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Attachment B:

Domain Specific Measures

The OMB control number for this project is 0915-0298. Public reporting burden for this collection of information is estimated to average 36 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857.

Health Resources and Services Administration
Maternal and Child Health Bureau

Discretionary Grant Performance Measures

OMB No. 0915-0298
Expires: 06/30/2019

Attachment B
Part 1- Detail Sheets
OMB Clearance Package

Updated DGIS Performance Measures, Numbering by Domain

(All Performance Measures are revised from 2012 OMB package)			
Performance Measure	**New/Revised Measure**	**Prior PM Number (if applicable)**	**Topic**
Core			
Core 1	New	N/A	Grant Impact
Core 2	New	N/A	Quality Improvement
Core 3	New	N/A	Health Equity – MCH Outcomes
Capacity Building			
CB 1	New	N/A	State Capacity for Advancing the Health of MCH Populations
CB 2	New	N/A	Technical Assistance
CB 3	New	N/A	Impact Measurement
CB 4	Revised	5	Sustainability
CB 5	Revised	3, 4	Scientific Publications
CB 6	New	N/A	Products
CB 7	New	N/A	State capacity for accessing electronic health data
Women's/ Maternal Health			
WMH 1	New	N/A	Prenatal Care
WMH 2	New	N/A	Perinatal/ Postpartum Care
WMH 3	New	N/A	Well Woman Visit/ Preventive Care
WMH 4	New	N/A	Depression Screening
Perinatal Infant Health			
PIH 1	New	N/A	Safe Sleep
PIH 2	New	N/A	Breast Feeding
PIH 3	New	N/A	Newborn Screening
Child Health			
CH 1	New	N/A	Well Child Visit
CH 2	New	N/A	Quality of Well Child Visit
CH 3	New	N/A	Developmental Screening
CH 4	New	N/A	Injury Prevention
Children and Youth with Special Health Care Needs			
CSHCN 1	Revised	7	Family Engagement
CSHCN 2	Revised	40, 41	Access to and Use of Medical Home
CSHCN 3	New	N/A	Transition to Adult Health Care
Adolescent Health			
AH 1	New	N/A	Adolescent Well Visit
AH 2	New	N/A	Injury Prevention
AH 3	New	N/A	Screening for Major Depressive Disorder
Life Course/ Cross Cutting			
LC 1	New	N/A	Adequate Health Insurance Coverage
LC 2	Revised	39	Tobacco and eCigarette Cessation
LC 3	New	N/A	Oral Health

Core 1 Performance Measure **Goal: Grant Impact** **Level: Grantee** **Domain: Core**	The percent of programs meeting the stated aims of their grant at the end of the current grant cycle
GOAL	To ensure that planned grant impact was met.
MEASURE	The percent of MCHB funded projects meeting their stated objectives.
DEFINITION	**Tier 1**: Have you met the planned objectives as stated at the beginning of the grant cycle? *Prepopulated with the objectives from FOA:* • Did you meet objective 1_____? Y/N • Did you meet objective 2_____? Y/N
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported
SIGNIFICANCE	

Core 2 Performance Measure **Goal: Quality Improvement** **Level: Grantee** **Domain: Core**	The percent of programs engaging in quality improvement and through what means, and related outcomes.
GOAL	To measure quality improvement initiatives.
MEASURE	The percent of MCHB funded projects implementing quality improvement initiatives.
DEFINITION	**Tier 1**: Are you implementing quality improvement (QI) initiatives in your program? € Yes € No **Tier 2**: QI initiative: What type of QI structure do you have? (Check all that apply) € Team established within a division, office, department, etc. of an organization to improve a process, policy, program, etc. € Team within and across an organization focused on organizational improvement € Cross sectorial collaborative across multiple organizations What types of aims are included in your QI initiative? (Check all that apply) € Population health € Improve service delivery (process or program) € Improve client satisfaction/ outcomes € Improve work flow € Policy improvement € Reducing variation or errors **Tier 3**: Implementation Are QI goals directly aligned with organization's strategic goals? Y/ N Has the QI team received training in QI? Y/N Do you have metrics to track improvement? Y/N Which methodology are you utilizing for quality improvement? (Check all that apply) € Plan, Do, Study, Act Cycles € Lean € Six Sigma € Other: _____ **Tier 4**: What are the related outcomes? Is there data to support improvement in population health as a result of the QI activities? Y/N Is there data to support organizational improvement as a result of QI activities? Y/N Is there data to support improvement in cross sectorial collaboration as a result of QI activities? Y/N
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	

Core 3 Performance Measure **Goal: Health Equity** **Level: Grantee** **Domain: Capacity Building**	The percent of programs promoting and/ or facilitating improving health equity.
GOAL	To ensure MCHB grantees have established specific aims related to improving health equity.
MEASURE	The percent of MCHB funded projects with specific measurable aims related to promoting health equity.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating health equity in your program? € Yes € No **Tier 2**: Please select within which of the following domains your program addresses health equity (check all that apply): € Income € Race € Ethnicity € Language € Socioeconomic Status € Health Status € Disability € Sexual Orientation € Sex € Gender € Age € Geography – Rural/ Urban € Other: _____ **Tier 3**: Implementation Has your program set stated goal/ objectives for health equity? Y/N If yes, what are those aims? _____ **Tier 4**: What are the related outcomes? % of programs that met stated goals/ objectives around health equity **Numerator:** # of programs that met stated specific aims around health equity **Denominator:** # of programs that set specific aims around health equity ** Health equity exists when challenges and barriers have been removed for those groups who experience greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.*
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	Health equity is achieved when every individual has the opportunity to attain his or her full health potential and no one is "disadvantaged from achieving this potential because of social position or socially determined consequences." Achieving health equity is a top priority in the United States.

CB 1 Performance Measure **Goal: State capacity for advancing the health of MCH populations (for National programs)** **Level: Grantee** **Domain: Capacity Building**	The percent of programs promoting and facilitating state capacity for advancing the health of MCH populations.
GOAL	To ensure adequate and increasing state capacity for advancing the health of MCH populations.
MEASURE	The percent of MCHB-funded projects of a national scale promoting and facilitating state capacity for advancing the health of MCH populations, and through what processes.
DEFINITION	Tier 1: Are you promoting and facilitating state capacity for advancing the health of MCH populations for _____'s* priority topic? € Yes € No ***prepopulated with program focus** Tier 2: Through what activities are you promoting and facilitating state capacity for advancing the health of MCH populations? € Delivery of training on program priority topic € Support state strategic planning activities € Serve as expert and champion on the priority topic € Facilitate state level partnerships to advance priority topics € Maintain consistent state-level staffing support for priority topic (State-level programs only) € Collect data to track changes in prevalence of program priority issues € Utilize available data to track changes in prevalence of program priority issue on national/ regional level € Issue model standards of practice for use in the clinical setting Tier 3: Implementation € # of professionals trained on program priority topic € How frequently are data collected and analyzed to monitor status and refine strategies?: o Less frequently than annually o Bi-annual o Quarterly o Monthly € # of MOUs between State agencies addressing priority area • # of State agencies/departments participating on priority area. This includes the following key state agencies (check all that apply): € Commissions/ Task Forces € MCH/CSHCN € Genetics € Newborn Screening € Early Hearing and Detection € EMSC € Oral Health € Developmental Disabilities € Medicaid € Mental & Behavioral Health

CB 1 Performance Measure **Goal: State capacity for advancing the health of MCH populations (for National programs)** **Level: Grantee** **Domain: Capacity Building**	The percent of programs promoting and facilitating state capacity for advancing the health of MCH populations.

- Housing
- Early Intervention/Head Start
- Education
- Child Care
- Juvenile Justice/Judicial System
- Foster Care/Adoption Agency
- Transportation
- Higher Education
- Law Enforcement
- Children's Cabinet
- Other (Specify_____)

- Have model standards of practice been established to increase integration of MCH priority issue into clinical setting? Y/N
- Development or identification of reimbursable services codes to cover delivery of clinical services on MCH priority topic? Y/N
- Inclusion of specific language in Medicaid managed care contracts to assure coverage of payment for clinical services on MCH priority topic? Y/N

Tier 4: What are the related outcomes in the reporting year? (National Programs Only)

- % of state/ jurisdictions have a strategic plan on program priority topic
- % of states/ jurisdictions receiving training on this program topic
- % of states/ jurisdictions which have state FTEs designated for this MCH topic
- % of MCH programs have an identified state lead designated on this topic
- % of states/ jurisdictions utilizing reimbursable services codes to cover delivery of clinical services on MCH priority topic?
- % of states/jurisdictions which report progress on strategic plan goals and objectives?

BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee Self-Reported.

CB 2 Performance Measure **Goal: Technical Assistance** **Level: Grantee** **Domain: Capacity Building**	The percent of programs providing technical assistance on MCH priority topics.
GOAL	To ensure supportive programming for technical assistance.
MEASURE	The percent of MCHB funded projects providing technical assistance, on which MCH priority topics, and to whom.
DEFINITION	**Tier 1**: Are you providing technical assistance (TA) though your program? € Yes € No **Tier 2**: To whom are you providing TA (check all that apply)? € Participants/ Public € Providers/ Health Care Professionals € Local/ Community Partners € State/ National Partners **Technical Assistant refers to collaborative problem solving on a range of issues, which may include program development, program evaluation, needs assessment, and policy or guideline formulation. It may include administrative services, site visitation, and review or advisory functions. TA may be a one-time or ongoing activity of brief or extended frequency.* **Tier 3**: Implementation *(populated from prior domain questions)* # CSHCN/Developmental Disabilities TA # Autism TA # Prenatal Care TA # Perinatal/ Postpartum Care TA # Maternal and Women's Depression Screening TA # Safe Sleep TA # Breastfeeding TA # Newborn Screening TA # Genetics TA # Quality of Well Child Visit TA # Well Visit TA # Injury Prevention TA # Family Engagement TA # Medical Home TA # Transition TA # Adolescent Major Depressive Disorder Screening TA # Health Equity TA # Adequate health insurance coverage TA # Tobacco and eCigarette Use TA # Oral Health TA # Nutrition TA # Data Research and Evaluation TA # Other TA (Please specify additional topics:_____) **Tier 4**: What are the related outcomes in the reporting year? *(populated from prior questions)* # receiving TA # technical assistance activities # TA activities by target audience (Local, Title V, Other state agencies,/ partners, Regional, National, International)
GRANTEE DATA SOURCES	Grantee self-reported.

CB 2 Performance Measure **Goal: Technical Assistance** **Level: Grantee** **Domain: Capacity Building**	The percent of programs providing technical assistance on MCH priority topics.
SIGNIFICANCE	National Resource Centers, Policy Centers, leadership training institutes and many other MCHB discretionary grantees provide technical assistance and training to various target audiences, including grantees, health care providers, state agencies, community-based programs, 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.

Data Collection Form for #CB 2

The form below will be prepopulated by TA selected in domain-specific measures.
All measures for which a grantee reported that they provide TA will be triggered in this table.

Instructions: Please report the number of TA activities for each audience. If TA activities reached multiple audiences, please count for each audience, without concern for duplication. Participants/ public include infants, children, adolescents, adult participants, and families. Community/ local partners are considered to be community-based organizations or municipal or city divisions, programs, or organizations including schools. State or national partners include state or federal divisions or programs, as well as statewide or national organizations, such as non-profit organizations and non-governmental organizations.

Technical Assistance Area	Participants/ Public	Providers/ Health Care Professionals	Community/ Local Partners	State or National Partners
Prenatal Care				
Perinatal/ Postpartum Care				
Maternal and Women's Depression Screening				
Safe Sleep				
Breastfeeding				
Newborn Screening				
Genetics				
Quality of Well Child Visit				
Developmental Screening				
Well Visit				
Injury Prevention				
Family Engagement				
Medical Home				
Transition				
Adolescent Major Depressive Disorder Screening				
Health Equity				
Adequate health insurance coverage				
Tobacco and eCigarette Use				
Oral Health				
N				
Data Research and Evaluation				
Other (Specify:_____)				

CB 3 Performance Measure **Revised for Accuracy** **Goal: Impact Measurement** **Level: Grantee** **Domain: Capacity Building**	The percent of grantees that collect and analyze data on the impact of their grants on the field.
GOAL	To ensure supportive programming for impact measurement.
MEASURE	The percent of grantees that collect and analyze data on the impact of their grants on the field, and the methods used to collect data.
DEFINITION	**Tier 1**: Are you collecting and analyzing data related to impact measurement in your program? € Yes € No **Tier 2**: How are you measuring impact? € Conduct participant surveys € Collect client level data € Qualitative assessments € Case reports € Other:_____ **Tier 3**: Implementation • List of tools used o _____ • Outcomes of qualitative assessment o # of participant surveys o # of clients whose client level data was collected o # of case reports **Tier 4**: What are the related outcomes in the reporting year? % of grantees that collect data on the impact of their grants on the field (and methods used to collect data) **Numerator:** # of grantees that collect data on the impact of their grants on the field **Denominator:** # of grantees How is data collected:_____ % of grantees that collect and analyze data on the impact of their grants on the field (and methods used to analyze data) **Numerator:** # of grantees that analyze data on the impact of their grants on the field **Denominator:** # of grantees How is data analyzed:_____
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	Impact as referenced here is a change in condition or status of life. This can include a change in health, social, economic or environmental condition. Examples may include improved health for a community/population or a reduction in disparities for a specific disease or increased adoption of a practice.

CB 4 Performance Measure **Revised for clarity (Tier 3 and 4 removed)** **Goal: Sustainability** **Level: Grantee** **Domain: Capacity Building**	The percent of MCHB funded initiatives working to promote sustainability of their programs or initiatives beyond the life of MCHB funding.
GOAL	To ensure sustainability of programs or initiatives over time, beyond the duration of MCHB funding.
MEASURE	The percent of MCHB funded initiatives working to promote sustainability of their programs or initiatives beyond the life of MCHB funding, and through what methods.
DEFINITION	**Tier 1**: Are you addressing sustainability in your program? € Yes € No **Tier 2**: Through what processes/ mechanisms are you addressing sustainability? € A written sustainability plan is in place within two years of the MCHB award with goals, objectives, action steps, and timelines to monitor plan progress € 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 I sustainability planning and implementation processes € 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 € 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 € 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 € The grantee identified, actively sought out, and obtained other funding sources and in-kind resources to sustain the entire MCHB-funded program or initiative € 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 € 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 € 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
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported.

CB 4 Performance Measure **Revised for clarity (Tier 3 and 4 removed)** **Goal: Sustainability** **Level: Grantee** **Domain: Capacity Building**	The percent of MCHB funded initiatives working to promote sustainability of their programs or initiatives beyond the life of MCHB funding.
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 Tier 2 data elements for this measure.

