of grant award and increase over time.
SIGNIFICANCE	In recognition of the increasing call for recipients of public funds to sustain their programs after initial funding ends, MCHB encourages grantees to work toward sustainability throughout their grant periods. A number of different terms and explanations have been used as operational components of sustainability. These components fall into four major categories, each emphasizing a distinct focal point as being at the heart of the sustainability process: (1) adherence to program principles and objectives, (2) organizational integration, (3) maintenance of health benefits, and (4) State or community capacity building. Specific recommended actions that can help grantees build toward each of these four sustainability components are included as the data elements for this PM.

Revised Data Collection Form – Detail Sheet # 33

Building Toward MCH Program Sustainability

Use the scale below to rate the degree to which your program has taken the following actions to promote sustainability of your program or initiative. Since these actions and their outcomes are necessarily progressive over the funding period, the ratings are expected to begin lower and progress over the grant period.

Please use the space provided for notes to clarify reasons for score.

0	1	2	3	Element
				1. A written sustainability plan is in place within two years of the MCHB grant award, with goals, objectives, action steps, and timelines to monitor plan progress.
				2. Staff and leaders in the organization engage and build partnerships with consumers, and other key stakeholders in the community, in the early project planning, and in sustainability planning and implementation processes.
				3. There is support for the MCHB-funded program or initiative within the parent agency or organization, including from individuals with planning and decision making authority.
				4. There is an advisory group or a formal board that includes family, community and state partners, and other stakeholders who can leverage resources or otherwise help to sustain the successful aspects of the program or initiative.
				5. The program's successes and identification of needs are communicated within and outside the organization among partners and the public, using various internal communication, outreach and marketing strategies.
				6. The grantee identified, actively sought, and obtained other funding sources and in-kind resources to sustain the entire MCHB-funded program or initiative.
				7. Policies and procedures developed for the successful aspects of the program or initiative are incorporated into the parent or another organization's system of programs and services.
				8. The responsibilities for carrying out key successful aspects of the program or initiative have begun to be transferred to permanent staff positions in other ongoing programs or organizations.
				9. The grantee has secured financial or in-kind support from within the parent organization or external organizations to sustain the successful aspects of the MCHB-funded program or initiative.

0 = Not Met

1 = Partially Met

2 = Mostly Met

3 = Completely Met

Total the numbers in the boxes (possible 0–27 score): _____

NOTES/COMMENTS:

35 PERFORMANCE MEASURE **Goal 4: Improve the Health Infrastructure and Systems of Care (Assist States and communities to plan and develop comprehensive, integrated health service systems)** **Level: State/Grantee** **Category: Women's Health**	The degree to which States and communities have implemented comprehensive systems for women's health services.
GOAL	To increase the number of States having comprehensive systems for women's health services.
MEASURE	The degree to which States and communities have implemented comprehensive systems for women's health services.
DEFINITION	Attached is a checklist of 14 elements that contribute to a comprehensive system of care for women. Please indicate the degree to which each of the listed elements has been implemented. Please keep the completed checklist attached. "Comprehensive system of women's health care" is defined as a system that provides a full array of health services utilizing linkages to all programs serving women. The system must address gaps/barriers in service provision. Services provided must be appropriate to women's age and risk status, emphasizing preventive health care.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People Objectives: AHS-2: (Developmental) Increase the proportion of insured persons with coverage for clinical preventive services AHS-3: Increase the proportion of persons with a usual primary care provider (Leading Health Indicator) AHS-5: Increase the proportion of persons who have a specific source of ongoing care NWS-6:Increase the proportion of physician office visits that include counseling or education related to nutrition or weight
DATA SOURCE(S) AND ISSUES	Attached data collection form is to be completed by State MCH Directors. MCHB program records
SIGNIFICANCE	Leading authorities including Grason, Hutchins, and Silver, (1999, eds.) "Charting a Course for the Future of Women's and Perinatal Health" recommend the development of models for delivering health services that are women-centered and incorporate the influences of biological, psychological and social factors on women's health. Such models, otherwise known as "holistic" must also embrace a wellness approach.

Also, the NIH “Agenda for Research on Women’s Health” States that women’s health must include the full biological life cycle of the woman and concomitant physical, mental and emotional changes that occur. In many States, Title V programs already provide an array of services for women beyond pregnancy related care, thus MCH programs are a logical avenue to improve systems of care for women.

DATA COLLECTION FORM FOR DETAIL SHEET #35

Using a scale of 0-2, please rate the degree to which the State or MCHB program has addressed each of the listed elements in a comprehensive system of care for women.

Please use the space provided for notes to describe activities related to each element and clarify any reasons for score.

0	1	2	Elements of a Comprehensive System of Care for Women
			1. State or program is coordinating services for women through a central organization or entity at the State or community level.
			2. State or program has partnerships with community-based agencies.
			3. State or program has linkages with family planning programs.
			4. State or program has linkages with breast and cervical cancer programs.
			5. State or program has linkages with DV/sexual assault programs.
			6. State or program has linkages with chronic disease programs.
			7. State or program has linkages with perinatal health programs.
			8. State or program has linkages with mental health programs.
			9. State or program has linkages with nutrition programs.
			10. State or program has linkages with substance abuse services programs.
			11. State or program has linkages with smoking cessation programs.
			12. State or program has linkages with health promotion/disease promotion.
			13. State or program includes consumers in advisory groups.
			14. State or program has linkages with oral health services programs.

0 = No, the State or MCH program does not provide this function or assure that this function is completed.

1 = Yes, the State or MCH program sometimes provides or assures the provision of this function but not on a consistent basis.

2 = Yes, the State or MCH program regularly provides or assures the provision of this function.

Total the numbers in the boxes (possible 0-28 score)_____

36 PERFORMANCE MEASURE **Goal 4: Improve the Health Infrastructure and Systems of Care (Work with States and communities to assure that services and systems of care reach targeted populations)** **Level: Grantee** **Category: Women's Health**	The percentage of pregnant participants in MCHB- funded programs receiving prenatal care beginning in the first trimester.
GOAL	To increase early entry into prenatal care.
MEASURE	The percentage of pregnant participants in MCHB funded programs receiving prenatal care beginning in the first trimester.
DEFINITION	**Numerator:** Number of program participants with reported first prenatal visit during the first trimester. **Denominator:** Number of program participants who are pregnant at any time during the reporting period. **Units:** 100 **Text:** Percentage Prenatal care visit is defined as a visit to qualified OB health care provider (OB, ARNP, midwife) for physical exam, pregnancy risk assessment, medical/pregnancy history, and determination of gestational age and EDC. Please use the space provided for notes to clarify type of visits counted as a prenatal care visit in the first trimester of pregnancy and included in the numerator for the purposes of this measure. Please use the space provided for notes to detail the data source and year of data used. *"Program participant"* is defined as a pregnant woman receiving MCHB-supported services.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective MICH-10: Increase the proportion of pregnant women who receive early and adequate perinatal care
DATA SOURCE(S) AND ISSUES	Provider and program patient records. Vital Records can be used if Birth Certificates can be matched to program participants
SIGNIFICANCE	Early identification of maternal disease and risks for complications of pregnancy or birth are the primary reasons for first trimester entry into prenatal care. Early entry into prenatal care can help assure that women with complex problems and women with other health risks are seen by specialists and receive the appropriate enhanced support services. This is particularly important for those women in vulnerable racial/ethnic subpopulations experiencing perinatal disparities. Late entry into prenatal care is highly associated

with poor pregnancy outcomes; therefore, early and high-quality prenatal care is critical to improving pregnancy outcomes.

37 PERFORMANCE MEASURE **Goal 4: Improve the Health Infrastructure and Systems of Care (Work with States and communities to assure that services and systems of care reach targeted populations)** **Level: Grantee** **Category: CSHN/Youth**	The degree to which grantees have worked to increase the percentage of youth who have received services necessary to transition to all aspects of adult life, including adult health care, work, and independence.
GOAL	To assure that youth with and without special health care needs, including those transitioning from foster care, receive the services necessary to transition to adult health care, work, and independence.
MEASURE	The degree to which grantees have assisted in ensuring that youth receive the services necessary to transition to adult health care, work, and independence.
DEFINITION	Attached is a checklist of 13 elements that demonstrate how a grantee has assisted ensuring appropriate transition for adolescents. Please check the degree to which the elements have been implemented.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: AH-4: (Developmental) Increase the proportion of adolescents and young adults who transition to self sufficiency from foster care AH-5: Increase the proportion of students who are served under the Individuals with Disabilities Education Act who graduate from high school with a diploma
DATA SOURCE(S) AND ISSUES	Attached data collection form to be completed by grantees. The data collection form represents 10 elements that demonstrate comprehensive transition services for youth.
SIGNIFICANCE	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the President's "New Freedom Initiative: Delivering on the Promise" (March, 2002). Health and health care are cited as two of the major barriers to making successful transitions. Currently SPRANS supported health and related transition services are available in only a few States. No other Federal agency is addressing these issues. Successful preparation for the adult work force is important for all youth and is based on healthy developmental transitions between childhood and adolescence, and between adolescence and adulthood.

DATA COLLECTION FORM FOR DETAIL SHEET #37

Using the scale below, please indicate for each element the degree to which you have assisted in the provision or assurance of comprehensive Healthy and Ready to Work services to adolescents and young adults. Please use the space provided for notes to describe activities related to each element and clarify reasons for score.

0	1	2	3	Elements
Outcome #1: Screening				
				1. Screening mechanisms include developmental and transition skills as a regular part of health services for youth.
Outcome #2: Family Partnerships				
				2. The grantee has created a youth advisory council and mentors youth leaders as they serve on this council.
				3. The grantee assures that youth leaders serve on state and local advisory boards and planning committees.
Outcome #3: Medical Home				
				4 The grantee has identified medical homes for young people which assume responsibility for health care, care coordination, and transition to an adult health care provider.
				5. Pediatric and adult medical care providers are trained to offer information and support in caring for young people with and without complex condition.
Outcome #4: Health Insurance				
				6. Primers on maintaining health insurance after age 18 are developed and distributed to a variety of community settings, including schools, providers, parent resource groups, and others.
				7. A matrix of health care insurance options (public and private) is developed.
				8. The grantee is working with a variety of partners to promote youth-friendly insurance policies, including the extension of dependent coverage to age 26.
Outcome #4: Community-Based Services				
				9. Information on medical aspects of pediatric-onset conditions and community resources for youth is provided in a variety of media, including conferences, newsletters, brochures, and Web sites.
				10. The focus of services is on development of self-care abilities,

0	1	2	3	Elements
				transportation, housing, access to quality health care and insurance, personal care assistants and job training and supports, independent living training, and assistive technology that is affordable and portable.
				11. The grantee has worked with providers of adult care to provide education in the needs of adolescents as they transition to adulthood, including the need to discuss the shift to adult providers.
Outcome #6: Transition				
				12. The grantee has worked to improve coordinated transition from pediatric to adult primary care providers for adolescents in the State, including the provision of health representation at transition planning meetings aimed at education, employment, or independence.
				13. The grantee has worked to provide adolescents with self-advocacy or self-determination training to help them to take responsibility for their own health and health care.

0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Total the numbers in the boxes (possible 0-39 score)_____

NOTES/COMMENTS:

Revised Detail Sheet

38 – PERFORMANCE MEASURE **Goal 3: Assure Quality of Care (Develop and promote health services and systems that assure appropriate follow-up services)** **Level: Grantee** **Category: Women's Health**	The percentage of completed referrals among women in MCHB-funded programs.
GOAL	Increase the percentage of completed referrals for women participating in MCHB-funded programs in need of services.
MEASURE	The percentage of completed referrals among women in MCHB-funded programs.
DEFINITION	**Numerator:** Number of referrals among women to health and other supportive services made by MCHB-funded programs that are completed **Denominator:** Number of referrals among women to health and other supportive services made by MCHB-funded programs **Units:** 100 **Text:** Percentage A "completed service referral" is defined as a client (who received the referral) attending one or more sessions with the provider to whom she was referred. The provider may be within or outside of the MCHB program/agency. The purpose of these referrals can be either treatment-related (e.g., AIDS or substance abuse treatment, domestic violence counseling), preventive (e.g., family planning, WIC, depression screening/referral, early intervention services) or supportive (e.g., job training, housing, transportation). This performance measure counts the number of referrals among women that are completed. Please use the space provided for notes to detail the data source and year of data used.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives : MICH-6:Reduce maternal illness and complications due to pregnancy (complications during hospitalized labor and delivery) MICH-10: Increase the proportion of pregnant women who receive early and adequate prenatal

	care MICH-11: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.
DATA SOURCE(S) AND ISSUES	Provider and MCHB program patient records. Projects will need to have a process to verify a completed referral.
SIGNIFICANCE	In order to be effective, health services must ensure that a client's risks are identified, and clients receive services that address their identified needs and are referred appropriately. There is no impact if the referral is not completed/services not obtained.