CB 5 PERFORMANCE MEASURE **Goal: Scientific Publications** **Level: Grantee** **Domain: Capacity Building**	The percent of programs supporting the production of scientific publications and through what means, and related outcomes.
GOAL	To ensure supportive programming for the production of scientific publications.
MEASURE	The percent of MCHB funded projects programs supporting the production of scientific publications.
DEFINITION	**Tier 1**: Are you supporting the production of scientific publications in your program? € Yes € No **Tier 2**: Indicate the categories of scientific publication that have been produced with grant support (either fully or partially) during the reporting period. € Submitted € In press € Published **Tier 3**: How many are reached through those activities? # of scientific/ peer-reviewed publications **Tier 4**: How, if at all, have these publications been disseminated (check all that apply)? *Note: research only; include this as Part B of publications form* € TV/ Radio interview(s) € Newspaper interview(s) € Online publication interview(s) € Press release € Social Networking sites € Listservs € Presentation at conference (poster, abstract, presentation) € Websites
GRANTEE DATA SOURCES	Grantee self-reported.
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 measure addresses the production and quality of new informational resources created by grantees for families, professionals, other providers, and the public.

CB 6 Performance Measure **Goal: Products** **Level: Grantee** **Domain: Capacity Building**	The percent of programs supporting the development of informational products and through what means, and related outcomes.
GOAL	To ensure supportive programming for the development of informational products.
MEASURE	The percent of MCHB funded projects supporting the development of informational products, and through what processes.
DEFINITION	**Tier 1**: Are you creating products as part of your MCHB-supported program? € Yes € No **Tier 2**: Indicate the categories of products that have been produced with grant support (either fully or partially) during the reporting period. *Count the original completed product, not each time it is disseminated or presented.* € Books € Book chapters € Reports and monographs (including policy briefs, best practice reports, white papers) € Conference presentations and posters presented € Web-based products (website, blogs, webinars, newsletters, distance learning modules, wikis, RSS feeds, social networking sites) *Excluding video/ audio products that are posted online post-production* € Audio/ Video products (podcasts, produced videos, video clips, CD-ROMs, CDs, or audio) € Press communications (TV/ Radio interviews, newspaper interviews, public service announcements, and editorial articles) € Newsletters (electronic or print) € Pamphlets, brochures, or fact sheets € Academic course development € Distance learning modules € Doctoral dissertations/ Master's theses € Other: _____ **Tier 3**: Implementation of products # products created in each category
GRANTEE DATA SOURCES	Grantee self-reported.
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.

CB 7 Performance Measure Added; SSDI program **Goal: Direct Annual Access to MCH Data** **Level: Grantee** **Domain: Capacity Building**	The percent of programs promoting and facilitating state capacity for direct annual access to MCH electronic health data

GOAL

To ensure state capacity for accessing electronic health data on a timely basis for programming and/or reporting.

MEASURE

The percent of programs that are consistently accessing direct electronic MCH health data to support planning, monitoring, and evaluation on a timely basis.

DEFINITION

Tier 1. State Capacity to Access MCH Data for Programming and/ or Reporting on a consistent, Direct and Timely Basis

	A	B	C	D	E	F
Data Sources	**State Has Consistent Annual Access to Data Source[1]**	**State Has Direct Access to an Electronic Database[2]**	**State Has Consistent Annual and Direct Access to Data Source[3]**	**Describe Periodicity[4] (if available more often than annually; does not need to be direct)**	**Describe Lag Length (for the most timely data available, annual or otherwise if more frequent)**	**Data Source Is Linked to Vital Records Birth**
1. Vital Records Birth				__Quarterly __Monthly __More often than monthly	__# months[5] __< 6mos[6]	
2. Vital Records Death				__Quarterly __Monthly __More often than monthly	_____# Months ___< 6mos	
3. Medicaid				__Quarterly __Monthly __More often than monthly	_____# Months ___< 6mos	
4. WIC				__Quarterly __Monthly __More often than monthly	_____# Months ___< 6mos	
5. Newborn				__Quarterly	_____#	

[1] Consistent Annual Access Yes = 1; No = 0

[2] Direct Access to an Electronic Database for Analysis Yes = 1; No = 0

[3] Consistent Annual and Direct Access Yes = 1; No = 0

[4] If Available More Often Than Annually, Indicate Most Frequent Availability Yes = 1; No = 0

[5] Indicate Lag Length for Most Timely Data Available in Number of Months

[6] Indicate Lag Lengths Less than 6 months Yes = 1; No = 0

Bloodspot Screening				__Monthly __More often than monthly	Months ___< 6mos	
6. Newborn Hearing Screening				__Quarterly __Monthly __More often than monthly	_____# Months ___< 6mos	
7. Hospital Discharge				__Quarterly __Monthly __More often than monthly	_____# Months ___< 6mos	
8. PRAMS or PRAMS-like				__Quarterly __Monthly __More often than monthly	_____# Months ___< 6mos	
9. Other: _____						
Sum[7]/N	___ /8	___ /8	___ /8	___ /8	___/8	____/6
Percentages[8]						

II. RELATED OUTCOMES

A. Percentage of unlinked data sources with consistent and direct annual access _____(Column C Percentage)
B. Percentage of data sources available more frequently than annually _____(Column D Percentage)
C. Percentage of data sources with a lag length of ≤6 months _____(Column E Percentage)
D. Percentage of data sources linked to Vital Records Birth_____(Column F Percentage)

GRANTEE DATA SOURCES MCH State Databases

SIGNIFICANCE Timely and comprehensive data are required for needs assessments and program design.

[7] Only Sum 1's; Include only Unshaded Cells in Sums

[8] Calculate Percentage = Sum/N

Table 1: Activity Data Collection Form for Selected Measures

Please use the form below to identify what services you provide to each segment. For those you provide the service to, please provide the number of services provided (i.e. # of participants/members of the public receiving referrals or # of community/ local partners receiving TA). For those services you do not provide, or segments you do not reach, please leave the cell blank.

	Participants/ Public	Providers/ Health Care Professionals	Community/ Local Partners	State or National Partners
Technical Assistance				
Training				
Product Development				
Research/ Peer-reviewed publications				
Outreach/ Information Dissemination/ Education				
Screening/ Assessment				
Referral/ care coordination				
Direct Service				
Quality improvement initiatives				

WHM 1 PERFORMANCE MEASURE **Edited for Clarity and Consistency** **Goal: Prenatal Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/or facilitating timely prenatal care.
GOAL	To ensure supportive programming for prenatal care.
MEASURE	The percent of MCHB funded projects addressing prenatal care. The percent of pregnant program participants who receive prenatal care beginning in the first trimester.
DEFINITION	**Tier 1**: Are you addressing prenatal care in your program? € Yes € No **Tier 2**: Through what processes/ mechanisms are you addressing prenatal care? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of pregnant women who receive prenatal care beginning in the first trimester **Numerator:** Pregnant program participants who began prenatal care in the first trimester of pregnancy. **Denominator**: Pregnant program participants who were enrolled prenatally, prior to their second trimester of pregnancy..
BENCHMARK DATA SOURCES	Related to MICH Objective #10: Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester (Baseline: 70.8% in 2007, Target: 77.9%)
GRANTEE DATA SOURCES	Title V Ntnl Outcome Measure #1, Healthy People 2020 MICH-10
SIGNIFICANCE	Entry of prenatal care during the first trimester is important to ensuring a healthy pregnancy. Women who receive delayed prenatal care (entry after the first 12 weeks) are at risk for having undetected complications in pregnancy that can result in undesirable consequences for both mother and baby.

WMH 2 PERFORMANCE MEASURE **Edited for Clarity and Consistency** **Goal: Perinatal/ Postpartum Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating timely postpartum care.
GOAL	To ensure supportive programming for postpartum care.
MEASURE	The percent of MCHB funded projects addressing perinatal and postpartum care. The percent of pregnant women with a postpartum visit within 4-6 weeks of delivery.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating timely postpartum care in your program? € Yes € No **Tier 2**: Through what processes/ mechanisms are you promoting and/ or facilitating perinatal and postpartum care? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of women with a postpartum visit between 4 to 6 weeks after delivery[9] **Numerator:** Women program participants who enrolled prenatally or within 30 days after delivery and received a postpartum visit between 4-6 weeks after delivery[10]. **Denominator:** Women program participants who enrolled prenatally or within 30 days after delivery during the reporting period. ACOG recommends that the postpartum visit occur

[9] Consistent with Healthy Start Benchmark 3: The percent of Healthy Start women participants who receive a postpartum visit.
[10] PRAMS measures 4-6 weeks, a visit between 28-42 days of delivery.

between 4-6 weeks after delivery. ACOG suggests a 7-14 day postpartum visit for high-risk women.[11] A participant who has a visit prior to 4-6 weeks must still have a visit between 4-6 weeks to meet the standard and be included in the numerator.

BENCHMARK DATA SOURCES	Related to Healthy People 2020 MICH- 19: Increase the proportion of women giving birth who attend a postpartum care visit with a health worker. Pregnancy Risk Assessment Monitoring System (PRAMS) (91% in 14 states with no timing restriction, 2011); Healthcare Effectiveness Data and Information Set (HEDIS) – (61.8% Medicaid HMO, 2014)
GRANTEE DATA SOURCES	Grantee Data System; Pregnancy Risk Assessment Monitoring System
SIGNIFICANCE	Since the period immediately following birth is a time of many physical and emotional adjustments, the postpartum visit is important for educating new mothers on what to expect during this period and address any concerns which may arise. Additional issues include any health complications the mother may have and the health benefits of breastfeeding for the mother and baby. [12]ACOG Committee on Obstetric Practice. Guidelines for Perinatal Care (7th Edition, p. 207) state that 4 to 6 weeks after delivery, women should have a postpartum visit with her doctor.

[11] Note: ACOG suggests a 7-14 day postpartum visit for high-risk women.
[12] http://www.aafp.org/afp/2005/1215/p2491.html

WMH 3 Performance Measure **Edited for Clarity and Consistency** **Goal: Well Woman Visit/ Preventive Health Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating well woman visits/ preventive health care.
GOAL	To ensure supportive programming for well woman visits/ preventive health care.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating well woman visits/ preventive health care and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating well woman visits/ preventive health care in your program? € Yes € No **Tier 2**: Through what activities are you promoting and/ or facilitating well woman visits/ preventive health care? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of women with a well woman/ preventative visit in the past year.[13] **Numerator:** Women program participants who received a well-woman or preventive (including prenatal or postpartum) visit in the 12 months prior to last assessment within the reporting period. **Denominator:** Women program participants during the reporting period. **Definition:** A participant is considered to have a well-woman or preventive visit and included in the numerator if she has a documented health assessment visit where she obtained recommended preventive services that are age and developmentally appropriate within twelve months of her last contact with the Program in the reporting year.

[13] Consistent with Healthy Start Benchmark 5: The percent of Healthy Start women participants who have a well-woman visit.

For purposes of reporting, a prenatal visit or postpartum visit during the twelve month period would meet the standard.

BENCHMARK DATA SOURCES	BRFSS (Women 18-44 with a past-year preventive visit: 65.2%, 2013); Vital Statistics (any prenatal care: 98.4%, 2014); PRAMS (postpartum visit: 91%, 2011)
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	A number of illnesses that affect women can be prevented when proper well-woman care is a priority and even illnesses that can't be prevented have a much better prognosis when detected early during a regular well-woman care exam. ACOG recommends annual assessments to counsel patients about preventive care and to provide or refer for recommended services. These assessments should include screening, evaluation and counseling, and immunizations based on age and risk factors. [14]

[14] http://www.acog.org/About-ACOG/ACOG-Departments/Annual-Womens-Health-Care/Well-Woman-Recommendations

WMH 4 Performance Measure **Edited for Clarity and Consistency** **Goal: Depression Screening** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating depression screening.
GOAL	To ensure supportive programming for depression screening.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating depression screening and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating depression screening in your program? € Yes € No **Tier 2**: Through what activities are you promoting and/ or facilitating depression screening? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? (*Report in Table 1: Activity Data Collection Form*) # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of women screened for depression using a validated tool[15] **Numerator:** Number of women program participants who were screened for depression with a validated tool during the reporting period. **Denominator:** Number of women program participants in the reporting period. A participant is considered to have been screened and included in the numerator if a standardized screening tool which is appropriately validated for her circumstances is used. Several screening instruments have been validated for use to assist with systematically identifying patients with depression.[16] % of women who screened positive for depression who received a referral for services

[15] Consistent with Healthy Start Benchmark 12a and 12b: Percent of Healthy Start women participants who receive depression screening and referral.
[16] http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression

Numerator: Number of women participants who screened positive for depression during the reporting period and received a subsequent referral for follow-up services.
Denominator: Number of HS women participants who screened positive for depression during the reporting period.

A participant is considered to have been referred for follow-up services and included in the numerator if she is referred to a qualified practitioner for further assessment for depression. Referral can be to either an internal or external provider depending on availability and staffing model.

BENCHMARK DATA SOURCES	Related to Healthy People 2020 MICH #34 Objective: (Developmental) Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms. PRAMS (depression screening)
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	Perinatal depression is one of the most common medical complications during pregnancy and may include major and minor depressive episodes. It is important to identify women with depression because when untreated, mood disorders can have adverse effects on women, infants, and families. Often, perinatal depression goes unrecognized because the changes are often attributed to normal pregnancy, such as changes in sleep and appetite. Therefore, it is important and recommended that clinicians screen patients at least once during the perinatal period for depression. Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be paired with appropriate follow-up and treatment when indicated.[17]

[17] http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression

PIH 1 Performance Measure **Edited for Clarity and Consistency** **Goal: Safe Sleep** **Level: Grantee** **Domain: Perinatal Infant Health**	The percent of Healthy Start participants who engage in safe sleep practices.
GOAL	To ensure supportive programming for safe sleep practices.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating safe sleep practices.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating safe sleep in your program? € Yes € No **Tier 2**: Through what activities are you promoting and/ or facilitating safe sleep? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of infants placed to sleep following safe sleep practices[18] **Numerator:** Number of child program participants (aged <12 months) whose parent/ caregiver reports that they are placed to sleep following all three AAP recommended safe sleep practices .[19] **Denominator:** Total number of child program participants aged <12 months A participant is considered to engage in safe sleep practices and included in the numerator if it is reported that the baby is 'always' or 'most often' 1) placed to sleep on their back, 2) always or often sleeps alone in his or her own crib or bed with no bed sharing, and 3) sleeps on a firm sleep surface (crib, bassinet, pack and play, etc.) with no soft objects or loose bedding. [20]

[18] Consistent with Healthy Start Benchmark 6: Percent of Healthy Start participants who are placed to sleep following safe sleep behaviors.

[19] http://nccd.cdc.gov/PRAMStat/rdPage.aspx?rdReport=DRH_PRAMS.ExploreByTopic&islClassId=CLA8&islTopicId=TOP23&go=GO

PIH 1 Performance Measure **Edited for Clarity and Consistency** **Goal: Safe Sleep** **Level: Grantee** **Domain: Perinatal Infant Health**	The percent of Healthy Start participants who engage in safe sleep practices.
	The requirement is that the baby is placed on their back to sleep. If they roll over onto their stomach after being placed to sleep, the standard is met. Although safe sleep behaviors are self-reported, programs are encouraged to observe safe sleep practices during home visits, as possible.
BENCHMARK DATA SOURCES	Related to MICH Objective #20: Increase the proportion of infants placed to sleep on their backs (Baseline: 69.0%, Target: 75.9%), Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 7, Question 48 (Sleep Position) and F1 (Bed Sharing).[21].
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	Sleep-related infant deaths, called Sudden Unexpected Infant Deaths (SUIDS), are the leading cause of infant death after the first month of life. Risk of SUIDS increases when babies are placed on their side or stomach to sleep. Placing babies on their back, on a firm surface without loose bedding or soft objects, as well as no bed-sharing are the recommended practices to follow according to American Assoc. of Pediatrics. It is estimated that 14% of infant deaths—those categorized as Sudden Unexpected Infant Death (SUID)—may be prevented by changing the ways babies are put down to sleep.[22]

[20] https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/aap-expands-guidelines-for-infant-sleep-safety-and-sids-risk-reduction.aspx#sthash.1nnEJQwk.dpuf
[21]http://nccd.cdc.gov/PRAMStat/rdPage.aspx?rdReport=DRH_PRAMS.ExploreByTopic&islClassId=CLA8&islTopicId=TOP23&go=GO
[22] http://nappss.org/plan/background.php

PIH 2 PERFORMANCE MEASURE **Edited for Clarity and Consistency** **Goal: Breastfeeding** **Level: Grantee** **Domain: Perinatal Infant Health**	The percent of programs promoting and/ or facilitating breastfeeding.
GOAL	To ensure supportive programming for breastfeeding.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating breastfeeding.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating breastfeeding in your program? € Yes € No **Tier 2**: Through what activities are you promoting and/ or facilitating breastfeeding? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of child program participants ever breastfed[23] **Numerator:** Total number of HS child participants aged <12 months whose parent was enrolled prenatally or at the time of delivery who were ever breastfed or fed pumped breast milk to their infant. **Denominator:** Total number of HS child participants aged <12 months whose parent was enrolled prenatally or at the time of delivery. **Definition:** A participant is considered to have ever breastfed and included in the numerator if the child received breast milk direct from the breast or expressed at any time in any amount. % of child program participants breastfed at 6 months[24] **Numerator:** Total number of HS child participants age 6 through 11 months whose parent was enrolled

[23] Consistent with Healthy Start Benchmark 7: Percent of Healthy Start child participants whose parent reports the child was ever breastfed or fed breastmilk, even for a short period of time.
[24] Consistent with Healthy Start Benchmark 8: Percent of Healthy Start child participants whose parent reports the child was breastfed or fed breastmilk at 6 months.

PIH 2 PERFORMANCE MEASURE **Edited for Clarity and Consistency** **Goal: Breastfeeding** **Level: Grantee** **Domain: Perinatal Infant Health**	The percent of programs promoting and/ or facilitating breastfeeding.
	prenatally or at the time of delivery that were breastfed or were fed pumped breast milk in any amount at 6 months of age. **Denominator:** Total number of HS child participants age 6 through 11 months whose parent was enrolled prenatally or at the time of delivery. **Definition:** A participant is considered to have ever breastfed at 6 months and included in the numerator if the child received breast milk direct from the breast or expressed at any time in any amount during the sixth month.
BENCHMARK DATA SOURCES	Ever breastfed: Pregnancy Risk Assessment Monitoring System (83.9%, 2011); Vital Statistics (81%, 2014); National Immunization Survey (80%, 2012) Breastfed at 6 months: CDC National Immunization Survey (51.4%, 2012)
GRANTEE DATA SOURCES	Grantee data systems.
SIGNIFICANCE	The American Academy of Pediatrics recommends breastfeeding for the first six months because scientific studies have shown that breastfeeding is good for both the baby's and mother's health.[25] Breastmilk contains vitamins and nutrients babies need for good health and to protect the baby from disease. Research shows that any amount of breastfeeding is beneficial for the baby and that skin-to-skin contact of breastfeeding has physical and emotional benefits. Some studies have found that breastfeeding may reduce risk for certain diseases while also increasing cognitive development.[26]

[25] http://www.babycenter.com/0_how-breastfeeding-benefits-you-and-your-baby_8910.bc
[26] http://www.nichd.nih.gov/health/topics/breastfeeding/conditioninfo/Pages/benefits.aspx

PIH 3 Performance Measure **Goal: Newborn Screening** **Level: Grantee** **Domain: Perinatal Infant Health**	Percent of programs promoting newborn screenings and follow-up.
GOAL	To ensure supportive programming for newborn screenings.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating newborn screening and follow-up.
DEFINITION	**Tier 1**: Are you promoting and/or facilitating newborn screening and follow-up in your program? € Yes € No **Tier 2**: Through what processes/ mechanisms are you promoting or facilitating newborn screening and follow-up? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of eligible newborns screened with timely notification for out of range screens **Numerator:** # of eligible newborns screened with out of range results whose caregivers receive timely notification **Denominator:** # of eligible newborns screened with out of range results % of eligible newborns screened with timely notification for out of range screens who are followed up in a timely manner **Numerator:** # of eligible newborns screened with out of range results whose caregivers receive timely notification and receive timely follow up **Denominator:** # of eligible newborns screened with out of range results whose caregivers receive timely notification
BENCHMARK DATA SOURCES	Objective # MICH-32: Increase appropriate newborn-blood spot screening and follow-up testing (Baseline: 98.3% in 2006, Target: 100%)

PIH 3 Performance Measure **Goal: Newborn Screening** **Level: Grantee** **Domain: Perinatal Infant Health**	Percent of programs promoting newborn screenings and follow-up.
GRANTEE DATA SOURCES	Title V National Outcome Measure #12
SIGNIFICANCE	Newborn screening detects thousands of babies each year with potentially devastating, but treatable disorders. The benefits of newborn screening depend upon timely collection of the newborn blood-spots or administration of a point-of-care test (pulse oximeter for critical congenital heart disease), receipt of the newborn blood spot at the laboratory, testing of the newborn blood spot, and reporting out all results. Timely detecting prevents death and other significant health complications.

CH 1 Performance Measure **Edited for Clarity and Consistency** **Goal: Well-Child Visit** **Level: Grantee** **Domain: Child Health**	The percent of programs promoting and/ or facilitating well-child visits.
GOAL	To ensure supportive programming for well-child visits.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating well-child visits.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating well-child visits in your program? € Yes € No **Tier 2**: Through what activities are you promoting and/ or facilitating well-child visits? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of children who received recommended well child visits.[27] **Numerator:** Number of child program participants whose parent/ caregiver reports that they received the last recommended well child visit based on the AAP schedule well child visit as of the last assessment within the reporting period. **Denominator:** Total number of child program participants in the reporting period. A participant is considered to have received the last recommended a well child visit based on the AAP schedule when they have been seen by a healthcare provider for preventive care, generally to include age-appropriate developmental screenings and milestones, and immunizations, in the month recommended by AAP. The AAP recommends children be seen by a healthcare provider for preventive care at each of the following ages: by 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 24 months/ 2 years, 30 months, 3 years, and then annually

[27] Consistent with Healthy Start Benchmark 11: The percent of Healthy Start child participants who recive well child visits.

CH 1 Performance Measure **Edited for Clarity and Consistency** **Goal: Well-Child Visit** **Level: Grantee** **Domain: Child Health**	The percent of programs promoting and/ or facilitating well-child visits.
	thereafter.[28] % of children enrolled in Medicaid/ CHIP with at least one well care visit in the past year **Numerator**: Medicaid/ CHIP-enrolled child program participants who received a well-child visit in the reporting year. **Denominator:** Medicaid/ CHIP-enrolled child program participants in the reporting year
BENCHMARK DATA SOURCES	National Survey of Children's Health K4Q20
GRANTEE DATA SOURCES	Title V National Performance Measure #10,
SIGNIFICANCE	As childhood is a time of growth and development, it is important that children are seeing their pediatrician on a regular basis.

[28] https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

CH 2 Performance Measure **Edited for Consistency** **Goal: Quality of Well Child Visit** **Level: Grantee** **Domain: Child Health**	The percent of programs promoting and/ or facilitating quality of well-child visits.
GOAL	To ensure supportive programming for quality of well child visits.
MEASURE	The percent of MCHB funded projects promoting or facilitating quality of well child visits.
DEFINITION	**Tier 1**: Are you addressing the quality of well child visits in your program? € Yes € No **Tier 2**: Through what activities are you addressing quality of well child visits? € Technical Assistance € Training € Product Development € Guideline Setting € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Quality improvement initiatives **Tier 3**: How many are reached through those activities? # receiving TA # receiving training # product disseminated # reached through guideline setting # peer-reviewed publications published # receiving information and education through outreach # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % providers trained in conducting a quality well-child visit **Numerator:** # of providers trained **Denominator:** # of providers targeted through the program
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	Children grow and develop very rapidly so it is important they see a pediatrician on a regular basis. Each visit should include a complete physical examination, record of height and weight, and information regarding hearing, vision, and annual screenings.

	Providers/ Health Care Professionals	Community/ Local Partners	State or National Partners
Technical Assistance			
Training			
Product Development			
Research/ Peer-reviewed publications			
Guideline Setting			
Outreach/ Information Dissemination/ Education			
Quality improvement initiatives			

CH 3 Performance Measure **Goal: Developmental Screening** **Level: Grantee** **Domain: Child Health**	Percent of programs promoting developmental screenings and follow-up for children.
GOAL	To ensure supportive programming for developmental screenings.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating developmental screening and follow-up for children.
DEFINITION	**Tier 1**: Are you promoting and/or facilitating developmental screening and follow-up in your program? € Yes € No **Tier 2**: Through what processes/ mechanisms are you promoting or facilitating developmental screening and follow-up? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of children 9 through 71 months receiving a developmental screening using a parental-completed tool? **Numerator:** Children of program participants aged 9 to 71 months who have received a developmental screening using a parent/ caretaker-completed tool **Denominator:** Children, aged 9 to 71 months, of program participants
BENCHMARK DATA SOURCES	National Survey of Children's Health Indicator 4.16: Developmental screening during health care visit, age 10 months-5 years (2011/2012)
GRANTEE DATA SOURCES	Title V National Performance Measure #6, Title V National Outcome Measure #12

CH 3 Performance Measure **Goal: Developmental Screening** **Level: Grantee** **Domain: Child Health**	Percent of programs promoting developmental screenings and follow-up for children.
SIGNIFICANCE	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home and an appropriate responsibility of all pediatric health care professionals. The early identification of developmental problems should lead to further developmental and medical evaluation, diagnosis, and treatment, including early developmental intervention. Children diagnosed with developmental disorders should be identified as children with special health care needs, and chronic-condition management should be initiated. Identification of a developmental disorder and its underlying etiology may also drive a range of treatment planning, from medical treatment of the child to family planning for his or her parents.

CH 4 Performance Measure **Goal: Injury Prevention** **Level: Grantee** **Domain: Child Health**	The percent of programs promoting and/ or facilitating injury prevention among children.
GOAL	To ensure supportive programming for injury prevention among children.
MEASURE	The percent of MCHB funded projects addressing injury prevention and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating injury prevention among children in your program? € Yes € No **Tier 2**: Through what processes/ mechanisms are you addressing injury-prevention? *See data collection form.* € Technical Assistance € Training € Research/ dissemination € Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Referral/ care coordination € Quality improvement initiatives € Use of fatality review data Please check which child safety domains which program activities were designed to impact: € Motor Vehicle Traffic € Suicide/ Self-Harm € Falls € Bullying € Child Maltreatment € Unintentional Poisoning € Prescription drug overdose € Traumatic Brain Injury € Drowning € Other **Tier 3**: How many are reached through those activities? # receiving TA # receiving professional/organizational development training # of peer-reviewed publications published # receiving information and education through outreach # referred/ managed % using fatality review data *See data collection form.* **Tier 4**: What are the related outcomes in the reporting year? Rate of injury-related hospitalization to children ages 1-9. **Numerator:** Injury-related hospitalizations to children ages 1-9 **Denominator:** Children ages 1-9 in the target population Target Population: _____ Percent of children ages 6-11 missing 5 or more days of school because of illness or injury. **Numerator:** # of children ages 6-11 missing 5 or more days of school **Denominator:** Total number of children ages 6-11 represented in National Survey of Children's Health results Dataset reporting from: _____
BENCHMARK DATA SOURCES	Related to Healthy People 2020 Injury and Violence Prevention objectives 1 through 39.

CH 4 Performance Measure **Goal: Injury Prevention** **Level: Grantee** **Domain: Child Health**	The percent of programs promoting and/ or facilitating injury prevention among children.
GRANTEE DATA SOURCES	Title V National Performance Measure #7 Child Injury, AHRQ Healthcare Cost and Utilization Project: National Inpatient Sample or State Inpatient Database; National Survey of Children's Health, Question G1 in the 6-11 year old survey
SIGNIFICANCE	Two dozen children die every day in the United States from an unintentional or intentional injury. In addition, millions of children survive their injury and have to live the rest of their lives with negative health effects. Although there has been much progress in the United States in reducing child injuries, more is needed.

Data Collection Form for Detail Sheet # CH 4

Please use the form below to report what services you provided in which safety domains, and how many received those services. Please use the space provided for notes to specify the recipients of each type of service.

	Motor Vehicle Traffic	Suicide/ Self-Harm	Falls	Bullying	Child Maltreatment	Unintentional Poisoning	Prescription drug overdose	Traumatic Brain Injury	Drowning	Other (Specify)
Technical Assistance										
Training										
Research/ dissemination										
Peer-reviewed publications										
Outreach/ Information Dissemination/ Education										
Referral/ care coordination										
Quality improvement initiatives										
Use of fatality review data										
Notes:										

CSHCN 1 Performance Measure **Goal: Family Engagement** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/ or facilitating family engagement among children and youth with special health care needs.
GOAL	To ensure supportive programming for family engagement among children and youth with special health care needs.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating family engagement among children and youth with special health care needs.
DEFINITION	**Tier 1**: Tier 1: Are you promoting and/ or facilitating family engagement among children and youth with special health care needs in your program? € Yes € No **Tier 2**: Through what processes/ mechanisms are you promoting and/ or facilitating family engagement? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives *(continued on next page→)*

CSHCN 1 Performance Measure **Goal: Family Engagement** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/ or facilitating family engagement among children and youth with special health care needs.

DEFINITION (continued)

Tier 4: What are the related outcomes in the reporting year?