REVISED DETAIL SHEET

39 – PERFORMANCE MEASURE **Goal 4: Improve the Health Infrastructure and Systems of Care** **(Work with States and communities to address selected issues within targeted populations.)** **Level: Grantee** **Category: Women's Health**	The percentage of women participating in MCHB-funded programs who smoke in the last three months of pregnancy.
GOAL	Decrease smoking during pregnancy.
MEASURE	The percentage of women participating in MCHB-funded programs who smoke in the last three months of pregnancy.
DEFINITION	**Numerator:** Number of MCHB-funded program participants who smoked during the last three months of pregnancy. (HRSA/MCHB defines cigarette smoking as ANY amount of smoking (e.g., one puff to a pack a day) reported during the last trimester. **Denominator:** Number of MCHB-funded program participants who are pregnant at any time during the reporting period. **Units:** 100 **Text:** Percentage Please space provided for notes to detail the data source and year of data used.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: MICH-11: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women TU-6: Increase smoking cessation during pregnancy.
DATA SOURCE(S) AND ISSUES	Provider and MCHB program records. Vital Records can be used if Birth Certificates can be matched to program participants to determine birthweight of baby. Home Visitor notes can be used as supportive documentation.

SIGNIFICANCE

Birth weight is the single most important determinant of a newborn's survival during the first year. Low birth weight has been associated with maternal smoking during pregnancy.

40 – PERFORMANCE MEASURE **Goal 3: Ensure Quality of Care** **(Develop and promote health services and systems designed to improve quality of care)** **Level: National** **Category: Medical Home**	The degree to which grantees have facilitated access to medical homes for MCH populations.
GOAL	To increase the prevalence of medical homes within the systems that serve MCH populations.
MEASURE	The degree to which grantees have assisted in achieving a medical home for the MCH populations that they serve.
DEFINITION	The family/patient-centered medical home is an approach to providing comprehensive primary care for children, youth, and adults. In 2002 the American Academy of Pediatrics (AAP) described the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The concept was expanded in 2007 and adopted by the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and the American Osteopathic Association as the Joint Principles of the Patient Centered Medical Home.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective MICH-30: Increase the proportion of children, including children with special health care needs, who have access to a medical home.
DATA SOURCE(S) AND ISSUES	The family/patient-centered medical home is an approach to providing comprehensive primary care for children, youth, and adults. In 2002 the American Academy of Pediatrics (AAP) described the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The concept was expanded in 2007 and adopted by the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and the American Osteopathic Association as the Joint Principles of the Patient Centered Medical Home.
SIGNIFICANCE	Medical home is the model for 21st century health care, with a goal

of addressing and integrating high quality health promotion, acute care and chronic condition management in a planned, coordinated and family/patient-centered manner. This model is built upon the documented value of primary care and aims to promote the implementation of family/patient-centered care, care coordination and continuous quality improvement. Universal medical home implementation is a key strategy to promote the health and well-being of all children, youth, and adults and to improve the quality of care for patients facing a fragmented health system.

The medical home model has the potential to promote equitable health care and address racial and ethnic disparities in access to care. Reduction in racial and ethnic differences in receiving health care when adults received care within a medical home has been documented. Research also has shown increased preventative screenings, better managed chronic conditions, and better coordination between primary and specialty care providers.

Data Collection Form – Detail Sheet # 40

Facilitating Access to the Medical Home

Using the scale below, indicate the degree to which your grant has facilitated access to medical homes for MCH populations. Please use the space provided for notes to describe activities related to each element and clarify reasons for score.

Indicate the population focus: [drop-down box with options: pregnant and postpartum women, infants, children, children with special health care needs, adolescents]

(While this is a single performance measure, for analytic purposes each of the categories will be scored as an independent measure. Grantees may identify specific categories as not applicable to their grant program by selecting a score of 0 for every item within the category.)

0	1	2	3	Element
Category A: Facilitating Access to a Medical Home				
				1. The grantee has disseminated/marketed information about the availability of appropriate medical home sites.
				2. The grantee has facilitated access to sources of financing for medical homes.
				3. The grantee has provided patients and families with direct referral to medical home sites.
Category A Subtotal (possible 0-9):				
Category B: Screening				
				4. The grantee provides tools for consistent screening for risk factors.
				5. The grantee provides tools for consistent screening for developmental delays or chronic conditions.
				6. The grantee develops and promotes policies that support and facilitate systematic screening by providers.
Category B Subtotal (possible 0-9):				
Category C: Identification and Referral				
				7. The grantee ensures that MCH populations with special health care needs and those who are at risk of access and health outcome disparities are identified.

0	1	2	3	Element
				8. The grantee provides appropriate referrals for early intervention services.
				9. The grantee follows up to ensure that referral appointments are kept.
Category C Subtotal (possible 0-9):				
Category D: Coordination of Services				
				10. The grantee has developed tools to support the coordination of primary and specialty services.
				11. The grantee has provided training in effective coordination of services.
				12. The grantee provides monitoring to assure that services are coordinated.
Category D Subtotal (possible 0-9):				

0=Not Met
1=Partially Met
2=Mostly Met
3=Completely Met

Total the numbers in the boxes (possible 0-36 score)_____

NOTES/COMMENTS:

REVISED DETAIL SHEET

41 - PERFORMANCE MEASURE **Goal 3: Ensure Quality of Care (Develop and promote health services and systems designed to improve quality of care)** **Level: National** **Category: Medical Home**	The degree to which grantees have assisted in developing, supporting, and promoting medical homes for MCH populations.
GOAL	To increase the prevalence of medical homes within the systems that serve MCH populations.
MEASURE	The degree to which grantees have assisted in developing and supporting systems of care for MCH populations that promote the medical home.
DEFINITION	Attached is a set of five elements that contribute to a family/patient-centered, accessible, comprehensive, continuous, and compassionate system of care for MCH populations. Please use the space provided for notes to describe activities related to each element and clarify reasons for score.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective MICH-30: Increase the proportion of children, including children with special health care needs, who have access to a medical home.
DATA SOURCE(S) AND ISSUES	Attached is a data collection form to be completed by grantees. The data collection form presents a range of activities that contribute to the development of medical homes for MCH populations.
SIGNIFICANCE	Providing primary care to children in a “medical home” is the standard of practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, less likely to be hospitalized for preventable conditions, and more likely to be diagnosed early for chronic or disabling conditions. Data collected for this measure would help to ensure that children have access to a medical home and help to document the performance of several programs, including EPSDT, immunization, and IDEA in reaching that goal.

REVISED Data Collection Form – Detail Sheet # 41

Medical Home – Infrastructure Building

Using the scale below, indicate the degree to which your grant has assisted in the development and implementation of medical homes for MCH populations. Please use the space below to indicate the year the score is reported for and clarify reasons for the score. These elements are specific to the purpose of the funded MCHB grant program.

Indicate population: [drop-down box with options: pregnant and postpartum women, infants, children, children with special health care needs, adolescents]

(While this is a single performance measure, for analytic purposes each of the categories will be scored as an independent measure. Grantees may identify specific categories as not applicable to their grant program by selecting a score of 0 for every item within the category.)

0	1	2	3	Element
Category A: Establishing and Supporting Medical Home Practice Sites				
				1. The grantee has conducted needs and capacity assessments to assess the adequacy of the supply of medical homes in their community, state, or region.
				2. The grantee has recruited health care providers to become the medical homes.
				3. The grantee has developed or adapted training curricula for primary care providers in the medical home concept.
				4. The grantee has provided training to health care providers in the definition and implementation of the medical home and evaluated its effectiveness.
				5. The grantee has assisted practice sites in implementing health information technologies in support of the medical home.
				6. The grantee has developed/implemented tools for the monitoring and improvement of quality within medical homes.
				7. The grantee has disseminated validated tools such as the Medical Home Index to practice sites and trained providers in their use.
				8. The grantee has developed/implemented quality improvement activities to support medical home implementation.

0	1	2	3	Element
Category A Subtotal (possible 0-24):				

				Category B: **Developing and Disseminating Information and Policy Development Tools: The grantee has developed tools for the implementation of the medical home and promoted the medical home through policy development**
				9. Referral resource guides
				10.Coordination protocols
				11. Screening tools
				12.Web sites
				13. The grantee has developed and promoted policies, including those concerning data-sharing, on the State or local level to support the medical home
				14. The grantee has provided information to policymakers in issues related to the medical home
Category B Subtotal (possible 0-18):				
				Category C: Public Education and Information Sharing: **The grantee has implemented activities to inform the public about the medical home and its features and benefits**
				15.The grantee has developed Web sites and/or other mechanisms to disseminate medical home information to the public.
				16. The grantee has provided social service agencies, families and other appropriate community-based organizations with lists of medical home sites.
				17. The grantee has engaged in public education campaigns about the medical home.
Category C Subtotal (possible 0-9):				
				Category D: Partnership-Building Activities
				18. The grantee has established a multidisciplinary advisory group, including families and consumers representative of the populations served, to

0	1	2	3	Element
				oversee medical home activities
				19. The grantee has coordinated and/or facilitated communication among stakeholders serving MCH populations (e.g., WIC, domestic violence shelters, local public health departments, rape crisis centers, and ethnic/culturally-based community health organizations)
				20. The grantee has worked with the State Medicaid agency and other public and private sector purchasers on financing of the medical home.
				21. The grantee has worked with health care providers and social service agencies to implement integrated data systems.
Category D Subtotal (possible 0-12):				

0	1	2	3	Element
Category E: Mentoring Other States and Communities				
				22. The degree to which the grantee has shared medical home tools with other communities and States
				23. The degree to which the grantee has presented its experience establishing and supporting medical homes to officials of other communities, family champions, and/or States at national meetings
				24. The degree to which the grantee has provided direct consultation to other States on policy or program development for medical home initiatives
Category E Subtotal (possible 0-9):				

0 = Not Met
1 = Partially Met
2 = Mostly Met
3 = Completely Met

Total the numbers in the boxes (possible 0-72 score)_____

NOTES/COMMENTS:

NEW DETAIL SHEET

PERFORMANCE MEASURE **Goal 3: Assure Quality of Care (Develop and promote health services and systems designed to improve quality of care)** **Level: National** **Category: Child Health/Medical Home**	The percentage of children age 0 to 2 participating in MCHB-funded programs who receive coordinated, ongoing, comprehensive care within a medical home.
GOAL	To increase the number of children in the State who have a medical home.
MEASURE	The percentage of all children age 0 to 2 participating in MCHB-funded programs who receive coordinated, ongoing, comprehensive care within a medical home.
DEFINITION	**Numerator:** The number of children participating in MCHB funded projects age 0 to 2 who receive coordinated, ongoing, comprehensive care within a medical home during the reporting period. **Denominator:** The number of children participating in MCHB funded projects age 0 to 2 during the reporting period. **Units:** 100 **Text:** Percentage The MCHB uses the American Academy of Pediatrics (AAP) definition of "medical home." The definition establishes that the medical care of infants, children and adolescents should be accessible, continuous, comprehensive, family centered, coordinated and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them. These characteristics define the "medical home" and describe the care that has traditionally been provided in an office setting by pediatricians. (AAP, Volume 90, No. 5, 11/92). Please use the space provided for notes to detail the data source and year of data used.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objective MICH-30: Increase the proportion of children, including those with special health care needs who have access to a medical home
DATA SOURCE(S) AND ISSUES	Provider and MCHB program patient records.

SIGNIFICANCE

Providing primary care to children in a “medical home” is the standard of practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. Data collected for this measure would help to ensure that children have access to a medical home and help to document the performance of several programs including EPSDT, Immunization, and IDEA in reaching that goal.

New Form - Healthy Start Sites

SECTION 1

GRANTEE INFORMATION			
Grant #:			
Grantee Name:			
Street Address:			
City:	State:	Zip code:	
Project Director Name:			
Phone 1:		Phone 2:	
E-mail:			

SECTION 2

HEALTHY START SITES

SITE 1	
Project Manager Name:	
Project Name:	
Street Address:	
City:	State:
Service Area Zip code(s):	
Service Area County(ies):	
Initial Year of Funding:	Initial Funding Amount:

SITE 2	
Project Manager Name:	
Project Name:	
Street Address:	
City:	State:
Service Area Zip code(s):	
Service Area County(ies):	
Initial Year of Funding:	Initial Funding Amount:

SITE 3	
Project Manager Name:	
Project Name:	
Street Address:	
City:	State:
Service Area Zip code(s):	
Service Area County(ies):	
Initial Year of Funding:	Initial Funding Amount:

SITE 4	
Project Manager Name:	
Project Name:	
Street Address:	
City:	State:
Service Area Zip code(s):	
Service Area County(ies):	
Initial Year of Funding:	Initial Funding Amount:

SITE 5	
Project Manager Name:	
Project Name:	
Street Address:	
City:	State:
Service Area Zip code(s):	
Service Area County(ies):	
Initial Year of Funding:	Initial Funding Amount:

SITE 6	
Project Manager Name:	
Project Name:	
Street Address:	
City:	State:
Service Area Zip code(s):	
Service Area County(ies):	
Initial Year of Funding:	Initial Funding Amount:

INSTRUCTIONS FOR THE COMPLETION OF HEALTHY START SITES FORM

Section 1 – Grant Identifier Information

Grant #:	Enter the number that is assigned to the project upon award
Grantee Name:	Enter the name of the organization receiving the grant award
Project Director:	Enter the name of Project Director of the Healthy Start project
Phone # 1:	Enter the main phone number for the Project Director
Phone # 2:	Enter an alternate phone number for the Project Director
E-mail:	Enter e-mail address of the Project Director

Section 2 – Healthy Start Project Site Information
* Do not list a location that only has a contractual staff working in that location to provide a specific service.