% of target population with family and CSHCN leaders with meaningful roles on community/ state/ regional/ national level teams focused on CSHCN systems

Numerator: # of Family and CSHCN leaders with meaningful roles on community/state/regional/national level teams focused on CSHCN systems

Denominator: # of CSHCN in catchment area

% of racial and ethnic family and CSCHN leaders who are trained and serving on community/ state/ regional/ national level teams focused on CSHCN systems

Numerator: #of racial and ethnic family and CSHCN leaders trained and serving on community/state/ regional/ national level teams focused on CSHCN systems

Denominator: # of CSHCN in catchment area

% of target population with family of CSHCN participating in information exchange forums

Numerator: # participating in information exchange forums

Denominator: # CSHCN in catchment area

% of family and CSCHN leaders trained who report increased knowledge, skill, ability and self-efficacy to serve as leaders on systems-level teams

Numerator: # of family and CSHCN leaders trained who report increased knowledge, skill, ability and self-efficacy to serve as leaders on systems-level teams

Denominator: # of CSHCN in catchment area

Definitions:

Family Engagement is defined as "patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system to improve health and health care." This definition is not intended to negate the various levels or degree to which the interaction between families and professionals can take place.

Family and Youth Leaders are family members who have experience navigating through service systems and are knowledgeable and skilled in partnering with professionals to carry out necessary system changes. Family members are not limited to the immediate family within the household.

Meaningful [Support] Roles for family members/leaders are above and beyond "feedback" surveys. Families are considered to have a meaningful role in decision making when the partnership involves all elements of shared decision-making which are: collaboration, respect, information sharing, encouragement and consideration of preferences and values, and shared responsibility for outcomes.

BENCHMARK DATA SOURCES

Related to Healthy People 2020 Family Planning Objectives

CSHCN 1 Performance Measure **Goal: Family Engagement** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/ or facilitating family engagement among children and youth with special health care needs.
GRANTEE DATA SOURCES	Title V National Performance Measure #2
SIGNIFICANCE	In recent years, policy makers and program administrators have emphasized the central role of family engagement in policy-making activities. In accordance with this philosophy, MCHB is facilitating such partnerships at the local, state and national levels. While there has been a significant increase in the level and types of family engagement, there is still a need to share strategies and mechanisms to recruit, train, monitor, and evaluate family engagement as a key component for CSHCN.

CSHCN 2 Performance Measure **Goal: Access to and Use of Medical Home** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/ or facilitating medical home access and use among children and youth with special health care needs.
GOAL	To ensure supportive programming medical home access and use among children and youth with special health care needs.
MEASURE	The percent of MCHB-funded projects promoting and/ or facilitating medical home access and use among children and youth with special health care needs.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating medical home access and use among children and youth with special health care needs? € Yes € No **Tier 2**: Through what processes/ mechanisms are you addressing medical home access and use? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of target population that demonstrate a direct linkage to a coordinated medical home community as a direct result of activities conducted by project **Numerator:** Target population with a demonstrated direct linkage to a coordinated medical home. **Denominator:** Target population (as identified in grantee application) **Definitions:** Medical Home: The pediatric medical home can be defined by the AAP as having the following characteristics: the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care.

CSHCN 2 Performance Measure **Goal: Access to and Use of Medical Home** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/ or facilitating medical home access and use among children and youth with special health care needs.
BENCHMARK DATA SOURCES	Objective # MICH-30.2: Increase the proportion of children with special health care needs who have access to a medical home (Baseline: 47.1% in 2005-2006, Target: 51.8%)
GRANTEE DATA SOURCES	NSCH Indicator 4.8, NSCH Indicator 4.9d, Title V National Performance Measure #3
SIGNIFICANCE	Medical homes are a cultivated partnership between patients, family, and primary care providers in coordination with support from the community. These models ensure that care must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.

CSHCN 3 Performance Measure **Goal: Transition** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/or facilitating transition to adult health care for youth with special health care needs.
GOAL	To ensure supportive programming for transition to adult health care for youth with special health care needs.
MEASURE	The percent of MCHB funded projects promoting and/or facilitating transition to adult health care for youth with special health care needs.
DEFINITION	**Tier 1**: Are you addressing the transitional needs to adult health care for youth with special health care needs in your program? € Yes € No **Tier 2**: Through what activities are you promoting or facilitating the transition to adult health care for youth with special health care needs? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ readiness assessment # referred/ care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of grantees promoting an evidence-informed framework and clinical recommendations for transition from pediatric to adult health care. **Numerator:** Number of Grantees promoting an evidence informed framework **Denominator:** Total Number of grantees reporting transition performance measure % of grantees involving both pediatric and adult providers/systems in transition efforts **Numerator:** Number of pediatric and adult providers involved in grantee transition efforts **Denominator:** Total number of transition practices sponsored by grantee % of grantees initiating or encouraging transition planning early in adolescence

CSHCN 3 Performance Measure **Goal: Transition** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/or facilitating transition to adult health care for youth with special health care needs.

Numerator: Number of Grantees promoting transition planning early in adolescence
Denominator: Total number of grantees reporting transition performance measure

% of grantees linking transition efforts with medical home initiatives

Numerator: Number of Grantees promoting transition as part of routine medical home care
Denominator: Total number of grantees reporting transition performance measure

% of grantees linking transition efforts with adolescent preventive care efforts

Numerator: Number of grantees promoting transition as part of routine adolescent preventive care
Denominator: Total number of grantees reporting transition performance measure

Definitions: The terms "assessed for readiness" and "deemed ready" used here refer to language utilized by gottransition.org.
Health care transition: is the process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.
Transition Readiness: Assessing youth's transition readiness and self-care skills is the third element in these health care transition quality recommendations. Use of a standardized transition assessment tool is helpful in engaging youth and families in setting health priorities; addressing self-care needs to prepare them for an adult approach to care at age 18, and navigating the adult health care system, including health insurance. Providers can use the results to jointly develop a plan of care with youth and families. Transition readiness assessment should begin at age 14 and continue through adolescence and young adulthood, as needed.

BENCHMARK DATA SOURCES	NA
GRANTEE DATA SOURCES	Title V National Performance Measure #6 and #12, NS-CSHCN Survey Outcome #6
SIGNIFICANCE	Transitioning of children to adolescent services to adult services is important to ensure that growth and development is adequately and accurately screened throughout all stages. These stages of life represent a time of rapid development and it is important to make sure changes are documented and children and receiving appropriate treatment, preventive services, and screenings.

AH 1 Performance Measure **Goal: Adolescent Well Visit** **Level: Grantee** **Domain: Adolescent Health**	The percent of programs promoting and/ or facilitating adolescent well visits.
GOAL	To ensure supportive programming for adolescent well visits.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating adolescent well visits.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating adolescent well visits in your program? € Yes € No **Tier 2**: Through what processes/ mechanisms are you promoting and/ or facilitating adolescent well visits? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment training # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of adolescents with an adolescent well visit in the past year **Numerator:** Adolescents reached by the program in reporting year who had an adolescent well visit during the reporting period. **Denominator:** Adolescents reached by the program in reporting year % of adolescents enrolled in Medicaid/ CHIP with at least one adolescent well visit in the past year **Numerator:** Adolescents enrolled in Medicaid/ CHIP reached by the program in reporting year with at least one adolescent well visit in the reporting year **Denominator:** Adolescents enrolled in Medicaid/ CHIP reached by the program in reporting year. Age range of adolescents served: _____
BENCHMARK DATA SOURCES	Related to Adolescent Health Objective 1: Increase the proportion of adolescent who have had a wellness checkup in the past 12 months Baseline: 68.7%, Target: 75.6%).

AH 1 Performance Measure **Goal: Adolescent Well Visit** **Level: Grantee** **Domain: Adolescent Health**	The percent of programs promoting and/ or facilitating adolescent well visits.
GRANTEE DATA SOURCES	Title V National Performance Measure 10, Adolescent Health (AH), National Vital Statistics System (NVSS) Birth File, Home Visiting
SIGNIFICANCE	Adolescence is an important period of development physically, psychologically, and socially. As adolescents move from childhood to adulthood, they are responsible for their health including annual preventive well visits which help to maintain a healthy lifestyle, avoid damaging behaviors, manage chronic conditions, and prevent disease.

AH 2 Performance Measure **Goal: Injury Prevention** **Level: Grantee** **Domain: Adolescent Health**	The percent of programs promoting and/ or facilitating adolescent injury prevention.
GOAL	To ensure supportive programming for adolescent injury prevention.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating injury prevention and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating injury prevention in your program? € Yes € No **Tier 2**: Through what processes/ mechanisms are you promoting and/ or facilitating injury-prevention? *See data collection form.* € Technical Assistance € Training € Research/ dissemination € Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Referral/ care coordination € Quality improvement initiatives € Use of fatality review data Please check which child safety domains which program activities were designed to impact: € Motor Vehicle Traffic € Suicide/ Self-Harm € Falls € Bullying € Youth Violence (other than bullying) € Child Maltreatment € Unintentional Poisoning € Prescription drug overdose € Traumatic Brain Injury € Drowning € Other **Tier 3**: How many are reached through those activities? # receiving TA # receiving professional/organizational development training # of peer-reviewed publications published # receiving information and education through outreach # referred/ managed % using fatality review data *See data collection form.* **Tier 4**: What are the related outcomes in the reporting year? Rate of injury-related hospitalization to children ages 10-19. **Numerator:** # of injury-related hospitalizations to children ages 10-19 **Denominator:** # of children ages 10-19 in the target population **Target Population:**_____

Percent of children ages 12-17 missing 11 or more days of school

AH 2 Performance Measure **Goal: Injury Prevention** **Level: Grantee** **Domain: Adolescent Health**	The percent of programs promoting and/ or facilitating adolescent injury prevention.
	because of illness or injury. **Numerator:** # of children ages 12-17 missing 11 or more days of school **Denominator:** Total number of children ages 12-17 represented in National Survey of Children's Health result **Dataset used:** _____
BENCHMARK DATA SOURCES	Related to Healthy People Injury and Violence Prevention objectives 1 through 39.
GRANTEE DATA SOURCES	AHRQ Healthcare Cost and Utilization Project: National Inpatient Sample or State Inpatient Database National Survey of Children's Health, 6-11 year old survey, Question G1
SIGNIFICANCE	Two dozen children die every day in the United States from an unintentional or intentional injury. In addition, millions of children survive their injury and have to live the rest of their lives with negative health effects. Although there has been much progress in the United States in reducing child injuries, more is needed.

Data Collection Form for Detail Sheet # AH 2

Please use the form below to report what services you provided in which safety domains, and how many received those services. Please use the space provided for notes to specify the recipients of each type of service.

	Motor Vehicle Traffic	Suicide / Self-Harm	Falls	Bullying	Youth Violence (other than bullying)	Child Maltreatment	Unintentional Poisoning	Prescription drug overdose	Traumatic Brain Injury	Drowning	Other (Specify)
Technical Assistance											
Training											
Research/ dissemination											
Peer-reviewed publications											
Outreach/ Information Dissemination / Education											
Referral/ care coordination											
Quality improvement initiatives											
Use of fatality review data											
Notes:											

AH 3 Performance Measure **Edited for Accuracy** **Goal: Screening for Major Depressive Disorder** **Level: Grantee** **Domain: Adolescent Health**	The percent of programs promoting and/ or facilitating screening for major depressive disorder.
GOAL	To ensure supportive programming for screening for major depressive disorder.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating screening for major depressive disorder for adolescents and through what processes. **Tier 1**: Are you promoting and/ or facilitating screening major depressive disorder for adolescents in your program? € Yes € No **Tier 2**: Through what processes/ mechanisms are you addressing major depressive disorder? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? (*Report in Table 1: Activity Data Collection Form*) # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment training # referred/care coordinated # received direct service # participating in quality improvement initiatives
DEFINITION	**Tier 4**: What are the related outcomes in the reporting year? % of 12-17 year olds screened for MDD in the past year in community level or school health settings **Numerator:** Adolescents involved with your program in the reporting year who were screened for MDD in a community-level or school health setting. **Denominator:** Adolescents involved with your program in the reporting year. % of adolescent well care visits that include screening for MDD **Numerator:** Adolescents involved with your program in the reporting year that had a well-child that included a screening for MDD, in the reporting year. **Denominator:** Adolescents involved with your program in the reporting year that had a well-child visit in the reporting year. % of adolescents identified with a MDD that receive treatment

AH 3 Performance Measure **Edited for Accuracy** **Goal: Screening for Major Depressive Disorder** **Level: Grantee** **Domain: Adolescent Health**	The percent of programs promoting and/ or facilitating screening for major depressive disorder.
	Numerator: Adolescents involved with your program identified as having an MDD that received treatment during the reporting year **Denominator:** Adolescents involved with your program during the reporting year identified as having an MDD % of adolescents with a MDD **Numerator:** Adolescents involved with your program during the reporting year identified as having an MDD **Denominator:** Adolescents involved with your program in the reporting year. Age range of adolescents served: _____
BENCHMARK DATA SOURCES	Healthy People 2020, MHMD 11.2 – Increase the proportion of primary care physician office visits where youth aged 12 to 18 years are screened for depression (Baseline 2.1 in 2007, Target: 2.3%); Healthy People 2020 Objective MHMD-4.1. Percent of adolescents aged 12 to 17 years experienced a major depressive episode (Baseline: 8.3% in 2008, Target: 7.5%)
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	Major depression is becoming more and more common in the United States. Major depression entails interference with the ability to work, sleep, study, eat, and enjoy life. Screening for this disorder can identify individuals and effectively treat them.

LC 1 Performance Measure **Edited for Clarity and Consistency** **Goal: Adequate Health Insurance Coverage** **Level: Grantee** **Domain: Life Course/ Cross Cutting**	The percent of programs promoting and/ or facilitating adequate health insurance coverage.
GOAL	To ensure supportive programming for adequate health insurance coverage.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating adequate health insurance coverage.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating adequate health insurance coverage in your program? € Yes € No **Tier 2**: Through what activities are you promoting and/ or facilitating adequate health insurance coverage? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral to insurance enrollment € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *See data LC 1 Data Collection Form.* **Tier 4**: What are the related outcomes in the reporting year? % with health insurance[29] **Numerator:** Program participants with health insurance as of the last assessment during the reporting period **Denominator:** Program participants during the reporting period Participants are identified as not insured if they report not having any of the following: private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), State-sponsored or other government-sponsored health plan, or military plan at the time of the interview. A participant is also defined as uninsured if he or she reported having only Indian Health Service coverage, or only a private plan that paid for one type of service such as family planning, accidents, or dental care. For more information regarding health insurance questions please refer to Section VII (page 35) of the 2014 National Health Interview Survey (NHIS) Survey Description % with adequate health insurance in the reporting year **Numerator:** Program participants who reported having adequate insurance coverage during the reporting period **Denominator:** Program participants during the reporting period
BENCHMARK DATA SOURCES	Related to HP2020 Access to Health Services Objective 1: Increase the proportion of persons with health insurance.

[29] Consistent with Healthy Start Benchmark 1: The percent of Healthy Start women and child participants with health insurance.

LC 1 Performance Measure **Edited for Clarity and Consistency** **Goal: Adequate Health Insurance Coverage** **Level: Grantee** **Domain: Life Course/ Cross Cutting**	The percent of programs promoting and/ or facilitating adequate health insurance coverage.
	(Baseline: 83.2% persons had medical insurance in 2008, Target: 100%); National Survey of Children's Health (Children's Average 94.5%, 2011/2012),[30] National Health Interview Survey[31]
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Individuals who acquire health insurance are more likely to have access to a usual source of care, receive well child care and immunizations, to have developmental milestones monitored, and receive prescription drugs, appropriate care for asthma and basic dental services. Insured children not only receive more timely diagnosis of serious health care conditions but experience fewer avoidable hospitalizations, improved asthma outcomes and fewer missed school days.

[30] http://childhealthdata.org/browse/survey/results?q=2197&r=1
[31] http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201406.pdf

Data Collection form for #LC 1

Please check all population domains that you engage in each activity listed in Tier 2 related to adequate Health Insurance Coverage. For those activities or population domains that do not pertain to you, please leave them blank.

	Pregnant/ Perinatal Women (Col 1)	Infants (Col 2)	Children (Col 3)	CSHCN (Col 4)	Adolescents (Col 5)	Non-pregnant Adults (Col 5)	Providers/ Health Care Professionals (Col 6)	Community/ Local Partners (Col 7)	State or National Partners (Col 8)	Other Specify___ _ (Col 9)
Technical Assistance										
Training										
Product Development										
Research/ Peer-reviewed publications										
Outreach/ Information Dissemination/ Education										
Tracking/ Surveillance										
Screening/ Assessment										
Referral										
Direct Service										
Quality improvement initiatives										

LC 2 Performance Measure **Edited for Accuracy** **Goal: Tobacco and eCigarette Use** **Level: Grantee** **Domain: Life Course/ Cross Cutting**	The percent of programs promoting and/ or facilitating tobacco and eCigarette cessation.
GOAL	To ensure supportive programming promoting and/ or facilitating tobacco and eCigarette cessation.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating tobacco and eCigarette cessation, and through what processes.
DEFINITION	**Tier 1**: Are you addressing tobacco and eCigarette cessation in your program? € Yes € No **Tier 2**: Through what activities are you promoting and/ or facilitating tobacco and eCigarette cessation? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives **Tier 3**: How many are reached through those activities? *See data LC 2 Data Collection Form.* **Tier 4:** What are the related outcomes in the reporting year? % of program participants who abstain from smoking **Numerator:** Number of program participants who do not smoke cigarettes as of their last contact in the reporting year. **Denominator:** Number of program participants. % of prenatal program participants that abstain from smoking cigarettes in their third trimester. **Numerator:** Number of Healthy Start prenatal women participants who abstained from using any tobacco products during the last 3 months of pregnancy. **Denominator:** Total number of Healthy Start prenatal women participants who were enrolled at least 90 days before delivery. Smoking includes all tobacco products and e-cigarettes.
BENCHMARK DATA SOURCES	Healthy People 2020 (Baseline 89.6%, 2007), Pregnancy Risk Assessment Monitoring System (PRAMS) (89.8%, 2011); Vital Statistics (94.4%, 2014)
GRANTEE DATA SOURCES	Grantee data systems

LC 2 Performance Measure **Edited for Accuracy** **Goal: Tobacco and eCigarette Use** **Level: Grantee** **Domain: Life Course/ Cross Cutting**	The percent of programs promoting and/ or facilitating tobacco and eCigarette cessation.
SIGNIFICANCE	Research shows that smoking in pregnancy is directly linked to problems including premature birth, certain birth defects, sudden infant death syndrome (SIDS), and separation of the placenta from the womb prematurely. Women who smoke may have a harder time getting pregnant and have increased risk of miscarriage.

Data Collection form for #LC 2

Please check all population domains that you engage in each activity listed in Tier 2 related to tobacco cessation. For those activities or population domains that do not pertain to you, please leave them blank.

	Pregnant/ Perinatal Women (Col 1)	**Infants (Col 2)**	**Children (Col 3)**	**CSHCN (Col 4)**	**Adolescents (Col 5)**	**Non-pregnant Adults (Col 5)**	**Providers/ Health Care Professionals (Col 6)**	**Community/ Local Partners (Col 7)**	**State or National Partners (Col 8)**	**Other Specify___ _ (Col 9)**
Technical Assistance										
Training										
Product Development										
Research/ Peer-reviewed publications										
Outreach/ Information Dissemination/ Education										
Tracking/ Surveillance										
Screening/ Assessment										
Referral										
Direct Service										
Quality improvement initiatives										

LC 3 Performance Measure **Goal: Oral Health** **Level: Grantee** **Domain: Life Course/ Cross Cutting**	The percent of programs promoting and/ or facilitating oral health.
GOAL	To ensure supportive programming for oral health.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating oral health, and through what activities.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating oral health in your program? € Yes € No **Tier 2**: Through what activities are you promoting and/ or facilitating oral health? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral € Direct Service € Quality improvement initiatives **Tier 3**: How many from each population are reached through each of the activities? *See data LC 3 Data Collection Form.* **Tier 4: What are the related outcomes in the reporting year?** % of program participants receiving an oral health risk assessment **Numerator:** Number of program participants who received an oral health risk assessment in the reporting year **Denominator:** All program participants % of women in program population who had a dental visit during pregnancy **Numerator:** Program participants who were pregnant during the reporting year who had a dental visit **Denominator:** Program participants who were pregnant during the reporting year % of those aged 1 through 17 who had preventative oral health visit during the last year **Numerator:** Infants and children involved with the program who received a preventative oral health visit in the reporting year **Denominator:** Infants and children involved with the program during the reporting year.
BENCHMARK DATA SOURCES	Related to Oral Health Objective 7: Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year (Baseline: 30.2%, Target: 49.0%). Related to Oral Health Objective 8: Increase the proportion of low-income children and adolescents who receive any preventive dental service during the past year (Baseline: 30.2%, Target: 33.2%).

LC 3 Performance Measure **Goal: Oral Health** **Level: Grantee** **Domain: Life Course/ Cross Cutting**	The percent of programs promoting and/ or facilitating oral health.
GRANTEE DATA SOURCES	Title V National Performance Measure #13
SIGNIFICANCE	Oral health is a vital component of overall health. Access to oral health care, good oral hygiene and adequate nutrition are essential components of oral health to help ensure individuals achieve and maintain oral health. Those with limited preventive oral health services access are at a greater risk for oral diseases.

Data Collection Form for #LC 3

Please use the form below to identify what services you provide to each population. For those that you provide the service to, please provide the number of services provided (i.e. number of children receiving referrals), for those that you do not, please leave blank.

	Pregnant/ Perinatal Women (Col 1)	Infants (Col 2)	Children (Col 3)	CSHCN (Col 4)	Adolescents (Col 5)	Non-pregnant Adults (Col 5)	Providers/ Health Care Professionals (Col 6)	Community/ Local Partners (Col 7)	State or National Partners (Col 8)	Other Specify___ _ (Col 9)
Technical Assistance										
Training										
Product Development										
Research/ Peer-reviewed publications										
Outreach/ Information Dissemination/ Education										
Tracking/ Surveillance										
Screening/ Assessment										
Referral										
Direct Service										
Quality improvement initiatives										

DIVISION OF MCH WORKFORCE DEVELOPMENT:

PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

Performance Measure	New/Revised Measure	Prior PM Number (if applicable)	Topic
Training 01	New	N/A	MCH Training Program and Healthy Tomorrows Family Member/Youth/Community Member participation
Training 02	New	N/A	MCH Training Program and Healthy Tomorrows Cultural Competence
Training 03	New	N/A	Healthy Tomorrows Title V Collaboration
Training 04	Revised	59	Title V Collaboration
Training 05	Revised	85	Policy
Training 06	Revised	09	Diversity of Long-Term Trainees
Training 07	New	N/A	MCH Pipeline Program – Work with MCH populations
Training 08	New	N/A	MCH Pipeline Program – Work with underserved or vulnerable populations
Training 09	Revised	83	MCH Pipeline - Graduate Program Enrollment
Training 10	Revised	08	Leadership
Training 11	Revised	84	Work with MCH Populations
Training 12	Revised	60	Interdisciplinary Practice
Training 13	No changes	64	Diverse Adolescent Involvement (LEAH-specific)
Training 14	Revised	86	Medium-Term Trainees Skill and Knowledge (PPC-Specific)

Training 01 PERFORMANCE MEASURE **Goal: Family/ Youth/ Community Engagement in MCH Training and Healthy Tomorrows Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB training and Healthy Tomorrows programs that ensure family, youth, and community member participation in program and policy activities.
GOAL	To increase family, youth, and/or community member participation in MCH Training and Healthy Tomorrows programs.
MEASURE	The percent of MCHB training and Healthy Tomorrows programs that ensure family/ youth/ community member participation in program and policy activities.
DEFINITION	Attached is a table of five elements that demonstrate family member/youth/community member participation, including an emphasis on partnerships and building leadership opportunities for family members/youth/community members in MCH Training or Healthy Tomorrows programs. Please check yes or no to indicate if your MCH Training Program or Healthy Tomorrows program has met each element.
BENCHMARK DATA SOURCES	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
GRANTEE DATA SOURCES	Attached data collection form to be completed by grantee.
SIGNIFICANCE	Over the last decade, policy makers and program administrators have emphasized the central role of families and other community members as advisors and participants in program and policy-making activities. In accordance with this philosophy, MCH Training Programs and Healthy Tomorrows Programs are facilitating such partnerships at the local, State and national levels. MCH Training programs support interdisciplinary/interprofessional graduate education and training programs that emphasize leadership, and family-centered, community-based, and culturally competent systems of care. Training programs are required to incorporate family members/youth/community members as faculty, trainees, and partners. The Healthy Tomorrows program supports community initiated and community-based projects that apply principles of health promotion, disease prevention, and the benefits of coordinated health care to the provision of services that improve access to comprehensive, community-based, family-centered, culturally/linguistically competent, and coordinated care. Healthy Tomorrows projects are required to incorporate

Training 01 PERFORMANCE MEASURE **Goal: Family/ Youth/ Community Engagement in MCH Training and Healthy Tomorrows Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB training and Healthy Tomorrows programs that ensure family, youth, and community member participation in program and policy activities.

family members/youth/community members as project staff, advisors, volunteers, and partners.

DATA COLLECTION FORM FOR DETAIL SHEET: Training 01 - Family/ Youth/ Community Engagement in MCH Training and Healthy Tomorrows Programs

Please indicate if your MCH Training or Healthy Tomorrows program has included family members, youth, **and/or** community members in each of the program elements listed below. Use the space provided for notes to provide additional details about activities, as necessary. (NOTE: Programs are only required to have participation from family members **or** youth **or** community members for each element to answer "Yes")

Element	No	Yes
Participatory Planning Family members/youth/community members participate in and provide feedback on the planning, implementation and/or evaluation of the training or Healthy Tomorrows program's activities (e.g. strategic planning, program planning, materials development, program activities, and performance measure reporting).		
Cultural Diversity Culturally diverse family members/youth/community members facilitate the training or Healthy Tomorrows program's ability to meet the needs of the populations served.		
Leadership Opportunities Within your training or Healthy Tomorrows program, family members/youth/community members are offered training, mentoring, and/or opportunities for leadership roles on advisory committees or task forces.		
Compensation Family members/youth/community members who participate in the MCH Training or Healthy Tomorrows program are paid faculty, staff, consultants, or compensated for their time and expenses.		
Train MCH/CSHCN staff Family members/youth/community members work with their training or Healthy Tomorrows program to provide training (pre-service, in-service and professional development) to MCH/CSHCN faculty/staff, students/trainees, and/or providers.		

NOTES/COMMENTS:

Training 02 PERFORMANCE MEASURE **Goal: Cultural Competence in MCH Training and Healthy Tomorrows Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB training and Healthy Tomorrows programs that have incorporated cultural and linguistic competence elements into their policies, guidelines, and training.
GOAL	To increase the percentage of MCH Training and Healthy Tomorrows programs that have integrated cultural and linguistic competence into their policies, guidelines, and training.
MEASURE	The percent of MCHB training and Healthy Tomorrows programs that have integrated cultural and linguistic competence into their policies, guidelines, and training.
DEFINITIONS	Attached is a checklist of 6 elements that demonstrate cultural and linguistic competency. Please check yes or no to indicate if your MCH Training or Healthy Tomorrows program has met each element. 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; cited from National Center for Cultural Competence (http://nccc.georgeto wn.edu/foundations/frameworks.html)
DEFINITIONS (cont…)	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

Training 02 PERFORMANCE MEASURE **Goal: Cultural Competence in MCH Training and Healthy Tomorrows Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB training and Healthy Tomorrows programs that have incorporated cultural and linguistic competence elements into their policies, guidelines, and training.
	efforts; research data on populations served according to racial, ethnic, and linguistic groupings; 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.
BENCHMARK DATA SOURCES	Related to the following HP2020 Objectives: 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 PHI-12: Increase the proportion of public health laboratory systems (including State, Tribal, and local) which perform at a high level of quality in support of the 10 Essential Public Health Services ECBP-11: Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs
GRANTEE DATA SOURCES	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, 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 Division of MCH Workforce Development strategic plan; and (2) in guidance materials related to the MCH Training and Healthy Tomorrows Programs. The Division of MCH Workforce Development provides support to programs that address cultural and linguistic competence through development of curricula, research, learning and practice environments

DATA COLLECTION FORM FOR DETAIL SHEET: Training 02 – Cultural Competence in MCH Training and Healthy Tomorrows Programs

Please indicate if your MCH Training or Healthy Tomorrows program has incorporated the following cultural/linguistic competence elements into your policies, guidelines, and training.
Please use the space provided for notes to provide additional details about the elements, as applicable.

Element	Yes 1	No 0
1. **Written Guidelines** Strategies for advancing cultural and linguistic competency are integrated into your training or Healthy Tomorrows program's written plan(s) (e.g., grant application, recruiting plan, placement procedures, monitoring and evaluation plan, human resources, formal agreements, etc.).		
2. **Training** Cultural and linguistic competence knowledge and skills building are included in training aspects of your program.		
3. **Data** Research or program information gathering includes the collection and analysis of data on populations served according to racial, ethnic, and linguistic groupings, where appropriate.		
4. **Staff/faculty diversity** MCH Training Program or Healthy Tomorrows staff and faculty reflect cultural and linguistic diversity of the significant populations served.		
5. **Professional development** MCH Training Program or Healthy Tomorrows staff and faculty participate in professional development activities to promote their cultural and linguistic competence.		
6. **Measure progress Measurement of Progress** A process is in place to assess the progress of MCH Training program or Healthy Tomorrows participants in developing cultural and linguistic competence.		