Project Manager:	Enter the name of the Healthy Start site Project Manager
Project Name:	Enter the name of the Healthy Start project
Service Area Zip code(s):	Enter one or more zip codes served by the Healthy Start site
Service Area County(ties):	Enter name of county(ies) served by the Healthy Start site
Initial Year of Funding:	Enter first year organization received Healthy Start funding
Initial Funding Amount:	Enter amount of funding received during first year

Definitions
Healthy Start Project Site is the physical location of the Healthy Start project. This does not include locations of contractual staff providing specific/limited services at a satellite location.

Service Area is the area in which the majority of the Healthy Start Program Participants reside and the geographical area for which the program is targeting services. Healthy Start projects may use other geographic or demographic characteristics to describe their service area. The service area should, to the extent practicable, be identifiable by county and/or by zip code. The size of such area is such that the services to be provided through the Healthy Start Project (including any satellite) are available and accessible to the residents of the area promptly and as appropriate. The boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs. These boundaries of such area eliminate, to the extent possible, barriers to access to the services of the Healthy Start Project, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social grouping, and available transportation.

Detail Sheets

MCHB Program Performance Measures

REVISED DETAIL SHEET

50	**PERFORMANCE MEASURE**	Percent of very low birth weight infants among all live births to program participants.
GOAL		To reduce the proportion of all live deliveries with very low birth weight.
DEFINITION		**Numerator:** Number of live births (singleton and multiple) with birth weight less than 1,500 grams in the calendar year among program participants. **Denominator:** Total number of live births (singleton and multiple) in the calendar year among program participants. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE		Objective MICH-8.2: Reduce very low birth weights to 1.4 percent. (Baseline: 1.5 percent in 2007).
DATA SOURCE(S) AND ISSUES		Birth certificates are the source for low birth weight.
SIGNIFICANCE		Prematurity is the leading cause of infant death. Many risk factors have been identified for low birth weight involving younger and older maternal age, poverty, late prenatal care, smoking and substance abuse.

51 PERFORMANCE MEASURE	The percent of live singleton births weighing less than 2,500 grams among all singleton births to program participants.
GOAL	To reduce the number of all live deliveries with low birth weight.
DEFINITION	**Numerator:** Number of live singleton births less than 2,500 grams to **program participants**. **Denominator:** Live singleton births among **program participants**. **Units:** 1,000 **Text:** Rate per 1,000
HEALTHY PEOPLE 2020 OBJECTIVE	Objective MICH-8.1: Reduce low birth weights (LBW) to 7.8 percent (Baseline 8.2 percent in 2007)
DATA SOURCE(S) AND ISSUES	Linked vital records available from the State or the program's own verifiable data systems/sources
SIGNIFICANCE	The general category of low birth weight infants includes pre-term infants and infants with intrauterine growth retardation. Many risk factors have been identified for low birth weight babies including: both young and old maternal age, poverty, late prenatal care, smoking, substance abuse, and multiple births.

REVISED DETAIL SHEET

52	**PERFORMANCE MEASURE**	The infant mortality rate per 1,000 live births.
GOAL		To reduce the number of infant deaths.
DEFINITION		**Numerator:** Number of deaths to infants from birth through 364 days of age to **program participants**. **Denominator:** Number of live births among **program participants**. **Units:** 1,000 **Text:** Rate per 1,000
HEALTHY PEOPLE 2020 OBJECTIVE		Objective MICH-1.3 (Leading Health Indicator): Reduce all infant deaths (within 1 year) to 6.0 per 1,000 live births. (Baseline: 6.7 in 2006)
DATA SOURCE(S) AND ISSUES		Linked vital records available from the State or the program's own verifiable data systems/sources
SIGNIFICANCE		All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate, but the rate of decline has slowed in the last 10 years. There is still significant racial disparity, as noted in the Healthy People 2000 Mid-course Review. Rates are much higher in the lower social class and in the lowest income groups across all populations.

Note: Include infant deaths that occurred during the reporting year among program participants enrolled prenatally and interconceptionally. For those enrolled interconceptionally, include infant deaths in the numerator and births in the denominator only if the project can link birth certificate to the death certificate.

53 PERFORMANCEMEASURE	The neonatal mortality rate per 1,000 live births.
GOAL	To reduce the number of neonatal deaths
DEFINITION	**Numerator:** Number of deaths to infants under 28 days born to **program participants.** **Denominator:** Number of live births **to program participants.** **Units:** 1,000 **Text:** Rate per 1,000
HEALTHY PEOPLE 2020 OBJECTIVE	Objective MICH-1.4: Reduce neonatal deaths (within the first 28 days of life) to 4.1 per 1,000 live births. (Baseline: 4.5 in 2006)
DATA SOURCE(S) AND ISSUES	Linked vital records available from the State or the program's own verifiable data systems/sources
SIGNIFICANCE	Neonatal mortality is a reflection of the health of the newborn and reflects health status and treatment of the pregnant mother and of the baby after birth.

REVISED DETAIL SHEET

54 PERFORMANCE MEASURE

The post-neonatal mortality rate per 1,000 live births.

GOAL	To reduce the number of post-neonatal deaths.
DEFINITION	**Numerator:** Number of deaths to infants 28 through 364 days of age born to **program participants.** **Denominator:** Number of live births to **program participants.** **Units:** 1,000 **Text:** Rate per 1,000
HEALTHY PEOPLE 2020 OBJECTIVE	Objective MICH-1.5: Reduce post-neonatal deaths (between 28 days and 1 year) to 2.0 per 1,000 live births. (Baseline: 2.2 in 2006)
DATA SOURCE(S) AND ISSUES	Linked vital records available from the State or the program's own verifiable data systems/sources
SIGNIFICANCE	This period of mortality reflects the environment and the care infants receive. SIDS deaths occur during this period and have been recently reduced due to new infant positioning in the U.S. Poverty and a lack of access to timely care are also related to late infant deaths.

Note: Include infant deaths that occurred during the reporting year among program participants enrolled prenatally and interconceptionally. For those enrolled interconceptionally, include infant deaths in the numerator and births in the denominator only if the project can link the birth certificate to the death certificate.

REVISED DETAIL SHEET

55 PERFORMANCE MEASURE	The perinatal mortality rate per 1,000 live births plus fetal deaths.
GOAL	To reduce the number of perinatal deaths.
DEFINITION	**Numerator:** Number of fetal deaths > 28 weeks gestation plus deaths occurring under 7 days to **program participants**. **Denominator:** Live births plus fetal deaths among **program participants.** **Units:** 1,000 **Text:** Rate per 1,000
HEALTHY PEOPLE 2020 OBJECTIVE	Objective MICH-1.2: Reduce fetal and infant deaths during the perinatal period (28 weeks of gestation to 7 days after birth) to 5.9 per 1,000 live births plus fetal deaths (Baseline 6.6 in 2005)
DATA SOURCE(S) AND ISSUES	Linked vital records available from the State or the program's own verifiable data systems/sources.
SIGNIFICANCE	Perinatal mortality is a reflection of the health of the pregnant woman and newborn and reflects the pregnancy environment and early newborn care.

Note: Include infant deaths that occurred during the reporting year among program participants enrolled prenatally and interconceptionally. For those enrolled interconceptionally, include infant deaths in the numerator and births in the denominator only if the project can link the birth certificate to the death certificate.

58 PERFORMANCE MEASURE	The percentage of PPC faculty who demonstrate field leadership in the areas of academic, clinical, public health/policy, and advocacy.
GOAL	To assure the highest quality of care of the Maternal and Child Health Populations by disseminating new knowledge to the field, influencing systems of care, professional organizations, and providers of health care services.
MEASURE	The percentage of PPC faculty who demonstrate field leadership in the areas of academic, clinical, public health/policy, and advocacy.
DEFINITION	PPC faculty is defined as an individual who receives PPC funding. Leadership: MCH field leadership definitions (from MCHB Performance Measure #8) of Academics, Clinical, Public Health/Public Policy, Advocacy.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective MICH-31:Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems
DATA SOURCES AND ISSUES	MCHB Performance Measure #8 Detail Sheet will be used. Data Source is self-report of faculty from faculty activity logs, performance evaluations, and other local data sources.
SIGNIFICANCE	Leadership training requires mentors to be recognized as leaders in their field. Current reporting of Technical Assistance, Training, and Continuing Education activities does not fully capture PPC Faculty Leadership activities.

DATA COLLECTION FORM FOR PROGRAM PERFORMANCE MEASURE 58

The total number of PPC Faculty included in this report

_____

Percent of faculty that demonstrate MCH leadership in **at least one** of the following areas:

_____%

- Academics--i.e. faculty member teaching-mentoring in MCH related field; and/or conducting MCH related research; and /or providing consultation or technical assistance in MCH; and/or publishing and presenting in key MCH areas; and/or success in procuring grant and other funding in MCH _____%

- Clinical--i.e. development of guidelines for specific MCH conditions; and/or participation as officer or chairperson of committees on State, National, or local clinical organizations, task forces, community boards, etc.; and/or clinical preceptor for MCH trainees; and/or research, publication, and key presentations on MCH clinical issues; and/or serves in a clinical leadership position as director, team leader, chairperson, etc. _____%

- Public Health/Public Policy--i.e. leadership position in local, State or National public organizations, government entity; and/or conducts strategic planning; participates in program evaluation and public policy development; and/or success in procuring grant and other funding; and/or influencing MCH legislation; and/or publication, presentations in key MCH issues. _____%

- Advocacy-- i.e. through efforts at the community, State, Regional and National levels influencing positive change in MCH through creative promotion, support and activities--both private and public. For example, developing a city-wide SIDS awareness and prevention program through community churches. _____%

59 PERFORMANCE MEASURE	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs.
GOAL	To assure that a training program has collaborative interactions related to training, technical assistance, continuing education, and other capacity-building services with relevant national, state and local programs, agencies and organizations.
MEASURE	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs and other professional organizations.
DEFINITION	Attached is a list of the 6 elements that describe activities carried out by training programs for or in collaboration with State Title V and other agencies on a scale of 0 to 1. If a value of '1' is selected, provide the number of activities for the element. The total score for this measure will be determined by the sum of those elements noted as '1.'
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: ECBP-2: Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education t prevent health problems in the following areas: unintentional injury; violence; tobacco use and addiction; alcohol or other drug use; unintended pregnancy; HIV/AIDS and STD infection; unhealthy dietary patterns; and inadequate physical activity ECBP-11: (Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent health promotion and disease prevention programs ECBP-12: Increase the inclusion of core clinical preventive and population health content in M.D.-granting medical schools ECBP-13: Increase the inclusion of core clinical preventive and population health content in D.O.-granting medical schools ECBP-14: Increase the inclusion of core clinical preventive and population health content in undergraduate nursing ECBP-15: Increase the inclusion of core clinical preventive and population health content in nurse practitioner training ECBP-16: Increase the inclusion of core clinical preventive and population health content in physician assistant training PHI-2: (Developmental) Increase the proportion of Tribal, State, and local health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals
DATA SOURCES AND ISSUES	The training program completes the attached table which describes the categories of collaborative activity.

SIGNIFICANCE

As a SPRANS, a training program enhances the Title V State block grants that support the MCHB goal to promote comprehensive, coordinated, family-centered, and culturally-sensitive systems of health care that serve the diverse needs of all families within their own communities. Interactive collaboration between a training program and Federal, Tribal, State and local agencies dedicated to improving the health of MCH populations will increase active involvement of many disciplines across public and private sectors and increase the likelihood of success in meeting the goals of relevant stakeholders.

This measure will document a training program's abilities to:

1) collaborate with State Title V and other agencies (at a systems level) to support achievement of the MCHB Strategic Goals and CSHCN Healthy People action plan;

2) make the needs of MCH populations more visible to decision-makers and can help states achieve best practice standards for their systems of care;

3) reinforce the importance of the value added to LEND program dollars in supporting faculty leaders to work at all levels of systems change; and

4) internally use this data to assure a full scope of these program elements in all regions.