NOTES/COMMENTS*:*

Training 03 PERFORMANCE MEASURE **Goal: Healthy Tomorrow's Partnership** **Level: Grantee** **Domain: MCH Workforce Development**	The degree to which the Healthy Tomorrows Partnership for Children program collaborates with State Title V agencies, other MCH or MCH-related programs.
GOAL	To assure that the Healthy Tomorrows program has collaborative interactions related to professional development, policy development and product development and dissemination with relevant national, state and local MCH programs, agencies and organizations.
MEASURE	The degree to which a Healthy Tomorrows program collaborates with State Title V agencies, other MCH or MCH-related programs and other professional organizations.
DEFINITION	Attached is a list of the 7 elements that describe activities carried out by Healthy Tomorrows programs for or in collaboration with State Title V and other agencies on a scale of 0 to 1 (0=no; 1=yes). If a value of '1' (yes) 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.'
BENCHMARK DATA SOURCES	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 … ECPB-2: Increase the proportion of elementary, middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems. 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 in D.O.-granting medical schools. ECBP-15: Increase the inclusion of core clinical prevention and population health content in in nurse practitioner training. ECBP-17: Increase the inclusion of core clinical prevention and population health content in in Doctor of Pharmacy (PharmD) granting colleges and schools of pharmacy 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
GRANTEE DATA SOURCES	The Healthy Tomorrows program completes the attached table which describes the categories of collaborative activity.

Training 03 PERFORMANCE MEASURE **Goal: Healthy Tomorrow's Partnership** **Level: Grantee** **Domain: MCH Workforce Development**	The degree to which the Healthy Tomorrows Partnership for Children program collaborates with State Title V agencies, other MCH or MCH-related programs.
SIGNIFICANCE	As a SPRANS grantee, 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 Healthy Tomorrows 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 Healthy People 2020 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) internally use this data to assure a full scope of these program elements in all regions.

DATA COLLECTION FORM FOR DETAIL SHEET: Training 03 – Healthy Tomorrows Partnership

Indicate the degree to which the Healthy Tomorrows program collaborates with State Title V (MCH Block Grant) agencies and other MCH-related programs***** using the following values:
0= Does not collaborate on this element 1= Does collaborate on this element.

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

	State Title V Agencies[1]			**Other MCH-related programs[2]**		
Element	0	1	Total number of activities	0	1	Total number of activities
1. **Advisory Committee** Examples might include: having representation from State Title V or other MCH program on your advisory committee						
2. **Professional Development & Training** Examples might include: collaborating with state Title V agency to develop state training activity						
3. **Policy Development** Examples might include: working with State Title V agency to develop and pass legislation						
4. **Research, Evaluation, and Quality Improvement** Examples might include: working with MCH partners on quality improvement efforts						
5. **Product Development** Examples might include: participating on collaborative with MCH partners to develop community materials						
6. **Dissemination** Examples might include: disseminating information on program implementation to local MCH partners						
7. **Sustainability** Examples might include: working with state and local MCH representatives to develop sustainability plans						
Total						

[1]State Title V programs include State Block Grant funded or supported activities.
[2]Other maternal and child health-related programs (both MCHB-funded and funded from other sources) include, but are not limited to:

- State Health Department
- State Adolescent Health
- Social Service Agency
- Medicaid Agency
- Education
- Juvenile Justice
- Early Intervention
- Home Visiting
- Professional Organizations/Associations
- Family and/or Consumer Group
- Foundations
- Clinical Program/Hospitals
- Local and state division of mental health
- Developmental disability agencies
- Other programs working with maternal and child health populations

Training 04 PERFORMANCE MEASURE **Goal: Collaborative Interactions** **Level: Grantee** **Domain: MCH Workforce Development**	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.'
BENCHMARK DATA SOURCES	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. ECPB-2: Increase the proportion of elementary, middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems. 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 in D.O.-granting medical schools. ECBP-15: Increase the inclusion of core clinical prevention and population health content in in nurse practitioner training. ECBP-17: Increase the inclusion of core clinical prevention and population health content in in Doctor of Pharmacy (PharmD) granting colleges and schools of pharmacy 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
GRANTEE DATA SOURCES	The training program completes the attached table which describes the categories of collaborative activity.
SIGNIFICANCE	As a SPRANS grantee, 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

Training 04 PERFORMANCE MEASURE **Goal: Collaborative Interactions** **Level: Grantee** **Domain: MCH Workforce Development**	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs.

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 MCHB Strategic Goals;
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; and
3) internally use this data to assure a full scope of these program elements in all regions.

DATA COLLECTION FORM FOR DETAIL SHEET PM #Training 04 – Collaborative Interactions

Indicate the degree to which your training program collaborates with State Title V (MCH Block Grant) agencies and other MCH-related programs***** using the following values:
0= Does not collaborate on this element 1= Does collaborate on this element.
If your program does collaborate, provide the total number of activities for the element.

Element	**State Title V programs[1]**			**Other MCH-related programs[2]**		
	0	1	Total number of activities	0	1	Total number of activities
Service* Examples might include: Clinics run by the training program and/ or in collaboration with other agencies						
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.						
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.						
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.						
Product Development Examples might include: Collaborative development of journal articles and training or informational videos.						
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						

[1]State Title V programs include State Block Grant funded or supported activities.
[2]Other maternal and child health-related programs (both MCHB-funded and funded from other sources) include, but are not limited to:

- State Health Department
- State Adolescent Health
- Social Service Agency
- Medicaid Agency
- Education
- Juvenile Justice
- Early Intervention
- Home Visiting
- Professional Organizations/Associations
- Family and/or Consumer Group
- Foundations
- Clinical Program/Hospitals
- Local and state division of mental health
- Developmental disability agencies
- Other programs working with maternal and child health populations

*Ongoing collaborations with clinical locations should be counted as one activity (For example: multiple trainees rotate through the same community-based clinical site over the course of the year. This should be counted as one activity.)

Training 05 PERFORMANCE MEASURE **Goal: Policy Development** **Level: Grantee** **Domain: MCH Workforce Development**	The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.
GOAL	To increase the number of MCH 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 MCH long-term training grantees engage in policy development, implementation, and evaluation.
DEFINITION	Attached is a list of six elements that demonstrate policy engagement. Please check yes or no to indicate which the elements have been implemented. 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.
BENCHMARK DATA SOURCES	Related to 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.
GRANTEE DATA SOURCES	• 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 list 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 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 4 of the Division of MCH Workforce Development Strategic Plan to “generate and translate new knowledge for the MCH field in order to advance science-based practice, innovation, and quality improvement in MCH training, policies and programs.”

DATA COLLECTION FORM FOR DETAIL SHEET: Training 05 - Policy Development

Using a response of Yes (1) or No (0), indicate whether your training program has addressed the following policy training and policy participation elements.

CATEGORY #1: Training on Policy and Advocacy

Element	No 0	Yes 1
1. Your MCHB-funded Training Program provides didactic opportunities for training on policy development and advocacy to increase understanding of how the policy process works at the federal, state and/or local levels.		
2. Your MCHB-funded Training Program provides an opportunity for application of policy and advocacy knowledge through one or more of the following educational experiences **If Yes, check all that apply:** ☐ Write a policy brief about an emerging local MCH public health issue ☐ Attend a meeting of a local MCH stakeholder group, provide a written summary of their approach ☐ Attend a professional association meeting and actively participate on a committee ☐ Educate Policymakers ☐ Provide written and/or oral testimony to the state legislature ☐ Write an article on an MCH topic for a lay audience ☐ Observe a legislative hearing on CSPAN, or if possible, attend a legislative hearing on an MCH topic ☐ Track a bill over the Internet over the course of a legislative session ☐ Interview an agency or organization-based MCH policy maker, administrator, or advocate and prepare written and/or oral mock testimony from the perspective of the agency/association interviewed ☐ Other, please describe _____		
3. A pre/post assessment is in place to measure increased policy knowledge and skills of **long-term** trainees (NOTE: Long-term trainees are defined as those who have completed a long-term [greater than or equal to 300 contact hours] MCH Training Program, including those who received funds and those who did not). If Yes, report: a. % of current trainees reporting increased policy knowledge _____ b. % of current trainees reporting increased policy skills _____		

CATEGORY #2: Participation in Policy Change and Translation of Research into Policy

Element	No 0	Yes 1
4. Trainees, faculty and/or staff contribute to the development of guidelines, regulation, legislation **or** other public policy at the local, state, and/or national level. If yes, indicate all policy arenas to which they have contributed: ☐ Local ☐ State ☐ National		
5. Trainees, faculty and/or staff participate in local, state and/or national MCH advocacy networks and initiatives If yes, indicate all policy arenas to which they have contributed : ☐ Local ☐ State ☐ National		
6. Trainees, faculty and/or staff participate in disseminating and communicating research findings (both original and non-original) directly to public health agency leaders and/or policy officials. If yes, indicate all policy arenas to which they have contributed: ☐ Local ☐ State ☐ National		

Training 06 Performance Measure **Goal: Long Term Training Programs** **Level: Grantee** **Domain: MCH Workforce Development**	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.
BENCHMARK DATA SOURCES	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
GRANTEE DATA SOURCES	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: Training 06 – Long Term Training Programs

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 trainees 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:

Training 07 PERFORMANCE MEASURE **Goal: MCH Pipeline Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB Pipeline Program graduates who have been engaged in work focused on MCH populations.
GOAL	To increase the percent of graduates of MCH Pipeline Programs who have been/are engaged in work focused on MCH populations.
MEASURE	The percent of MCHB Pipeline Program graduates who have been engaged in work focused on MCH populations since graduating from the MCH Pipeline Training Program.
DEFINITION	**Numerator**: Number of pipeline graduates reporting they have been engaged in work focused on MCH populations since graduating from the MCH Pipeline Training Program. **Denominator**: The total number of trainees responding to the survey **Units:** 100 **Text:** Percent MCH Pipeline trainees are defined as undergraduate students from economically and educationally disadvantaged backgrounds (including underrepresented racial and ethnic minorities: African American, Hispanic/Latino, Asian, Hawaiian/Pacific Islanders, American Indian/Alaskan) who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related fields **MCH Populations**: Includes women, infants and children, adolescents, young adults, and their families including fathers, and children and youth with special health care needs
BENCHMARK DATA SOURCES	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

Training 07 PERFORMANCE MEASURE **Goal: MCH Pipeline Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB Pipeline Program graduates who have been engaged in work focused on MCH populations.
GRANTEE DATA SOURCES	A pipeline program follow-up survey 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 FOR DETAIL SHEET: Training 07 - MCH Pipeline Program

MCH Pipeline Program graduates who report working with **the maternal and child health population** (i.e., women, infants, children, adolescents, young adults, and their families, including and children with special health care needs) 2 years and 5 years after graduating from their MCH Pipeline program.

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

2 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

A. The total number of graduates, 2 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 since graduating from the MCH Pipeline Training Program _____

E. Percent of respondents who report working with an MCH population Since graduating from the MCH Pipeline Training Program _____

5 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

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 since graduating from the MCH Pipeline Training Program _____

E. Percent of respondents who report working with an MCH population since graduating from the MCH Pipeline Training Program _____

Training 08 PERFORMANCE MEASURE **Goal: MCH Pipeline Program** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCH Pipeline Program graduates who have been engaged in work with populations considered to be underserved or vulnerable.
GOAL	To increase the percent of graduates of MCH Pipeline Programs who have been engaged in work with populations considered to be underserved or vulnerable.
MEASURE	The percent of MCH Pipeline Program graduates who have been engaged in work with populations considered to be underserved or vulnerable since graduating from the MCH Pipeline Training Program.
DEFINITION	**Numerator:** Number of pipeline graduates reporting they have been engaged in work with populations considered underserved or vulnerable since graduating from the MCH Pipeline Training Program. **Denominator**: The total number of trainees responding to the survey **Units**: 100 **Text**: Percent
DEFINITION (cont…)	MCH Pipeline trainees are defined as undergraduate students from economically and educationally disadvantaged backgrounds (including underrepresented racial and ethnic minorities: African American, Hispanic/Latino, Asian, Hawaiian/Pacific Islanders, American Indian/Alaskan) who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related fields The term “underserved” refers to “Medically Underserved Areas and Medically Underserved Populations with shortages of primary medical care, dental or mental health providers. Populations may be defined by geographic (a county or service area) or demographic (low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services) factors. The term "vulnerable groups," refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. (i.e, Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, etc) *Source: Center for Vulnerable Populations Research. UCLA.* *http://www.nursing.ucla.edu/orgs/cvpr/who-are-vulnerable.html*

Training 08 PERFORMANCE MEASURE **Goal: MCH Pipeline Program** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCH Pipeline Program graduates who have been engaged in work with populations considered to be underserved or vulnerable.
BENCHMARK DATA SOURCES	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
GRANTEE DATA SOURCES	A pipeline program follow-up survey 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 FOR DETAIL SHEET: Training 08 - MCH Pipeline Program

MCH Pipeline Program graduates who have worked with populations considered **underserved or vulnerable** 2 years and 5 years after graduating from their MCH Pipeline program.

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

2 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

A. The total number of graduates, 2 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 have worked with populations considered to be underserved or vulnerable since graduating from the MCH Pipeline Training Program _____

E. Percent of respondents who have worked with populations considered to be underserved or vulnerable since graduating from the MCH Pipeline Training Program _____

5 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

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 have worked with populations considered to be underserved or vulnerable since graduating from the MCH Pipeline Training Program _____

E. Percent of respondents who have worked with populations considered to be underserved or vulnerable since graduating from the MCH Pipeline Training Program _____

Training 09 PERFORMANCE MEASURE **Goal: Graduate Program Enrollment** **Level: Grantee** **Domain: MCH Workforce Development**	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 trainees enrolled in or who have completed a graduate school program* preparing them to work with the MCH population, 2 or 5 years after graduating from 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 Trainees who graduated from the MCH pipeline program 2 or 5 years previously.
BENCHMARK DATA SOURCES	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
GRANTEE DATA SOURCES	Attached data collection form to be completed by grantees.
SIGNIFICANCE	MCHB training programs assist in developing a public health workforce that addresses key MCH issues and fosters field leadership in the MCH arena.

DATA COLLECTION FORM FOR DETAIL SHEET: Training 09 – Graduate Program Enrollment

2 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

A. The total number of Pipeline Trainees, 2 years following graduation from the program _____

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

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

D. Number of respondents that are enrolled in or have completed graduate Programs preparing them work with the MCH population** _____

E. Percent of respondents that are enrolled in or have completed graduate Programs preparing them work with the MCH population _____

5 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

A. The total number of Pipeline Trainees, 5 years following graduation from the program _____

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

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

D. Number of respondents that are enrolled in or have completed graduate Programs preparing them work with the MCH population** _____

E. Percent of respondents that are enrolled in or have completed 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.

Training 10 PERFORMANCE MEASURE **Goal: Field Leadership** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of long term trainees that have demonstrated field leadership after completing an MCH training program.
GOAL	To increase the percentage of long term trainees that have demonstrated field leadership two and five years after completing their MCH Training Program.
MEASURE	The percentage of long-term trainees that have demonstrated field leadership after completing an MCH Training Program.
DEFINITION	Attached is a checklist of four elements that demonstrate field leadership. For each element, identify the number of long-term trainees that have demonstrated field leadership two and five years after program completion. Please keep the completed checklist attached. Long-term trainees are defined as those who have completed a long-term (greater than or equal to 300 contact hours) MCH training program, including those who received MCH funds and those who did not. "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 have completed an MCHB-funded training program 2 years and 5 years prior to the reporting period. Data form for each cohort year will be collected for five years.
BENCHMARK DATA SOURCES	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
GRANTEE DATA SOURCES	Attached data collection form to be completed by grantees.

Training 10 PERFORMANCE MEASURE **Goal: Field Leadership** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of long term trainees that have demonstrated field leadership after completing an MCH training program.
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: Training 10 – Field Leadership

SECTION A: 2 YEAR FOLLOW-UP

Numerator: The number of long-term trainees who have demonstrated field leadership **2 years** after completing their MCH Training Program.

Denominator: The total number of long-term trainees, **2 years** following completion of an MCHB-funded training program, included in this report.

Long-term trainees are defined as those who have completed a long-term (greater than or equal to 300 contact hours) MCH training program, including those who received MCH funds and those who did not.

A. The total number of long-term trainees, **2 years** post program completion, included in this report _____

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

C. Number of respondents (A-B) _____

D. Number of respondents who have demonstrated field leadership in **at least** one of the following areas below _____

E. Percent of long-term trainees (**2 years** post program completion) who have demonstrated field leadership in **at least one** of the following areas: _____

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

1. Number of trainees that have participated in **academic** leadership activities since completing their MCH Training Program _____
   - 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 since completing their MCH Training Program _____
   - 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 since completing their MCH Training Program _____

   - 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, provided testimony, educated policymakers, etc.)

4. Number of trainees that have participated in **public policy & advocacy** leadership activities since completing their MCH Training Program _____

- 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, commentaries, and chapters)

SECTION B: 5 YEAR FOLLOW-UP

Numerator: The number of long-term trainees who have demonstrated field leadership 5 years after completing their MCH Training Program.
Denominator: The total number of long-term trainees, 5 years following completion of an MCHB-funded training program, included in this report.

Long-term trainees are defined as those who have completed a long-term (greater than or equal to 300 contact hours) MCH training program, including those who received MCH funds and those who did not.

F. The total number of long-term trainees, **5 years** post program completion, included in this report _____
G. The total number of program completers lost to follow-up _____
H. Number of respondents (A-B)
I. Number of respondents who have demonstrated field leadership in **at least** one of the following areas below _____
J. Percent of long-term trainees (**5 years** post program completion) who have demonstrated field leadership in **at least one** of the following areas: _____

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

1. **Number of trainees that have participated in** academic **leadership activities** since completing their MCH Training Program _____

- 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** since _____

completing their MCH Training Program

- 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** since completing their MCH Training Program _____

- 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, provided testimony, educated policymakers , etc.)

4. **Number of trainees that have participated in** public policy & advocacy **leadership activities** since completing their MCH Training Program _____

- 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, commentaries, and chapters)

NOTES/COMMENTS:

Training 11 PERFORMANCE MEASURE **Goal: Long-term trainees working with MCH populations** **Level: Grantee** **Domain: MCH Workforce Development**	The percentage of long-term trainees who are engaged in work focused on MCH populations after completing their MCH Training Program.
GOAL	To increase the percent of long-term trainees engaged in work focused on MCH populations two and five years after completing their MCH Training Program.
MEASURE	The percentage of long-term trainees who are engaged in work focused on MCH populations after completing their MCH Training Program.
DEFINITION	**Numerator:** Number of long-term trainees reporting they are engaged in work focused on MCH populations after completing their MCH Training Program. **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) MCH Training Program, including those who received MCH funds and those who did not. Cohort is defined as those who have completed an MCHB-funded training program 2 years and 5 years prior to the reporting period. MCH Populations: Includes all of the Nation's women, infants, children, adolescents, young adults and their families, including and children with special health care needs.
BENCHMARK DATA SOURCES	Related to ECBP-10 Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services… Related to 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. Related to PHI-1Increase the proportion of Federal, Tribal, State, and local public health agencies that incorporate Core Competencies for Public Health Professionals into job descriptions and performance

Training 11 PERFORMANCE MEASURE **Goal: Long-term trainees working with MCH populations** **Level: Grantee** **Domain: MCH Workforce Development**	The percentage of long-term trainees who are engaged in work focused on MCH populations after completing their MCH Training Program.
GRANTEE DATA SOURCES	A revised trainee follow-up survey that incorporates the new form for collecting data on the involvement of those completing an MCH training program 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 FOR DETAIL SHEET: Training 11 - Long-term trainees working with MCH populations

Individuals completing a long-term training program who report working with the **maternal and child health population** (i.e., women, infants, children, adolescents, young adults and their families, including children with special health care needs) at 2 years and at 5 years after completing their training program.

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

2 YEAR FOLLOW-UP ☐

A. The total number of long-term trainees, **2 years** following program completion _____

B. The total number of long-term trainees lost to follow-up (**2 years** following program completion) _____

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

D. Number of respondents **2 years** following completion of program who report working with an MCH population _____

E. Percent of respondents **2 years** following completion of program who report working with an MCH population _____

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5 YEAR FOLLOW-UP ☐

F. The total number of long-term trainees, **5 years** following program completion _____

G. The total number of long-term trainees lost to follow-up (**5 years** following program completion), _____

H. The total number of respondents (F-G) = denominator _____

I. Number of respondents **5 years** following completion of program who report working with an MCH population _____

J. Percent of respondents **5 years** following completion of program who report working with an MCH population _____

Training 12 PERFORMANCE MEASURE **Goal: Long-term Trainees** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of long-term trainees who, at 2, 5 and 10 years post training, have worked 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 2, 5 and 10 years post training have worked in an interdisciplinary manner to serve the MCH population.
DEFINITION	**Numerator:** The number of long-term trainees indicating that they have worked in an interdisciplinary manner serving the MCH population. **Denominator:** The total number of long-term trainees responding to the survey **Units:** 100 **Text:** Percent In addition, data on the total number of the long-term 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) MCH Training program, including those who received MCH funds and those who did not.
BENCHMARK DATA SOURCES	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
GRANTEE DATA SOURCES	The trainee follow-up survey is used to collect these data.

Training 12 PERFORMANCE MEASURE **Goal: Long-term Trainees** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of long-term trainees who, at 2, 5 and 10 years post training, have worked in an interdisciplinary manner to serve the MCH population (e.g., individuals with disabilities and their families, adolescents and their families, etc.).
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/practice. 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.

DATA COLLECTION FORM FOR DETAIL SHEET: Training 12 – Long-term Trainees

A. 2 YEAR FOLLOW-UP

Numerator: The number of long-term trainees who have worked in an interdisciplinary manner **2 years** following completion of an MCHB-funded training program, demonstrating at least one of the interdisciplinary skills listed.

Denominator: The total number of long-term trainees, **2 years** following completion of an MCHB-funded training program, responding to the survey

The total number of long-term trainees, **2 years** following program completion _____

The total number of program completers lost to follow-up _____

Number of respondents (Denominator) _____

The number of long-term trainees who have worked in an interdisciplinary manner **2 years** following completion of an MCHB-funded training program, demonstrating at least one of the interdisciplinary skills listed _____

The total number of program completers lost to follow-up

Percent of long-term trainees (**2 years** post program completion) who have worked in an interdisciplinary manner, demonstrating **at least one** of the following interdisciplinary skills: _____%

Sought input or information from other professions or disciplines to address a need in your work _____%

Provided input or information to other professions or disciplines. _____%

Developed a shared vision, roles and responsibilities within an interdisciplinary group. _____%

Utilized that information to develop a coordinated, prioritized plan across disciplines to address a need in your work _____%

Established decision-making procedures in an interdisciplinary group. _____%

Collaborated with various disciplines across agencies/entities? _____%

Advanced policies & programs that promote collaboration with other disciplines or professions _____%

B. 5 YEAR FOLLOW-UP

Numerator: The number of long-term trainees who have worked in an interdisciplinary manner **5** years following completion of an MCHB-funded training program, demonstrating at least one of the interdisciplinary skills listed.

Denominator: The total number of long-term trainees**, 5 years** following completion of an MCHB-funded training program, responding to the survey.

The total number of long-term trainees, **5 years** following program completion _____

The total number of program completers lost to follow-up _____

The number of long-term trainees who have worked in an interdisciplinary manner 5 **years** following completion of an MCHB-funded training program, demonstrating at least one of the interdisciplinary skills listed _____

Percent of long-term trainees (**5 years** post program completion) who have worked in an interdisciplinary manner, demonstrating **at least one** of the following interdisciplinary skills: _____%

- **Sought input** or information from other professions or disciplines to address a need in your work _____%
- **Provided input** or information to other professions or disciplines. _____%
- **Developed a shared vision**, roles and responsibilities within an interdisciplinary group. _____%
- **Utilized that information** to develop a coordinated, prioritized plan across disciplines to address a need in your work _____%
- **Established decision-making** procedures in an interdisciplinary group. _____%
- **Collaborated** with various disciplines across agencies/entities? _____%
- **Advanced policies & programs** that promote collaboration with other disciplines or professions _____%

C. 10 YEAR FOLLOW-UP

Numerator: The number of long-term trainees who have worked in an interdisciplinary manner **10 years** following completion of an MCHB-funded training program, demonstrating at least one of the interdisciplinary skills listed.

Denominator: The total number of long-term trainees, **10 years** following completion of an MCHB-funded training program, responding to the survey.

The total number of long-term trainees, **10 years** following program completion _____

_____

The total number of program completers lost to follow-up

Percent of long-term trainees (**10 years** post program completion) who have worked in an interdisciplinary manner, demonstrating **at least one** of the following interdisciplinary skills: _____%

- **Sought input** or information from other professions or disciplines to address a need in your work _____%
- **Provided input** or information to other professions or disciplines. _____%
- **Developed a shared vision**, roles and responsibilities within an interdisciplinary group. _____%
- **Utilized that information** to develop a coordinated, prioritized plan across disciplines to address a need in your work _____%
- **Established decision-making** procedures in an interdisciplinary group. _____%
- **Collaborated** with various disciplines across agencies/entities? _____%
- **Advanced policies & programs** that promote collaboration with other disciplines or professions _____%

Training 13 PERFORMANCE MEASURE **Goal: Diverse Adolescent Involvement** **Level: Grantee** **Domain: MCH Workforce Development**	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.
BENCHMARK DATA SOURCES	Related to Objective HC/HIT-2: Increase the proportion of persons who report that their health care providers have satisfactory communication skills.
GRANTEE DATA SOURCES	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: Training 13 – Adolescent Involvement

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 = No 1 = Yes

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) _____

Training 14 PERFORMANCE MEASURE **Goal: Medium-Term Trainees Skill and Knowledge** **Level: Grantee** **Domain: MCH Workforce Development**	The percentage of Level I medium term trainees who report an increase in knowledge and the percentage of Level II medium term trainees who report an increase in knowledge or skills related to MCH core competencies .
GOAL	To increase the percentage of medium term trainees (MTT) who report increased knowledge or skills related to MCH core competencies.
MEASURE	The percentage of Level I medium term trainees who report an increase in knowledge and the percentage of Level II medium term trainees who report an increase in knowledge or skills related to MCH core competencies.
DEFINITION	**Numerator:** The number of Level I medium term trainees who report an increase in knowledge and Level II medium term trainees who report an increase in knowledge or skills related to MCH core competencies. **Denominator:** The total number of medium term trainees responding to the survey. Medium Term trainees: Level I MTT complete 40-149 hours of training. Level II MTT complete 150–299 hours of training.
BENCHMARK DATA SOURCES	MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems. ECBP-19: Increase the proportion of academic institutions with health professions education programs whose prevention curricula include interprofessional educational experiences. ECBP-12.2: Increase the inclusion of cultural diversity content in M.D.-granting medical schools. ECBP-13.2: Increase the inclusion of cultural diversity content in D.O.-granting medical schools. ECBP-15.2: Increase the inclusion of cultural diversity content in nurse practitioner training. ECBP-17.2: Increase the inclusion of cultural diversity content in Doctor of Pharmacy (PharmD) granting colleges and schools of pharmacy.
GRANTEE DATA SOURCES	End of training survey is used to collect these data.
SIGNIFICANCE	Medium Term trainees comprise a significant proportion of training efforts. These trainees impact the provision of care to CYSHCN nationally. The impact of this training must be measured and evaluated.

DATA COLLECTION FORM FOR DETAIL SHEET: Training 14 – Medium-Term Trainees Skill and Knowledge

Level I Medium Term Trainees - Knowledge

A. The total number of Level I Medium-Term Trainees (40-149 hours) _____
B. The total number of Level I MTT lost to follow-up _____
C. The total number of respondents (A-B) _____
D. Number of respondents reporting increased knowledge _____
E. Percentage of respondents reporting increased knowledge _____

Level II Medium Term Trainees – Knowledge:

A. The total number of Level II Medium-Term Trainees (150-299 hours) _____
B. The total number of Level II MTT lost to follow-up _____
C. The total number of respondents (A-B) _____
D. Number of respondents reporting increased knowledge _____
E. Percentage of respondents reporting increased knowledge _____

Level II Medium Term Trainees - Skills :

A. The total number of Level II Medium-Term Trainees (150-299 hours) _____
B. The total number of Level II MTT lost to follow-up _____
C. The total number of respondents (A-B) _____
D. Number of respondents reporting increased skills _____
E. Percentage of respondents reporting increased skills _____

DIVISION OF CHILD ADOLESCENT, AND FAMILY HEALTH

Emergency Medical Services for Children Program
PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

Performance Measure	New/Revised Measure	Prior PM Number (if applicable)	Topic
EMSC 01	New	N/A	Using NEMSIS Data to Identify Pediatric Patient Care Needs.
EMSC 02	New	N/A	Pediatric Emergency Care Coordination
EMSC 03	New	N/A	Use of pediatric-specific equipment
EMSC 04	Unchanged	74	Pediatric medical emergencies
EMSC 05	Unchanged	75	Pediatric traumatic emergencies
EMSC 06	Unchanged	76	Written inter-facility transfer guidelines that contain all the components as per the implementation manual.
EMSC 07	Unchanged	77	Written inter-facility transfer agreements that covers pediatric patients.
EMSC 08	Unchanged	79	Established permanence of EMSC
EMSC 09	Updated	80	Established permanence of EMSC by integrating EMSC priorities into statutes/regulations.