DATA COLLECTION FORM FOR DETAIL SHEET PM #59

Indicate the degree to which your training program collaborates with State Title V (MCH) agencies and other MCH or MCH-related programs using the following values:

0= The training program does not collaborate on this element.
1=The training program does collaborate on this element.

If your program does collaborate, provide the total number of activities for the element.

Element	0	1	Total Number of Activities
5. Service Examples might include: Clinics run by the training program and/ or in collaboration with other agencies			
6. Training Examples might include: Training in *Bright Futures…*; Workshops related to adolescent health practice; and Community-based practices. It would not include clinical supervision of long-term trainees.			
7. Continuing Education Examples might include: Conferences; Distance learning; and Computer-based educational experiences. It would not include formal classes or seminars for long-term trainees.			
8. **Technical Assistance** Examples might include: Conducting needs assessments with State programs; policy development; grant writing assistance; identifying best-practices; and leading collaborative groups. It would not include conducting needs assessments of consumers of the training program services.			
5. **Product Development** Examples might include: Collaborataive development of journal articles and training or informational videos.			
6. **Research** Examples might include: Collaborative submission of research grants, research teams that include Title V or other MCH-program staff and the training program's faculty.			

Total Score (possible 0-6 score) _____
Total Number of Collaborative Activities _____

60 PERFORMANCE MEASURE	The percent of long-term trainees who, at 1, 5 and 10 years post training, work in an interdisciplinary manner to serve the MCH population (e.g., individuals with disabilities and their families, adolescents and their families, etc.).
GOAL	To increase the percent of long-term trainees who, upon completing their training, work in an interdisciplinary manner to serve the MCH population.
MEASURE	The percent of long-term trainees who, at 1, 5 and 10 years post training work in an interdisciplinary manner to serve the MCH population.
DEFINITION	**Numerator:** The number of trainees indicating that they continue to work in an interdisciplinary setting serving the MCH population. **Denominator:** The total number of trainees responding to the survey **Units:** 100 **Text:** Percent In addition, data on the total number of the trainees and the number of non-respondents for each year will be collected. Long-term trainees are defined as those who have completed a long-term (300+ hours) leadership training program, including those who received MCH funds and those who did not.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: ECBP-12: Increase the inclusion of core clinical preventive and population health content in M.D.-granting medical schools ECBP-13: Increase the inclusion of core clinical preventive and population health content in D.O.-granting medical schools ECBP-14: Increase the inclusion of core clinical preventive and population health content in undergraduate nursing ECBP-15: Increase the inclusion of core clinical preventive and population health content in nurse practitioner training ECBP-16: Increase the inclusion of core clinical preventive and population health content in physician assistant training PHI-3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems

DATA SOURCE(S) AND ISSUES	The trainee follow-up survey is used to collect these data.
SIGNIFICANCE	Leadership education is a complex interdisciplinary field that must meet the needs of MCH populations. This measure addresses one of a training program's core values and its unique role to prepare professionals for comprehensive systems of care. By providing interdisciplinary coordinated care, training programs help to ensure that all MCH populations receive the most comprehensive care that takes into account the complete and unique needs of the individuals and their families.

61 PERFORMANCE MEASURE	The percentage of long term interdisciplinary trainees who report valuing their interdisciplinary training at 1 and 5 years
GOAL	To increase the percentage of former LEND trainees whose career choice and performance is positively impacted by their LEND training within five years of training completion.
MEASURE	The degree to which MCH long term interdisciplinary trainees report valuing their interdisciplinary training at 1, and 5 years.
DEFINITION	**Numerator:** Number of trainees responding with a 3 or 2. **Denominator:** Total number of trainees responding. **Units:** % **Text:** Aggregate % from network data
HEALTHY PEOPLE 2020 OBJECTIVE	Related to MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems
DATA SOURCE(S) AND ISSUES	This requires primary data collection. The collection tool, which will be the trainee follow-up survey, will ask trainees to rate how they have valued their interdisciplinary training on a scale of 0 to 3. Each program will then aggregate reported data and report the distribution of how many respondents rated their training a 1, how many 2, etc. through 3. *For the following questions, rank each answer 3=great positive influence; 2=some positive influence; 1=little influence; 0=negative influence* **My LEND training has positively influenced my current career choice and performance:** ___ 3 ___ 2 ___ 1 ___ 0
SIGNIFICANCE	Asking the recipients of any service about the value of the service provided to them is an important principle of customer service and evaluation. Understanding the degree to which MCH long term interdisciplinary trainees value training will have multiple affects on the long-term objectives of the program. Feedback from trainees is critical to insuring that training addresses the needs of future leaders in the field. The information could lead to strategic program improvements as well as increase the responsiveness of interdisciplinary training programs. Ultimately, the likelihood that trainees are practicing in an interdisciplinary system consistent with the principles of the CSHCN system should increase if training better meets their needs. Challenges include issues in tracking graduates in the future, obtaining a high response rate, and incorporating the evaluation in meaningful program decision-making.

63 PERFORMANCE MEASURE	The degree to which LEND programs incorporate medical home concepts into their curricula/training.
GOAL	To increase the number of LEND programs that incorporate medical home concepts into their interdisciplinary training programs.
MEASURE	The degree to which LEND programs incorporate medical home concepts into their curricula/training.
DEFINITION	A medical home is defined by the AAP as an approach to care that is "accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent. This is the definition that the MCHB uses. Attached is a checklist of 6 elements that are part of the medical home concept. Please check the degree to which the elements have been incorporated by on a scale of 0-4. Please keep the completed checklist attached. [Note: A baseline will be established and incremental goals set for the future.]
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective MICH-30: Increase the proportion of children, including children with special health care needs, who have access to a medical home.
DATA SOURCE(S) AND ISSUES	Data is collected via the data collection form that measures what elements of a medical home have been incorporated into its training program curricula.
SIGNIFICANCE	Providing primary care to children in a "medical home" is the standard of practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventative care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The inclusion of medical home concepts in interdisciplinary training will ensure that professionals serving children with special health care needs and their families provide the best type of care possible and involve the individual and/or his or her family in decision-making and care.

DATA COLLECTION FORM FOR DETAIL SHEET PM #63

Using the following scale of 0-4, please rate your training program's attention to medical home concepts in the six elements noted.

0=Not Taught
1=Taught at an awareness level—concept is presented
2=Taught at a knowledge level—reading, discussion and assignments on the concept
3=Taught at the skill level—students observe aspects of and get a chance to practice elements of a medical home
4=Concept woven throughout training program: information, knowledge and practice

Element	0	1	2	3	4
The importance of providing accessible care is incorporated into your curricula and clinical training experiences.					
Family-centered care is included in your curricula and clinical training experiences and trainees are taught to include families in health care decisions.					
The importance of providing continuous, comprehensive care and the skills to do so are incorporated in your curricula and clinical training experiences.					
Trainees are taught and encouraged to provide coordinated care across a range of disciplines.					
Cultural and linguistic competence is a regular part of the training experience.					
Faculty/staff who have expertise in providing a medical home are readily accessible to your program					

Total Score (possible 0-24) _____

64 PERFORMANCE MEASURE	The degree to which the LEAH program incorporates adolescents and parents from diverse ethnic and cultural backgrounds as advisors and participants in program activities.
GOAL	To increase appropriate involvement of adolescents and parents as consumers of LEAH program activities.
MEASURE	The degree to which adolescents and parents are incorporated as consumers of LEAH program activities.
DEFINITION	Attached is a checklist of 4 elements that document adolescent and parent participation. Respondents will note the presence or absence of this participation on a scale of 0-1 for a total possible score of 4.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective HC/HIT-2: Increase the proportion of persons who report that their health care providers have satisfactory communication skills
DATA SOURCE(S) AND ISSUES	Grantees report using a data collection form. These data may be collected with the LEAH self-assessment activities. Participation should be defined to permit assessment of youth and young adult involvement.
SIGNIFICANCE	Over the last decade, policy makers and program administrators have emphasized the central role of consumer of health services as advisors and participants in program activities. Satisfaction with health care is related to satisfaction with the quality of the communication with health providers. In accordance with this philosophy, LEAH facilitates such partnerships and believes that consumers (adolescents and parents) from diverse backgrounds have important roles in the training of future leaders in adolescent health care delivery systems.

DATA COLLECTION FORM FOR DETAIL SHEET PM #64

Indicate the degree to which your training program has the active involvement of adolescents and parents in your program and planning activities using the following values:

0 = The training program does not have active involvement of adolescents and parents in your program and planning activities.
1 = The training program does have active involvement of adolescents and parents in your program and planning activities.

If your program does collaborate, provide the total number of activities for the element.

Element	**0**	**1**
Adolescents from diverse ethnic backgrounds and cultures participate in an advisory capacity.		
Parents of adolescents from diverse ethnic backgrounds and cultures participate in an advisory capacity.		
Adolescents from diverse ethnic backgrounds and cultures participate in the planning, implementation and evaluation of program activities related to adolescents as consumers		
Parents of adolescents from diverse ethnic backgrounds and cultures participate in the planning, implementation and evaluation of program activities related to parents as consumers		

Total Score (possible 0-4 score) _____

65 PERFORMANCE MEASURE	The percent of individuals who participated in long-term nutrition training that are practicing in a Maternal and Child Health (MCH) related field within 5 years after receiving training.
GOAL	To increase the number of individuals who participated in long-term nutrition training that practice in the MCH field.
MEASURE	The percent of individuals who participated in long-term nutrition training that are practicing in a Maternal and Child Health (MCH) related field within 5 years after receiving training.
DEFINITION	**Numerator:** The number of individuals who participated in long term nutrition training that practice in an MCH related field. An MCH related field consists of any health care or related program or service targeting women, children, and families. **Denominator:** The total number of individuals who participated in long term nutrition training that completed training. Trainees are health care professionals receiving nutritional training supported by MCHB nutrition training grants including those receiving MCH stipends and those not receiving MCH stipends. **Units:** 100 **Text:** Percent
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: ECBP-10: Increase the number of community-based organizations (including local health departments, tribal health services, nongovernmental organizations and state agencies) providing population-based preventive services PHI-2: (Developmental) Increase the proportion of Tribal, State, and local public health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals
DATA SOURCE(S) AND ISSUES	These data are collected from an annual survey of trainees who completed a nutrition training program. This survey could be mailed by each grant program or done electronically.
SIGNIFICANCE	• Good nutrition is essential for growth, development, and well being. Four out of 10 leading causes of death are related to poor nutritional habits. In order to improve health outcomes among women and children, it is vital to improve nutritional habits within the MCH population. • It is essential to maintain and enhance the nutrition workforce in order to improve the quality of care and provide adequate nutrition counseling services. These workers are vital participants in the system of care and enhance the preventive services infrastructure. • Having data on the number of trainees continuing to work in the MCH field enables MCHB to assess the

adequacy of the nutrition services infrastructures.

DATA COLLECTION FORM FOR DETAIL SHEET PM #65

The total number of graduates of long term nutrition training programs*--5 years post graduation--being reported in this report #_____

The total number of graduates of long term nutrition training programs * lost to follow-up?
_____

What percent of graduates of long term nutrition training programs * --5 years post graduation--demonstrate MCH leadership in **at least one** of the following areas: _____%

- Academics--i.e., faculty member teaching-mentoring in MCH related field; and/or conducting MCH related research; and /or providing consultation-technical assistance in MCH; and/or publishing and presenting in key MCH areas; and/or success in procuring grant and other funding in MCH
  [#_____ meeting this criteria]

- Clinical--i.e., development of guidelines for specific MCH conditions; and/or participation as officer or chairperson of committees on State, National, or local clinical organizations, task forces, community boards, etc.; and/or clinical preceptor for MCH trainees; and/or research, publication, and key presentations on MCH clinical issues; and/or serves in a clinical leadership position as director, team leader, chairperson, etc.
  [#_____meeting this criteria]

- Public Health/Public Policy--i.e., leadership position in local, State or National public organizations, government entity; and/or conducts strategic planning; participates in program evaluation and public policy development; and/or success in procuring grant and other funding; and/or influencing MCH legislation; and/or publication, presentations in key MCH issues.
  [#_____meeting this criteria]

- Advocacy--i.e., through efforts at the community, State, Regional and National levels influencing positive change in MCH through creative promotion, support and activities--both private and public. For example, developing a city-wide pediatric obesity and prevention program through community churches.
- [#_____meeting this criteria]
- Decreasing Disparities—i.e., participating in community, state, regional or national activities specifically targeting reducing disparities; and/or participating in or providing cultural competency training.
  [#_____meeting this criteria]

Graduates of long term nutrition training programs include both those that receive MCH stipends and those not receiving MCH stipends.

70 PROGRAM PERFORMANCE MEASURE

Goal 1: Provide National Leadership for MCHB (Promote family participation in care) **Level: Grantee** **Category: Family Participation**	The percent of families with Children with Special Health Care Needs (CSHCN) that have been provided information, education, and/or training by Family-to-Family Health Information Centers.
GOAL	To increase the number of families with CSHCN receiving needed health and related information, training, and/or education opportunities in order to partner in decision making and be satisfied with services that they receive.
MEASURE	The percent of families with CSHCN that have been provided information, education and/or training by Family-to-Family Health Information Centers.
DEFINITION	**Numerator:** The total number of families with CSHCN in the State that have been provided information, education, and/or training from Family-To-Family Health Information Centers. **Denominator:** The estimated number of families having CSHCN in the State **Units:** 100
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objective MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems **Text:** Percent
DATA SOURCE(S) AND ISSUES	1) Progress reports from Family-To-Family Health Care Information and Education Centers 2) National Survey for Children with Special Health Care Needs (NS-CSHCN)
SIGNIFICANCE	The last decade has emphasized the central role of families as informed consumers of services and participants in policy-making activities. Research has indicated that families need information they can understand and information from other parents who have experiences similar to theirs and who have navigated services systems.

DATA COLLECTION FORM FOR DETAIL SHEET #70

A. PROVIDING INFORMATION, EDUCATION, AND/OR TRAINING

Estimated number of families with CSHCN in the State: _____

1. Our organization provided health care information/education /training to families with CSHCN to assist them in accessing information and services.

a. Total number of families served/trained: _____

b. Of the total number of families served/trained, how many families were provided information/education/training related to the following issues:

1. Partnering/decision making with providers
   Number of families served/trained _____
2. Accessing a medical home
   Number of families served/trained _____
3. Financing for needed health services
   Number of families served/trained _____
4. Early and continuous screening
   Number of families served/trained _____
5. Navigating systems/accessing community services easily
   Number of families served/trained _____
6. Adolescent transition issues
   Number of families served/trained _____
7. Other (Specify): _____
   Number of families served/trained _____

2. Our organization provided health care information/education to professionals/providers to assist them in better providing services.

a. Total number of professionals/providers served/trained: _____

b. Of the total number of professionals/providers served/trained, how many professionals/providers were provided health care information/education related to the following issues:

1. Partnering/decision making with families
   Number of professionals/providers served/trained: _____
2. Accessing/providing a medical home
   Number of professionals/providers served/trained: _____
3. Financing for needed services
   Number of professionals/providers served/trained: _____
4. Early and continuous screening
   Number of professionals/providers served/trained: _____
5. Navigating systems/accessing community services easily
   Number of professionals/providers served/trained: _____
6. Adolescent transition issues
   Number of professionals/providers served/trained: _____
7. Other (Specify):_____
   Number of professionals/providers served/trained: _____

3. Our organization worked with State agencies/programs to assist them with providing services to their populations and/or to obtain their information to better serve our families.

a. Types of State agencies/programs - Total: _____

b. Indicate the types of State agencies/programs with which your organization has worked:

- State level Commissions, Task Forces, etc.
- MCH/CSHCN
- Genetics/newborn screening
- Early Hearing Detection and Intervention/Newborn Hearing screening
- Emergency Medical Services for Children
- LEND Programs
- Oral Health
- NICHQ Learning Collaboratives
- Developmental Disabilities
- Medicaid (CMS),SCHIP
- Private Insurers
- Case Managers
- SAMHSA/Mental & Behavioral Health
- Federation of Families for Children's Mental Health
- HUD/housing
- Early Intervention/Head Start
- Education
- Child Care
- Juvenile Justice/Judicial System
- Foster Care/Adoption agencies
- Other (Specify): _____
- None

4. Our organization served/worked with community-based organizations to assist them with providing services to their populations and/or to obtain their information to better serve our families.

a. Types of community-based organizations - Total: _____

b. Indicate the types of community-based organizations with which your organization has worked:

- Other family organizations, groups
- Medical homes, providers, clinics
- American Academy of Pediatrics Chapter
- Hospitals - Residents, hospital staff training
- Hospitals - Other:_____
- Universities - Schools of Public Health
- Universities - Schools of Nursing
- Universities - Schools of Social Work
- Community Colleges
- Schools
- Interagency groups
- Faith-based organizations, places of worship
- Non-Profits, such as United Cerebral Palsy, March of Dimes, etc)
- Ethnic/racial specific organizations
- Community Teams
- Other (Specify): _____
- None

B. INCREASING FAMILY PARTICIPATION

1. Our organization provided training/technical assistance that increased family and youth participation in such systems building activities as committees, task forces, as contractors, etc.

a. Total number of family members and youth that received training (conferences, one-on-one, train-the-trainer, etc.)? _____

b. Total number of family members and youth that received technical assistance (by telephone, internet, in person)? _____

c. Of the total number that have received training and technical assistance, how many family members and youth served on systems building activities, such as boards, task forces, committees, etc.? _____

d. Of the total number that have received training and technical assistance, how many family members and youth participated at the following levels? (one person can participate at more than one level):

1. Local/Community Level
   # of family members _____ # of youth _____
2. State Level
   # of family members _____ # of youth _____
3. Regional Level
   # of family members _____ # of youth _____
4. Federal/National level
   # of family members _____ # of youth _____

71 PERFORMANCE MEASURE	The percent of pre-hospital provider agencies in the State/Territory that have on-line pediatric medical direction.
GOAL	By 2011: • 90% of basic life support (BLS) pre-hospital provider agencies in the State/Territory have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility. • 90% of advanced life support (ALS) pre-hospital provider agencies in the State/Territory have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.
MEASURE	The percent of pre-hospital provider agencies in the State/Territory that have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.
DEFINITION	**Numerator (BLS provider agencies):** Number of BLS pre-hospital provider agencies that have on-line pediatric medical direction according to the data collected. **Denominator (BLS provider agencies):** Total number of BLS pre-hospital provider agencies that provided data. **Units:** 100 **Text:** Percent **Numerator (ALS provider agencies):** Number of ALS pre-hospital provider agencies that have on-line pediatric medical direction according to the data collected. **Denominator (ALS provider agencies):** Total number of ALS pre-hospital provider agencies that provided data. **Units:** 100 **Text:** Percent **On-line pediatric medical direction**: An individual is available 24/7 to EMS providers who need medical advice when providing care to a pediatric patient. This person must be a medical professional (e.g., nurse, physician, physician assistant [PA], nurse practitioner or EMT-P) and must have a higher level of pediatric training/expertise than the EMS provider to whom he/she is providing medical advice. **Pre-hospital provider agency:** A provider of emergency medical services staffed with BLS and/or ALS personnel who render medical care in response to a 911 or similar emergency call. For purposes of this measure, agencies will be classified

as either BLS or ALS according to their highest level of licensure (BLS or ALS) from the state or local licensing/recognizing authority. Data will need to be gathered from both transporting and non-transporting agencies.

Pediatric: Any person 0 to 18 years of age.

EMSC STRATEGIC OBJECTIVE

Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care.

Objective 2.1: Develop evidence or consensus based on-line and off-line pediatric medical direction for basic and advanced life support providers

DATA SOURCE(S) AND ISSUES

- Surveys of pre-hospital provider agencies
- Other approved data source

SIGNIFICANCE

At the scene of an emergency, EMS providers that may not have the expertise to deal with pediatric patients need 24/7 access to a higher level medical provider who can provide real time patient care advice.

72 PERFORMANCE MEASURE	The percent of pre-hospital provider agencies in the State/Territory that have off-line pediatric medical direction.
GOAL	By 2011: • 90% of basic life support (BLS) pre-hospital provider agencies in the State/Territory have off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility. • 90% of advanced life support (ALS) pre-hospital provider agencies in the State/Territory have off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility.
MEASURE	The percent of pre-hospital provider agencies in the State/Territory that have pediatric off-line medical direction available from dispatch through patient transport to a definitive care facility.
DEFINITION	**Numerator (BLS provider agencies):** Number of BLS pre-hospital provider agencies that have off-line pediatric medical direction according to the data collected. **Denominator (BLS provider agencies):** Total number of BLS pre-hospital provider agencies that provided data. **Units:** 100 **Text:** Percent **Numerator (ALS provider agencies):** Number of ALS pre-hospital provider agencies that have off-line pediatric medical direction according to the data collected. **Denominator (ALS provider agencies):** Total number of ALS pre-hospital provider agencies that provided data. **Units:** 100 **Text:** Percent **Off-line pediatric medical direction:** Treatment guidelines and protocols used by EMS providers to ensure the provision of appropriate pediatric patient care, available in written or electronic (e.g., laptop/tablet computer) form in the unit or with a provider. **Protocols must be available from the time of dispatch through patient transport to a definitive care facility.** **Pre-hospital provider agency:** A provider of emergency medical services staffed with BLS and/or ALS personnel who render medical care in response to a 911 or similar emergency call. For purposes of this measure, agencies will be classified as either BLS or ALS according to their highest

	level of licensure (BLS or ALS) from the state or local licensing/recognizing authority. Data will need to be gathered from both transporting and non-transporting agencies. **Pediatric**: Any person 0 to 18 years of age.
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care. Objective 2.1: Develop evidence or consensus based on-line and off-line pediatric medical direction for basic and advanced life support providers.
DATA SOURCE(S) AND ISSUES	• Surveys of pre-hospital provider agencies. • Review of state inspection reports
SIGNIFICANCE	There are gaps that currently exist in the pediatric emergency care system. For example, while pediatric patient care protocols are available, standardized adoption and use of the guidelines among providers is problematic. These gaps can result in poor pediatric outcomes (e.g., increased morbidity and mortality). This measure will ensure that providers across the pre-hospital and hospital settings are delivering optimal pediatric emergency care based on a standardized set of guidelines, which will ultimately improve the quality and adequacy of pediatric emergency care.

73 PERFORMANCE MEASURE	The percent of patient care units in the State/Territory that have essential pediatric equipment and supplies.
GOAL	By 2011: • 90% of basic life support (BLS) patient care units in the State/Territory have the essential pediatric equipment and supplies, as outlined in national guidelines for pediatric equipment and supplies for basic life support ambulances. • 90% of advanced life support (ALS) patient care units in the State/Territory have the essential pediatric equipment and supplies, as outlined in national guidelines for pediatric equipment and supplies for advanced life support ambulances.
MEASURE	The percent of patient care units in the State/Territory that have the essential pediatric equipment and supplies as outlined in national guidelines.
DEFINITION	**Numerator (BLS patient care units):** Number of BLS patient care units that have the essential pediatric equipment and supplies according to the data collected. **Denominator (BLS patient care units):** Total number of BLS patient care units for which data was provided. **Units:** 100 **Text:** Percent **Numerator (ALS patient care units):** Number of ALS patient care units that have the essential pediatric equipment and supplies according to the data collected. **Denominator (ALS patient care units):** Total number of ALS patient care units for which data was collected. **Units:** 100 **Text:** Percent **Patient Care Unit:** A patient care unit is defined as a vehicle staffed with EMS providers (BLS and/or ALS) dispatched in response to a 911 or similar emergency call AND responsible for transporting a patient to the hospital. Examples include an ambulance, or other type of transporting unit. This definition excludes non-transport vehicles (such as chase cars) to provide additional personnel resources, air ambulances, exclusively defined specialty care units, and water ambulances/units. **Pediatric:** Any person 0 to 18 years of age. **National guidelines:** Equipment list recognized by

	the EMSC Program. **Essential:** The item is deemed necessary for the care of pediatric patients and should be carried by a patient care unit.
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care Objective 2.2: Assess the availability of essential pediatric equipment and supplies for basic and advanced life support ambulances.
DATA SOURCE(S) AND ISSUES	• Surveys of pre-hospital provider agencies that transport patients. • Review of state inspection reports.
SIGNIFICANCE	There are gaps that currently exist in the pediatric emergency care system. For example, while equipment guidelines are available, standardized adoption and use of the guidelines among providers is problematic. These gaps can result in poor pediatric outcomes (e.g., increased morbidity and mortality). This measure will ensure that providers across the pre-hospital and hospital settings are delivering optimal pediatric emergency care based on a standardized set of equipment guidelines, which will ultimately improve the quality and adequacy of pediatric emergency care.

74 PERFORMANCE MEASURE	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
GOAL	By 2017: • 25% of hospitals are recognized as part of a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
MEASURE	The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
DEFINITION	**Numerator:** Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies. **Denominator:** Total number of hospitals with an ED in the State/Territory. **Units:** 100 **Text:** Percent **Standardized system:** A system that recognizes the readiness and capability of a hospital and its staff to triage and provide care appropriately, based upon the severity of illness/injury of the child. The system designates/verifies hospitals as providers of a certain level of emergency care within a specified geographic area (e.g., region). A facility recognition process usually involves a formal assessment of a hospital's capacity to provide pediatric emergency care via site visits and/or a formal application process implemented by a State/Territory or local government body, such as the State EMSC Program, State EMS Office, and/or local hospital/health care provider association. **Hospital:** Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department. Excludes Military and Indian Health Service hospitals.
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care. Objective 2.3: Develop a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage

pediatric medical emergencies and trauma.

DATA SOURCE(S) AND ISSUES

- This performance measure will require grantees to determine how many hospitals participate in their facility recognition program (if the state has a facility recognition program) for trauma and for medical.

SIGNIFICANCE

The performance measure emphasizes the importance of the existence of a standardized statewide, territorial, or regional system that recognizes hospitals capable of stabilizing and/or managing pediatric medical emergencies and trauma. A standardized categorization and/or designation process assists hospitals in determining their capacity and readiness to effectively deliver pediatric emergency and specialty care.

DATA COLLECTION FORM FOR DETAIL SHEET # 74

The percent of hospitals with an Emergency Department (ED) that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.

Numerator:	
Denominator:	
Percent	

Numerator: Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.
Denominator: Total number of hospitals with an ED in the State/Territory.

Using a scale of 0-5, please rate the degree to which your State/Territory has made towards establishing a recognition system for pediatric medical emergencies.

Element	0	1	2	3	4	5
1. Indicate the degree to which a standardized system for pediatric medical emergencies exists.						

0= No progress has been made towards developing a statewide, territorial, or regional system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies

1= Research has been conducted on the effectiveness of a pediatric medical facility recognition program (i.e., improved pediatric outcomes)
And/or
Developing a pediatric medical facility recognition program has been discussed by the EMSC Advisory Committee and members are working on the issue.

2= Criteria that facilities must meet in order to receive recognition as a pediatric medical facility have been developed.

3= An implementation process/plan for the pediatric medical facility recognition program has been developed.

4= The implementation process/plan for the pediatric medical facility recognition program has been piloted.

5= At least one facility has been formally recognized through the pediatric medical facility recognition program

75 PERFORMANCE MEASURE	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
GOAL	By 2017: • 50% of hospitals are recognized as part of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric trauma.
MEASURE	The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
DEFINITION	**Numerator:** Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies. **Denominator:** Total number of hospitals with an ED in the State/Territory. **Units:** 100 **Text:** Percent **Standardized system:** A system that recognizes the readiness and capability of a hospital and its staff to triage and provide care appropriately, based upon the severity of illness/injury of the child. The system designates/verifies hospitals as providers of a certain level of emergency care within a specified geographic area (e.g., region). A facility recognition process usually involves a formal assessment of a hospital's capacity to provide pediatric emergency care via site visits and/or a formal application process implemented by a State/Territory or local government body, such as the State EMSC Program, State EMS Office, and/or local hospital/health care provider association. **Hospital:** Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department. Excludes Military and Indian Health Service hospitals.
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care. Objective 2.3: Develop a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage

pediatric medical emergencies and trauma.

DATA SOURCE(S) AND ISSUES

- This performance measure will require grantees to determine how many hospitals participate in their facility recognition program (if the state has a facility recognition program) for trauma and for medical.

SIGNIFICANCE

The performance measure emphasizes the importance of the existence of a standardized statewide, territorial, or regional system that recognizes hospitals capable of stabilizing and/or managing pediatric medical emergencies and trauma. A standardized categorization and/or designation process assists hospitals in determining their capacity and readiness to effectively deliver pediatric emergency and specialty care.

DATA COLLECTION FORM FOR DETAIL SHEET # 75

The percent of hospitals with an Emergency Department (ED) that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.

Numerator:	
Denominator:	
Percent	

Numerator: Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
Denominator: Total number of hospitals with an ED in the State/Territory.

Using a scale of 0-5, please rate the degree to which your State/Territory has made towards establishing a recognition system for pediatric traumatic emergencies.

Element	0	1	2	3	4	5
1. Indicate the degree to which a standardized system for pediatric traumatic emergencies exists.						

0= No progress has been made towards developing a statewide, territorial, or regional system that recognizes hospitals that are able to stabilize and/or manage pediatric trauma emergencies

1= Research has been conducted on the effectiveness of a pediatric trauma facility recognition program (i.e., improved pediatric outcomes)
And/or
Developing a pediatric trauma facility recognition program has been discussed by the EMSC Advisory Committee and members are working on the issue.

2= Criteria that facilities must meet in order to receive recognition as a pediatric trauma facility have been developed.

3= An implementation process/plan for the pediatric trauma facility recognition program has been developed.

4= The implementation process/plan for the pediatric trauma facility recognition program has been piloted.

5= At least one facility has been formally recognized through the pediatric trauma facility recognition program

76 PERFORMANCE MEASURE	The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and that contain all the components as per the implementation manual.
GOAL	By 2011: • 90% of hospitals in the State/Territory have written inter-facility transfer guidelines that cover pediatric patients and that include specific components of transfer.
MEASURE	The percentage of hospitals in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and that include the following components of transfer: • Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication). • Process for selecting the appropriate care facility. • Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.). • Process for patient transfer (including obtaining informed consent). • Plan for transfer of patient medical record • Plan for transfer of copy of signed transport consent • Plan for transfer of personal belongings of the patient • Plan for provision of directions and referral institution information to family
DEFINITION	**Numerator:** Number of hospitals with an ED that have written inter-facility transfer guidelines that cover pediatric patients and that include specific components of transfer according to the data collected. **Denominator:** Total number of hospitals with an ED that provided data. **Units:** 100 **Text:** Percent **Pediatric:** Any person 0 to 18 years of age. **Inter-facility transfer guidelines:** Hospital-to-hospital, including out of State/Territory, guidelines that outline procedural and administrative policies for transferring critically ill patients to facilities that provide specialized pediatric care, or pediatric

	services not available at the referring facility. Inter-facility guidelines do not have to specify transfers of pediatric patients only. A guideline that applies to **all patients or patients of all ages** would suffice, as long as it is not written only for adults. Grantees should consult the EMSC Program representative if they have questions regarding guideline inclusion of pediatric patients. In addition, hospitals may have one document that comprises both the inter-facility transfer guideline and agreement. This is acceptable as long as the document meets the definitions for pediatric inter-facility transfer guidelines and agreements (i.e., the document contains all components of transfer). All hospitals in the State/Territory should have guidelines to transfer to a facility capable of providing pediatric services not available at the referring facility. If a facility cannot provide a particular type of care (e.g., burn care), then it also should have transfer guidelines in place. Consult the NRC to ensure that the facility (facilities) providing the highest level of care in the state/territory is capable of definitive care for all pediatric needs. Also, note that being in compliance with EMTALA does not constitute having inter-facility transfer guidelines. **Hospital:** Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department (ED). Excludes Military and Indian Health Service hospitals.
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care Objective 2.4: Develop written pediatric inter-facility transfer guidelines for hospitals.
DATA SOURCE(S) AND ISSUES	• Surveys of hospitals with an emergency department. • Hospital licensure rules and regulations
SIGNIFICANCE	In order to assure that children receive optimal care, timely transfer to a specialty care center is essential. Such transfers are better coordinated through the presence of inter-facility transfer agreements and guidelines.

77 PERFORMANCE MEASURE	The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
GOAL	By 2011: • 90% of hospitals in the State/Territory have written inter-facility transfer agreements that cover pediatric patients.
MEASURE	The percentage of hospitals in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
DEFINITION	**Numerator:** Number of hospitals with an ED that have written inter-facility transfer agreements that cover pediatric patients according to the data collected. **Denominator:** Total number of hospitals with an ED that provided data. **Units:** 100 **Text:** Percent **Pediatric:** Any person 0 to 18 years of age. **Inter-facility transfer agreements:** Written contracts between a referring facility (e.g., community hospital) and a specialized pediatric center or facility with a **higher level of care** and the appropriate resources to provide needed care required by the child. The agreements must formalize arrangements for consultation and transport of a pediatric patient to the higher-level care facility. Inter-facility agreements do not have to specify transfers of pediatric patients only. An agreement that applies to **all** patients or patients of **all** ages would suffice, as long as it is not written ONLY for adults. Grantees should consult the NRC if they have questions regarding inclusion of pediatric patients in established agreements.
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care. Objective 2.5: Develop written pediatric inter-facility transfer agreements to facilitate timely movement of children to appropriate facilities.
DATA SOURCE(S) AND ISSUES	• Surveys of hospitals with an emergency department. • Hospital licensure rules and regulations
SIGNIFICANCE	In order to assure that children receive optimal care, timely transfer to a specialty care center is essential. Such transfers are better coordinated through the presence of inter-facility transfer agreements and

guidelines.

78 PERFORMANCE MEASURE	The adoption of requirements by the State/Territory for pediatric emergency education for the license/certification renewal of basic life support (BLS) and advanced life support (ALS) providers.
GOAL	By 2011, the State/Territory will have adopted requirements for pediatric emergency education for the recertification of BLS and ALS providers.
MEASURE	The adoption of requirements by the State/Territory for pediatric emergency education for the license/certification renewal of basic life support (BLS) and advanced life support (ALS) providers.
DEFINITION	**Calculation:** Calculation of this measure involves completing the attached Data Collection Form. Indicate whether your State/Territory has adopted requirements for pediatric emergency education for the recertification of BLS and ALS providers. If yes, provide information on the number of hours and courses required for BLS and ALS providers. If your State/Territory has <u>not</u> adopted requirements, please indicate on the form reasons why, and the steps you have taken towards adopting requirements. You may need to collaborate with the State/Territory EMS Office to complete the form. **Definition of Terms:** ***Adoption*** The requirements have been formally put into place in a mandate at either the State/Territory or County/Regional level (i.e., at every county/region in the State/Territory) and apply to BLS and ALS providers in the State/Territory. ***Requirements*** Formal written recommendations and guidelines exist for pediatric emergency care education as part of the recertification of BLS and ALS providers. Recommended training curricula and/or courses for BLS and ALS providers may include, but are not limited to, Pediatric Education for Pre-hospital Professionals (PEPP), Advanced Pediatric Life Support (APLS), and Pediatric Advanced Life Support (PALS) courses. Recommended training courses exclude cardiopulmonary resuscitation (CPR) courses. Requirements that offer a choice of topics, including pediatrics, do not meet the measure. The requirements must be specific to pediatric education. ***Pediatric*** Any person 0 to 18 years of age.

Recertification

Refers to the process of re-registering and fulfilling requirements for certification or licensure to continue practicing as a BLS or ALS provider.

Paramedic

Among other procedures, Advanced Life Support (ALS) providers administer higher life and limb saving assessment and interventions including the administration of medications, advanced airway procedures, and cardiac rhythm analysis as well as interpretation and electrical interventions. ALS personnel will include the EMT-Paramedic (EMT-P).and Advanced Cardiac Rescue certifications/ratings.

EMSC STRATEGIC OBJECTIVE

Related to EMSC Strategic Plan Objective 2: Ensure the operational capacity and infrastructure to provide pediatric emergency care

- Objective 2.6: Develop and adopt minimum requirements for pediatric emergency education as part of the recertification requirements of BLS and ALS emergency medical service providers

DATA SOURCE(S)

Data Sources:

- *State/Territory* EMS rules, regulations, codes or policies
- *County/regional* EMS rules, regulations, codes or policies

IMPLEMENTATION PROCESS

Process to Collect Data For This Measure:

A process for data collection and analysis, as well as an example of supporting documentation are provided below under each data source.

1. ***State/Territory*** **EMS Rules, Regulations, Codes, or Policies**: Your State/Territory EMS Rules, Regulations, Codes, or Policies may include requirements for pediatric emergency education for the re-certification of BLS and ALS providers. These requirements may include those developed by the National Registry of Emergency Medical Technicians (NREMT) or any other recertification requirements adopted by your State/Territory.
   - Review State/Territory EMS Rules, Regulations, Codes, or Policies on an annual basis for pediatric emergency education requirements for the re-certification of BLS and ALS providers.
   - *Supporting documentation* for the measure may include a copy of the State/Territory EMS Rules, Regulations, Codes, or Policies stating the requirements for pediatric emergency education for the re-certification of BLS and ALS providers. Supporting documentation will only need to be submitted if requested by HRSA.
2. ***County/Regional*** **EMS Rules, Regulations, Codes,**

Policies, **or Requirements:** If requirements for pediatric emergency education for the re-certification of BLS and ALS providers have *not* been adopted at the State/Territory level, requirements may have been adopted at the county/regional level in the State/Territory.

- Review County/Regional EMS Rules, Regulations, Codes, Policies, or Requirements on an annual basis for pediatric emergency education requirements for the re-certification of BLS and ALS providers.
- Supporting documentation for the measure may include a copy of the County/Regional EMS Rules, Regulations, Codes, Policies, or Requirements stating the requirements for pediatric emergency education for the re-certification of BLS and ALS providers. Supporting documentation will only need to be submitted if requested by HRSA.

SIGNIFICANCE

Adopting requirements for pediatric emergency care education as part of the recertification of BLS and ALS providers helps to ensure the provision of appropriate pediatric emergency care. This, as a result, helps to improve the quality and adequacy of pediatric emergency care, and thereby, improve pediatric outcomes (e.g., reduced morbidity and mortality).

Data Collection Form for Performance Measure #78

The adoption of requirements by the State/Territory for pediatric emergency education for the recertification of basic life support (BLS) and advanced life support (ALS) providers:

1. Has your State/Territory adopted requirements for pediatric education for the license/certification renewal of BLS providers?

☐**YES** ☐**NO** ☐**NOT APPLICABLE**

1.a If "**Yes,"** please provide the following information.

- Total number of hours required for BLS license/certification renewal: _____
- Of the total number of hours required for BLS license/certification renewal, indicate the number of hours that need to be dedicated to pediatrics: _____

Note: Supporting documentation for the measure will only need to be submitted if requested by HRSA.
Comments:
_____
_____
_____
_____
_____

1.b. If "**No**," please indicate the reasons why your State/Territory has not adopted requirements for pediatric education for the license/certification of BLS providers. Please also indicate what steps you have taken towards adopting requirements, highlighting any major barriers towards adoption.
_____
_____
_____
_____
_____

1.c. If "**Not Applicable**," please provide reasons why the measure is not applicable to your State/Territory (e.g., State/Territory does not have BLS providers).
_____
_____
_____
_____
_____

2. Has your State/Territory adopted requirements for pediatric education for the license/certification renewal of ALS providers?

☐**YES** ☐**NO** ☐**NOT APPLICABLE**

2.a. If "**Yes,"** please provide the following information.

- Total number of hours required for ALS license/certification renewal: _____
- Of the total number of hours required for ALS license/certification renewal, indicate the number of hours that need to be dedicated to pediatrics: _____

Note: Supporting documentation for the measure will only need to be submitted if requested by HRSA.

Comments:

2.b. If "**No**," please indicate the reasons why your State/Territory has not adopted requirements for pediatric education for the license/certification of ALS providers. Please also indicate what steps you have taken towards adopting requirements, highlighting any major barriers towards adoption.

2.c. If "**Not Applicable**," please provide reasons why the measure is not applicable to your State/Territory (e.g., State/Territory does not have ALS providers).

79 PERFORMANCE MEASURE	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system.
GOAL	To increase the number of States/Territories that have established permanence of EMSC in the State/Territory EMS system.
MEASURE	The degree to which States/Territories have established permanence of EMSC in the State/Territory EMS system.
DEFINITION	**Permanence of EMSC in a State/Territory EMS system** is defined as: • The EMSC Advisory Committee has the required members as per the implementation manual. • The EMSC Advisory Committee meets at least four times a year. • By 2011, pediatric representation will have been incorporated on the State/Territory EMS Board. • By 2011, the State/Territory will mandate requiring pediatric representation on the EMS Board. • By 2011, one full time EMSC Manager that is dedicated solely to the EMSC Program will have been established. **EMSC** The component of emergency medical care that addresses the infant, child, and adolescent needs, and the Program that strives to ensure the establishment and permanence of that component. EMSC includes emergent at the scene care as well as care received in the emergency department, surgical care, intensive care, long-term care, and rehabilitative care. EMSC extends far beyond these areas yet for the purposes of this manual this will be the extent currently being sought and reviewed. **EMS system** The continuum of patient care from prevention to rehabilitation, including pre-hospital, dispatch communications, out-of-hospital, hospital, primary care, emergency care, inpatient, and medical home. It encompasses every injury and illness
EMSC STRATEGIC OBJECTIVE	Related to EMSC Strategic Plan Objective 4: Establish permanence of EMSC in each State/Territory EMS system. Objective 4.1: Establish an EMSC Advisory Committee within each State/Territory

Objective 4.2: Incorporate pediatric representation on the State/Territory EMS Board

Objective 4.3: Establish one full-time equivalent EMSC manager that is dedicated solely to the EMSC Program.

DATA SOURCE(S) AND ISSUES

- Attached data collection form to be completed by grantee.

SIGNIFICANCE

Establishing permanence of EMSC in the State/Territory EMS system is important for building the infrastructure of the EMSC Program and is fundamental to its success. For the EMSC Program to be sustained in the long-term and reach permanence, it is important to establish an EMSC Advisory Committee to ensure that the priorities of the EMSC Program are addressed. It is also important to establish one full time equivalent EMSC Manager whose time is devoted solely (i.e., 100%) to the EMSC Program. Moreover, by ensuring pediatric representation on the State/Territory EMS Board, pediatric issues will more likely be addressed.

DATA COLLECTION FORM FOR DETAIL SHEET # 79

Please indicate the elements that your grant program has established to promote permanence of EMSC in the State/Territory EMS system.

Element	Yes	No
1. The EMSC Advisory Committee has the required members as per the implementation manual.		
2. The EMSC Advisory Committee has met four or more times during the grant year.		
3. There is pediatric representation on the EMS Board.		
4. There is a State/Territory mandate requiring pediatric representation on the EMS Board.		
5. There is one full-time EMSC Manager that is dedicated solely to the EMSC Program.		

Yes = 1
No = 0

Total number of elements your grant program has established (possible 0-5 score) _____

80 PERFORMANCE MEASURE	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.
GOAL	By 2011, the six EMSC priorities will have been integrated into existing EMS or hospital/healthcare facility statutes/regulations.
MEASURE	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.
DEFINITION	**Priorities**: The priorities of the EMSC Program include the following six areas: 1. BLS and ALS pre-hospital provider agencies in the State/Territory have on-line and off-line pediatric medical direction available from dispatch through patient transport to a definitive care facility. 2. BLS and ALS patient care units in the State/Territory have the essential pediatric equipment and supplies, as outlined in the nationally recognized and endorsed guidelines. 3. The existence of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage • pediatric medical emergencies • trauma 4. Hospitals in the State/Territory have written inter-facility transfer guidelines that cover pediatric patients and that include the following components of transfer: • Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication). • Process for selecting the appropriate care facility. • Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.). • Process for patient transfer (including obtaining informed consent). • Plan for transfer of patient

medical record
- Plan for transfer of copy of signed transport consent
- Plan for transfer of personal belongings of the patient
- Plan for provision of directions and referral institution information to family

5. Hospitals in the State/Territory have written inter-facility transfer agreements that cover pediatric patients.

6. The adoption of requirements by the State/Territory for pediatric emergency education for the license/certification renewal of BLS and ALS providers.

EMSC STRATEGIC OBJECTIVE

Related to EMSC Strategic Plan Objective 4: Establish permanence of EMSC in each State/Territory EMS system.

DATA SOURCE(S) AND ISSUES

- Attached data collection form to be completed by grantee.

SIGNIFICANCE

For the EMSC Program to be sustained in the long-term and reach permanence, it is important for the Program's priorities to be integrated into existing State/Territory mandates. Integration of the EMSC priorities into mandates will help ensure pediatric emergency care issues and/or deficiencies are being addressed State/Territory-wide for the long-term.

DATA COLLECTION FORM FOR DETAIL SHEET # 80

Please indicate the elements that your grant program has established to promote the permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.

Element	Yes	No
1. There is a statute/regulation for pediatric on-line medical direction for ALS and BLS pre-hospital provider agencies.		
2. There is a statute/regulation for pediatric off-line medical direction for ALS and BLS pre-hospital provider agencies.		
3. There is a statute/regulation for pediatric equipment for BLS and ALS patient care units.		
4. There is a statute/regulation for a hospital recognition system for identifying hospitals capable of dealing with pediatric medical emergencies.		
5. There is a statute/regulation for a hospital recognition system for identifying hospitals capable of dealing with pediatric traumatic emergencies.		
6. There is a statute/regulation for written inter-facility transfer guidelines that cover pediatric patients and include specific components of transfer.		
7. There is a statute/regulation for written inter-facility transfer agreements that cover pediatric patients.		
8. There is a statute/regulation for the adoption of requirements for continuing pediatric education during recertification of BLS and ALS providers.		

Yes = 1
No = 0

Total number of elements your grant program has established (possible 0-8 score) _____

REVISED DETAIL SHEET

81 PERFORMANCE MEASURE	The percent of program participant mothers who breastfeed their infants at 6 months of age.
GOAL	To increase the percent of program participant mothers who breastfeed their infants at 6 months of age.
MEASURE	The percent of program participant mothers who breastfeed their infants at 6 months of age.
DEFINITION	**Numerator:** Number of program participant mothers who indicate that breast milk is at least one of the types of food their infant is fed at 6 months of age. **Denominator** Number of program participant mothers with infants at 6 months of age. **Units:** 100 **Text:** Percent **Breastfeeding** is defined as including any amount of breast milk in the infant's diet, regardless of additional food substances consumed by an infant. **Exclusive breastfeeding** is defined as being fed breast milk or water only. Introduction of other substances to an infant, such as formula, cow's milk, juice and solid foods, in addition to breast milk does not qualify as "exclusive" breastfeeding. A **program participant** is defined as an individual who has direct contact with Healthy Start staff or subcontractors that receives Healthy Start core services on an ongoing systemic basis Include all program participants who have an infant 6 months of age regardless of the time of enrollment in the program. Healthy Start projects can report these numbers by enrollment (pre/interconception) in the data note section.
HEALTHY PEOPLE 2020 OBJECTIVE	Objective # MICH-21.2: Increase the proportion of infants who are breastfed at 6 months. (Baseline: 43.5 percent in 2006)
DATA SOURCE(S) AND ISSUES	Provider and MCHB program participant records. In the grant application, designated MCHB supported projects will need to indicate how they will identify and document that program participants are still breastfeeding at 6months.
SIGNIFICANCE	Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for

approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits.

82 PERFORMANCE MEASURE **Goal 1: Provide National Leadership for MCHB (both graduate level and continuing education training to assure interdisciplinary MCH public health leadership nationwide)** Level: Grantee Category: Training	The degree to which MCH training programs use principles of adult learning, scholarly and scientific research, and effective education models that utilize available technology.
GOAL	To increase the number of MCHB distance learning programs that make use of principles of adult learning and effective education models that utilize available technology
MEASURE	The degree to which MCH training programs use principles of adult learning and effective education models that utilize available technologies.
DEFINITION	Attached is a checklist of 8 elements that reflect the use of adult learning and education models that utilize technology. Please check the degree to which the elements have been implemented. The answer scale is 0-24. Please keep the completed checklist attached. Alternative education methodologies provide effective and efficient means by which MCH professionals can enhance and advance their analytic, managerial, administrative, and clinical skills while continuing to meet their on-site responsibilities. Alternative education methodologies include the following elements: (1) **Relevance:** Relation to MCH Training Program Strategic Plan Goals and Objectives, such as cultural and linguistic competency, family-centered practice, interdisciplinary training, and integration of evidence-based knowledge. (2) **Access:** Provision of training to a variety of users including those who cannot benefit from training because of barriers related to travel, schedule restraints, time away from work, and/or cost. (3) **Quality:** Employment of adult learning principles, interactive training, and effective education models that utilize technologies, such as the Internet, multimedia networking, and teleconferencing. (4) **Collaboration:** Collaboration with State Title V agencies, other relevant State and/or community agencies, and other Title V-funded training programs in the development, delivery, and evaluation of training. (5) **Representation:** Successful marketing to and recruitment of MCH professionals who represent the diversity of the general population. (6) **Accessibility:** Accessibility related to Section 508 of the Americans with Disabilities Act. (7) **Assessment:** An evaluation plan that provides for regular assessment and improvement of program elements. (8) **Sustainability:** A plan that addresses the sustainability of the program beyond the Federal funding period including a range of possibilities from ongoing maintenance of the project and training materials to ensuring the availability of program materials beyond the project period.

HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: ECBP 12:Increase the inclusion of core clinical preventive and population health content in M.D.-granting medical schools ECBP-13: Increase the inclusion of core clinical preventive and population health content in D.O.-granting medical schools ECBP-14: Increase the inclusion of core clinical preventive and population health content in undergraduate nursing ECBP 15: Increase the inclusion of core clinical preventive and population health content in nurse practitioner training ECBP-16: Increase the inclusion of core clinical preventive and population health content in physician assistant training
DATA SOURCE(S) AND ISSUES	• Attached data collection form to be completed by the grantee. • Data will be collected from competitive and continuation applications as part of the grant application process and annual reports. The elements of a quality distance learning program need to be operationally defined and a draft checklist is attached.
SIGNIFICANCE	Recent reports confirm that continuing education needs for MCH personnel are largely unmet and that state and local agencies have limited capacity to meet those training needs. In addition to geographic barriers, lack of funding, time away from work and travel restrictions are barriers for professionals seeking education opportunities. Distance learning projects address the need for MCH continuing education and eliminate many reported barriers including geographic access.

Data Collection Form

Using a scale of 0-3, please rate the degree to which your grant program has incorporated the following elements into your curricula and training. Please add comments in the notes section explaining any data that requires clarification.

0	1	2	3	
				1. Program relates to MCH Training Program Strategic Plan Goals and Objectives and to the MCH leadership competencies.
				2. Program provides training by addressing barriers of travel, schedule restraints, time away from work, and/or cost.
				3. Program uses adult learning principles, validated educational models, instructional technology, and relevant scholarly and scientific research where appropriate.
				4. Program collaborates with critical partners such as State Title V agencies, other relevant State and/or community agencies, and other Title V-funded training programs in the development, delivery, and evaluation of training.
				5. Program successfully markets to and recruits MCH professionals who represent the diversity of the general population.
				6. Curricula and training developed are accessible for persons with disabilities as outlined in Section 508 of the Americans with Disabilities Act.
				7. An evaluation plan assures regular assessment and improvement of program elements.
				8. A plan is in place that addresses the sustainability of the program beyond the Federal funding period.

0 = Not Incorporated
1 = Partially Incorporated
2 = Mostly Incorporated
3 = Completely Incorporated
Total the numbers in the boxes (possible 0-24 score) _____

83 - PROGRAM PERFORMANCE MEASURE

MCHB Goal 3: Eliminate health barriers and disparities Level: Grantee Category: Training	The percent of pipeline graduates that enter graduate programs preparing them to work with the MCH population.
GOAL	To increase the number of pipeline graduates that enter graduate programs preparing them to work with the MCH population.
MEASURE	The percent of pipeline graduates that enter graduate programs preparing them to work with the MCH population.
DEFINITION	Numerator: Total number of MCH Pipeline graduates enrolled in a graduate school program preparing them to work with the MCH population, 5 years after completing the MCH Pipeline program. Graduate programs preparing students to work with the MCH population include: pediatric medicine, public health, pediatric nutrition, public health social work, pediatric nursing, pediatric dentistry, psychology, health education, health administration, pediatric occupational/physical therapy, or speech language pathology. Denominator: Total number of MCH Pipeline graduates who completed the MCH pipeline program 5 years previously.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020 Objectives: ECBP-12: Increase the inclusion of core clinical preventive and population health content in M.D.-granting medical schools ECBP-13: Increase the inclusion of core clinical preventive and population health content in D.O.-granting medical schools ECBP-14: Increase the inclusion of core clinical preventive and population health content in undergraduate nursing ECBP-15: Increase the inclusion of core clinical preventive and population health content in nurse practitioner training ECBP-16: Increase the inclusion of core clinical preventive and population health content in physician assistant training

	PHI-1: Increase the proportion of Federal, Tribal, State, and local public health agencies that incorporate Core Competencies for Public Health Professionals into job descriptions and performance evaluations
DATA SOURCE(S) AND ISSUES	Attached data collection form to be completed by grantees.
SIGNIFICANCE	MCHB training programs assist in developing a public health workforce that addresses MCH concerns and fosters field leadership in the MCH arena.

DATA COLLECTION FORM FOR DETAIL SHEET # 83

The total number of MCH Pipeline graduates; 5 years post graduation, included in this report
_____

The total number of MCH Pipeline graduates lost to follow-up _____

The total number of respondents _____

The total number of MCH Pipeline graduates that are enrolled in graduate Programs preparing them work with the MCH population _____

Graduate programs preparing graduate students to work in the MCH population include:
Pediatric medicine, public health, pediatric nutrition, public health social work, pediatric nursing, pediatric dentistry, psychology, health education, health administration, pediatric occupational/physical therapy, speech language pathology.

84 PROGRAM PERFORMANCE **MCHB Goal 2: Eliminate Health Barriers and Disparities** Level: Grantee Category: Training	The percent of long-term training graduates who are engaged in work related to MCH populations
GOAL	To increase the percent of graduates of MCHB long-term training programs who are engaged in work related to MCH populations.
MEASURE	The percent of long-term training graduates who are engaged in work related to MCH populations.
DEFINITION	**Numerator:** Number of trainees reporting they are engaged in work related to MCH populations **Denominator:** The total number of trainees responding to the survey **Units:** 100 **Text:** Percent Long-term trainees are defined as those who have completed a long-term (greater than or equal to 300 contact hours) leadership training program, including those who received MCH funds and those who did not. **MCH Populations**: Includes all of the Nation's women, infants, children, adolescents, and their families, including and children with special health care needs (MCHB Strategic Plan: FYs 2003-2007)
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Healthy People 2020: Access Goal: Improve access to comprehensive, high-quality health care services Educational Community Based Program Goal: Increase the quality, availability and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health and enhance quality of life. Specific objectives: 10-11 Related to Public Health Infrastructure: To ensure that Federal, Tribal, State, and local health agencies have the necessary infrastructure to effectively provide essential public health services. Specific objectives: 2, 3, and 5
DATA SOURCE(S) AND ISSUES	A revised trainee follow-up survey that incorporates the new form for collecting data on the involvement of MCH training program graduates in work related to MCH populations will be used to collect these data. Data Sources Related to Training and Work Settings/Populations: Rittenhouse Diane R, George E. Fryer, Robert L. Pillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps Participation. *Ann Fam Med* 2008;6:397-405. DOI: 10.1370/afm.885.

Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career
Choices Regarding Internal Medicine *JAMA*. 2008;300(10):1154-1164 (doi:10.1001/jama.300.10.1154)

SIGNIFICANCE

HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care.

DATA COLLECTION FORM - DETAIL SHEET # 84

Long-term training graduates who report working with **the maternal and child health population** (i.e., women, infants, children, adolescents, and their families, including and children with special health care needs) 5 years after completing their training program.

NOTE: If the individual works with more than one of these groups only count them once.

A. The total number of graduates, 5 years following completion of program _____

B. The total number of graduates lost to follow-up _____

C. The total number of respondents (A-B) = denominator _____

D. Number of respondents who report working with an MCH population _____

E. Percent of respondents who report working with an MCH population _____

Use the notes field to detail data source used and information that provides significant context for the data.

85 – PROGRAM PERFORMANCE MEASURE **MCHB Goal 5: Generate, translate, and integrate new knowledge to enhance MCH training, inform policy, and improve health outcomes** **Level: Grantee** **Category: Training**	The degree to which MCHB long-term training grantees engage in policy development, implementation, and evaluation.
GOAL	To increase the number of MCHB long-term training programs that actively promote the transfer and utilization of MCH knowledge and research to the policy arena through the work of faculty, trainees, alumni, and collaboration with Title V.
MEASURE	The degree to which MCHB long-term training grantees engage in policy development, implementation, and evaluation.
DEFINITION	Attached is a checklist of six elements that demonstrate policy engagement. Please check the degree to which the elements have been implemented. The answer scale is 0-18. Please keep the completed checklist attached. Policy development, implementation and evaluation in the context of MCH training programs relates to the process of translating research to policy and training for leadership in the core public health function of policy development. Actively – mutual commitment to policy-related projects or objectives within the past 12 months.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Public Health Infrastructure Goal: To ensure that Federal, tribal, State, and local health agencies have the necessary infrastructure to effectively provide essential public health services. Specific objective # 3
DATA SOURCE(S) AND ISSUES	• Attached data collection form to be completed by grantee. • Data will be collected from competitive and continuation applications as part of the grant application process and annual reports. The elements of training program engagement in policy development, implementation, and evaluation need to be operationally defined with progress noted on the attached draft checklist with an example described more fully in the narrative application.
SIGNIFICANCE	Policy development is one of the three core functions of public health as defined in 1988 by the Institute of Medicine in *The Future of Public Health*

(National Academy Press, Washington DC).

In this landmark report by the IOM, the committee recommends that "*every public health agency exercise its responsibility to serve the public interest in the development of comprehensive public health policies by promoting use of the scientific knowledge base in decision-making about public health and by leading in developing public health policy.*" Academic institutions such as schools of public health and research universities have the dual responsibility to develop knowledge and to produce well-trained professional practitioners.

This national performance measure relates directly to Goal 5 of the National MCHB Training Strategic Plan to "generate, translate, and integrate new knowledge to enhance MCH training, inform policy, and improve health outcomes".

DATA COLLECTION FORM FOR DETAIL SHEET # 85

Using a scale of 0-3, please rate the degree to which your training program has addressed the following policy development, implementation and evaluation elements.

0	1	2	3	Element
				1. Provide multiple didactic opportunities for training on policy development and advocacy to increase understanding of how the policy process works at the federal, state and local levels.
				2. Provide multiple opportunities within the practicum/field/clinical experience portion of the training curriculum for knowledge and skills building in policy development, implementation and evaluation.
				3. A process is in place for assessing the policy knowledge and skills of trainees.
				4. Research findings are disseminated and effectively communicated directly to public health agency leaders and policy officials with attention to how these findings add to the evidence-base for policy decisions and resource allocation.
				5. Faculty or staff contributes to the development of guidelines, regulations, legislation or other public policy at the local, state, and/or national level.
				6. Participate in developing and strengthening local, state, and/or national MCH advocacy networks and initiatives. Examples include MCH coalitions, teen pregnancy prevention initiatives, family advocacy groups, or advocacy groups in professional organizations.

0=Not Met
1=Partially Met
2=Mostly Met
3=Completely Met
Total the numbers in the boxes (possible 0-18 score) _____

NEW DETAIL SHEET

PERFORMANCE MEASURE **Goal 1: Provide National Leadership for Maternal and Child Health (Provide both graduate level and continuing education training to assure interdisciplinary MCH public health leadership nationwide)** **Level: Grantee** **Category: Training**	The percentage of graduates of MCHB long-term training programs that work in state and local health departments
GOAL	To increase the percentage of graduates of long-term training programs that work in state and local health departments five years after graduation.
MEASURE	The percentage of graduates of MCHB long-term training programs that work in state and local health departments
DEFINITION	Identify the number of graduates of MCHB long-term training programs that have worked in state and local health departments after the attainment of their degree. This includes those who have worked for a state or local health department for any length of time during the period of five years after graduation. Please keep the completed checklist attached.
HEALTHY PEOPLE 2020 OBJECTIVE	Related to Objectives: ECBP-12: Increase the inclusion of core clinical prevention and population health content in M.D.-granting medical schools ECBP-13: Increase the inclusion of core clinical prevention and population health content in D.O.-granting medical schools ECBP-14: Increase the inclusion of core clinical prevention and population health content in undergraduate nursing PHI-1: Increase the proportion of Federal, Tribal, State and local public health agencies that incorporate Core Competencies for Public Health Professionals in job descriptions and performance evaluations
DATA SOURCE(S) AND ISSUES	Attached data collection form to be completed by grantees.
SIGNIFICANCE	An MCHB trained workforce is a vital participant in state and local health departments. MCHB long-term training programs assist in developing a public health workforce that addresses MCH concerns and fosters field leadership in the MCH arena.

DATA COLLECTION FORM FOR NEW MEASURE

A.	The total number of graduates, five years following completion of program	_____
B.	The total number of graduates lost to follow-up	_____
C.	The total number of respondents (A-B)	_____
D.	Number of respondents who have worked in a state or local health department during the period of five years after graduation:	_____

NEW

PROPOSED Early Childhood Comprehensive Systems (ECCS) POPULATION-BASED INDICATORS ALIGNED WITH Maternal Infant and Early Childhood Home Visiting (MIECHV) BENCHMARKS

These indicators are to be used by ECCS grantees to measure at the level of program, city/county level, and statewide. This is a voluntary measurement effort for FY 2013.
Version 10/01/12

MIECHV Benchmarks and Indicators	*MIECHV Construct*	*Use in other indicator lists*
BENCHMARK AREA 1: Maternal and Newborn Health		
Percent of infants born preterm.		
Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations	Well-child visits	MCHB perf meas 07
The percent of mothers who breastfeed their infants at 6 months of age.	Breastfeeding	MCHB perf meas 11
BENCHMARK AREA 2. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits		
Rate of substantiated child abuse and neglect among children birth to age 6	Reported substantiated maltreatment for child	SR RFam 03
Childhood deaths due to external cause, by cause and age		IOM ChiHe 22
BENCHMARK AREA 3: School Readiness and Achievement		
Percentage of children who received ASQ screening and did not need follow up or referral.	Child's social behavior, self regulation, emotional well-being	
BENCHMARK AREA 4: Crime or Domestic Violence		
Percentage of families which screen positive for domestic violence and are referred	Domestic violence screening/referral	
BENCHMARK AREA 5: Family Economic Self Sufficiency		
Children in extreme poverty (income 50% below poverty level)	Household income and benefits	IOM Kids Cnt 09
Percent of households in which mother does not have high school diploma (*or GED*)	Employment or education of adult members of household	ACF Head Start FACES
BENCHMARK 6: Coordination and referral for other community resources and supports		
Percentage of children who transition to a group early care and education setting	Completed referrals	
Percentage of children who are enrolled in Part C and have an IFSP	Completed referrals	DOE IDEA