EMSC 01 PERFORMANCE MEASURE **Edited for clarity and based on additional feedback** **Goal: Submission of NEMSIS compliant version 3.x or higher data** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The degree to which EMS agencies submit NEMSIS compliant version 3.x of higher data to the State EMS Office.
GOAL	By 2018, baseline data will be available to assess the number of EMS agencies in the state/territory that submit National Emergency Medical Services Information System (NEMSIS) version 3.X or higher compliant patient care data to the State Emergency Medical Services (EMS) Office for all 911 initiated EMS activations. By 2021, 80% of EMS agencies in the state/territory submit NEMSIS version compliant patient care data to the State EMS Office for all 911 initiated EMS activations.
MEASURE	The degree to which EMS agencies submit NEMSIS compliant version 3.X or higher data to the State EMS Office.
DEFINITION	**Numerator:** The number of EMS agencies in the state/territory that submit NEMSIS version 3.X or higher compliant patient care data to the State Emergency Medical Services Office. **Denominator:** Total number of EMS agencies in the state/territory actively responding to 911 requests for assistance. **Units**: 100 **Text**: Percent **EMS:** Emergency Medical Services **EMS Agency**: A prehospital provider agency. An EMS agency is defined as an organization staffed with personnel who are actively rendering medical care in response to a 911 or similar emergency call. Data will be gathered from State EMS Offices for both transporting and non-transporting agencies (excludes air- and water-only EMS services). **NEMSIS**: National EMS Information System. NEMSIS is the national repository that is used to store EMS data from every state in the nation. **NEMSIS Version 3.X or higher compliant patient care data: A national set of standardized data elements collected by EMS agencies.** **NEMSIS Technical Assistance Center (TAC**): The NEMSIS TAC is the resource center for the NEMSIS project. The NEMSIS TAC provides assistance states, territories, and local EMS agencies, creates reference documents, maintains the NEMSIS database and XML schemas, and creates compliance policies. NHTSA – **National Highway Traffic Safety Administration**
HRSA STRATEGIC OBJECTIVE	Improve Access to Quality Health Care and Services by

EMSC 01 PERFORMANCE MEASURE **Edited for clarity and based on additional feedback** **Goal: Submission of NEMSIS compliant version 3.x or higher data** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The degree to which EMS agencies submit NEMSIS compliant version 3.x of higher data to the State EMS Office.
	strengthening health systems to support the delivery of quality health services. Improve Health Equity by monitoring, identifying, and advancing evidence-based and promising practices to achieve health equity.
GRANTEE DATA SOURCES	State EMS Offices
SIGNIFICANCE	Access to quality data and effective data management play an important role in improving the performance of an organization's health care systems. Collecting, analyzing, interpreting, and acting on data for specific performance measures allows health care professionals to identify where systems are falling short, to make corrective adjustments, and to track outcomes. However, uniform data collection is needed to consistently evaluate systems and develop Quality Improvement programs. The NEMSIS operated by the National Highway Traffic Safety Administration, provides a basic platform for states and territories to collect and report patient care data in a uniform manner. NEMSIS enables both state and national EMS systems to evaluate their current prehospital delivery. As a first step toward Quality Improvement (QI) in pediatric emergency medical and trauma care, the EMSC Program seeks to first understand the proportion of EMS agencies reporting to the state EMS office NEMSIS version 3.X or higher compliant data, then use that information to identify pediatric patient care needs and promote its full use at the EMS agency level. In the next few years, NEMSIS will enable states and territories to evaluate patient outcomes and as a result, the next phase will employ full utilization of NEMSIS data on specific measures of pediatric data utilization. This will include implementing pediatric-specific EMS Compass measures in states, publishing results, publishing research using statewide EMS kids data, linking EMS data, providing performance information back to agencies, and building education programs around pediatric data, etc. This measure also aligns with the Healthy People 2020 objective PREP-19: Increase the number of states reporting 90% of emergency medical services (EMS) calls to National EMS Information System (NEMSIS) using the current accepted dataset standard. While most localities collect and most states report NEMSIS version 2.X compliant data currently, NEMSIS version 3.X or higher is available today and in use in several states. Version 3 includes an expanded data set, which significantly increases the information available on critically ill or injured children. NHTSA is encouraging states and localities to upgrade to version 3.X or higher compliant software and submit version 3.X data by January

EMSC 01 PERFORMANCE MEASURE **Edited for clarity and based on additional feedback** **Goal: Submission of NEMSIS compliant version 3.x or higher data** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The degree to which EMS agencies submit NEMSIS compliant version 3.x of higher data to the State EMS Office.

1, 2017.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 01

The percentage of EMS agencies in the state/territory that submit National Emergency Medical Services Information System (NEMSIS) version 3.X or higher compliant patient care data to the State Emergency Medical Services Office for all 911 initiated EMS activations.

State EMS Offices will be asked to select which of six (6) statements best describes their current status. The measure will be determined on a scale of 0-5. The following table shows the scoring rubric for responses. Achievement for grantees will be reached when 80% of EMS agencies are submitting NEMSIS version 3.X or higher compliant patient care data to the State EMS Office. This is represented by a score of "5".

Which statement best describes your current status?	Current Progress
Our State EMS Office has not yet transitioned to NEMSIS compliant version 3.X or higher.	0
Our State EMS Office intends to transition to NEMSIS version 3.X or higher compliant patient care data to submit to NEMSIS TAC by or before 2021.	1
Our State EMS Office submits NEMSIS version 3.X or higher compliant patient care data to NEMSIS TAC with less than 10% of EMS agencies reporting.	2
Our State EMS Office submits NEMSIS version 3.X or higher compliant patient care data to NEMSIS TAC with at least 10% and less than 50% of the EMS agencies reporting.	3
Our State EMS Office submits NEMSIS version 3.X or higher compliant patient care data to NEMSIS TAC with at least 50% and less than 80% of the EMS agencies reporting.	4
Our State EMS Office submits NEMSIS version 3.X or higher compliant patient care data to NEMSIS TAC with at least 80% of the EMS agencies reporting.	5

Numerator: The number of EMS agencies in the state/territory that submit National Emergency Medical Services Information System (NEMSIS) version 3.X or higher compliant patient care data to the State Emergency Medical Services Office for all 911 initiated EMS activations

Denominator: Total number of EMS agencies in the state/territory actively responding to 911 requests for assistance.

Percent:

Proposed Survey Questions:

As part of the HRSA's quest to improve the quality of healthcare, the EMSC Program is interested to hear about current efforts to collect NEMSIS version 3.X or higher compliant patient care data from EMS agencies in the state/territory. The EMSC Program aims to first understand the proportion of EMS agencies that are submitting NEMSIS version 3.X or higher compliant patient care data to the state EMS office.

The NEMSIS Technical Assistance Center will only collect version 3.X or higher compliant data beginning on January 1, 2017.

Which one of the following statements best describes your current status toward submitting NEMSIS version 3.X or higher compliant patient care data to the NEMSIS TAC from currently active EMS agencies in the state/territory**?** (Choose one)

- ☐ Our State EMS Office does not submit patient care data to the NEMSIS Technical Assistance Center (TAC)
- ☐ Our State EMS Office intends to submit patient care data to the NEMSIS Technical Assistance Center (TAC) by or before 2021.
- ☐ Our State EMS Office submits NEMSIS version 3.X or higher compliant patient care data to the NEMSIS Technical Assistance Center (TAC) with less than 10% of EMS agencies reporting.
- ☐ Our State EMS Office submits NEMSIS version 3.X or higher compliant patient care data to the NEMSIS Technical Assistance Center (TAC) with at least 10% and less than 50% of EMS agencies reporting.
- ☐ Our State EMS Office submits NEMSIS version 3.X or higher compliant patient care data to the NEMSIS Technical Assistance Center (TAC) with at least 50% and less than 80% of EMS agencies reporting.
- ☐ Our State EMS Office submits NEMSIS version 3.X or higher compliant patient care data to the NEMSIS Technical Assistance Center (TAC) with at least 80% of EMS agencies reporting.

Annual targets for this measure:

Year	Target
2018	Baseline data
2019	10%
2020	50%
2021	80%

EMSC 02 PERFORMANCE MEASURE **Edited for clarity and based on additional feedback** **Goal: Pediatric Emergency Care Coordination Level: Grantee** **Domain: Emergency Medical Services for Children**	The percentage of EMS agencies in the state/territory that have a designated individual who coordinates pediatric emergency care.
GOAL	By 2020, 30% of EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care. By 2023, 60% of EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care. By 2026, 90% of EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care.
MEASURE	The percentage of EMS agencies in the state/territory that have a designated individual who coordinates pediatric emergency care.
DEFINITION	**Numerator:** The number of EMS agencies in the state/territory that score a '3' on a 0-3 scale. **Denominator:** Total number of EMS agencies in the state/territory that provided data. **Units**: 100 **Text**: Percent Recommended Roles: Job related activities that a designated individual responsible for the coordination of pediatric emergency care might oversee for your EMS agency are: • Ensure that the pediatric perspective is included in the development of EMS protocols • Ensure that fellow EMS providers follow pediatric clinical practice guidelines • Promote pediatric continuing education opportunities • Oversee pediatric process improvement • Ensure the availability of pediatric medications, equipment, and supplies • Promote agency participation in pediatric prevention programs • Promote agency participation in pediatric research efforts • Liaises with the emergency department pediatric emergency care coordinator • Promote family-centered care at the agency **EMS:** Emergency Medical Services **EMS Agency**: An EMS agency is defined as an organization staffed with personnel who render medical care in response to a 911 or similar emergency call. Data will be gathered from both transporting and non-transporting agencies. **IOM:** Institute of Medicine
HRSA STRATEGIC OBJECTIVE	Strengthen the Health Workforce

EMSC 02 PERFORMANCE MEASURE **Edited for clarity and based on additional feedback** **Goal: Pediatric Emergency Care Coordination Level: Grantee** **Domain: Emergency Medical Services for Children**	The percentage of EMS agencies in the state/territory that have a designated individual who coordinates pediatric emergency care.
GRANTEE DATA SOURCES	Survey of EMS agencies
SIGNIFICANCE	The Institute of Medicine (IOM) report "Emergency Care for Children: Growing Pains" (2007) recommends that EMS agencies and emergency departments (EDs) appoint a pediatric emergency care coordinator to provide pediatric leadership for the organization. This individual need not be dedicated solely to this role and could be personnel already in place with a special interest in children who assumes this role as part of their existing duties. Gausche-Hill et al in a national study of EDs found that the presence of a physician or nurse pediatric emergency care coordinator was associated with an ED being more prepared to care for children. EDs with a coordinator were more likely to report having important policies in place and a quality improvement plan that addressed the needs of children than EDs that reported not having a coordinator. The IOM report further states that pediatric coordinators are necessary to advocate for improved competencies and the availability of resources for pediatric patients. The presence of an individual who coordinates pediatric emergency care at EMS agencies may result in ensuring that the agency and its providers are more prepared to care for ill and injured children. The individual designated as the Pediatric Emergency Care Coordinator (PECC) may be a member of the EMS agency or that individual could serve as the PECC for one of more individual EMS agencies within the county or region.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 02

The percentage of EMS agencies in the state/territory that have a designated individual who coordinates pediatric emergency care.

Numerator: The number of EMS agencies in the state/territory that score a '3' on a 0-3 scale.	
Denominator: Total number of EMS agencies in the state/territory that provided data.	
Percent:	

EMS agencies will be asked to select which of four statements best describes their agency. The measure will be determined on a scale of 0-3. The following table shows the scoring rubric for responses.
Achievement for grantees will be reached when at least 90% of the EMS agencies in the state/territory report a '3' on the scale below.

Which statement best defines your agency?	Scale
Our EMS agency does NOT have a designated INDIVIDUAL who coordinates pediatric emergency care at this time	0
Our EMS agency does NOT CURRENTLY have a designated INDIVIDUAL who coordinates pediatric emergency care but we would be INTERESTED IN ADDING this role	1
Our EMS agency does NOT CURRENTLY have a designated INDIVIDUAL who coordinates pediatric emergency care but we HAVE A PLAN TO ADD this role within the next year	2
Our EMS agency HAS a designated INDIVIDUAL who coordinates pediatric emergency care for our agency	3

Proposed Survey Questions:

Now we are interested in hearing about how pediatric emergency care is coordinated at your EMS agency. This is an emerging issue within emergency care and we want to gather information on what is happening across the country within EMS agencies.

One way that an agency can coordinate pediatric emergency care is by DESIGNATING AN INDIVIDUAL who is responsible for pediatric-specific activities that could include:

- Ensure that the pediatric perspective is included in the development of EMS protocols
- Ensure that fellow providers follow pediatric clinical practice guidelines and/or protocols
- Promote pediatric continuing education opportunities
- Oversee pediatric process improvement
- Ensure the availability of pediatric medications, equipment, and supplies
- Promote agency participation in pediatric prevention programs
- Promote agency participation in pediatric research efforts
- Liaise with the ED pediatric emergency care coordinator
- Promote family-centered care at the agency

A DESIGNATED INDIVIDUAL who coordinates pediatric emergency care need not be dedicated solely to this role; he or she may be an individual already in place who assumes this role as part of their existing duties. The individual may be a member of your agency, or work at a county or region level and serve more than one agency.

Which one of the following statements best describes your EMS agency? (Choose one)

- ☐ Our EMS agency does ***NOT*** have a designated ***INDIVIDUAL*** who coordinates pediatric emergency care at this time
- ☐ Our EMS agency does ***NOT CURRENTLY*** have a designated ***INDIVIDUAL*** who coordinates pediatric emergency care but we would be ***INTERESTED IN ADDING*** this role
- ☐ Our EMS agency does ***NOT CURRENTLY*** have a designated ***INDIVIDUAL*** who coordinates pediatric emergency care but we ***HAVE A PLAN TO ADD*** this role within the next year
- ☐ Our EMS agency ***HAS*** a designated ***INDIVIDUAL*** who coordinates pediatric emergency care

You indicated that you have a designated individual who coordinates pediatric emergency care at your EMS agency.

Is this individual (choose one):

- A member of your agency
- Located at the county level
- Located at a regional level
- Other, please describe

To the best of your knowledge, does this individual serve as the pediatric coordinator for one or more than one EMS agency?

- Just my agency
- My agency as well as other agencies

We are interested in understanding a little bit more about what this individual does for your agency in the coordination of pediatric emergency care. Does this individual…
(Check Yes or No for each of the following questions)

Ensure that the pediatric perspective is included in the development of EMS protocols

- ☐ Yes
- ☐ No

Ensure that fellow providers follow pediatric clinical practice guidelines and/ or protocols

- ☐ Yes
- ☐ No

Promote pediatric continuing education opportunities

- ☐ Yes
- ☐ No

Oversee pediatric process improvement

- ☐ Yes
- ☐ No

Ensure the availability of pediatric medications, equipment, and supplies

- ☐ Yes
- ☐ No

Promote agency participation in pediatric prevention programs

- ☐ Yes
- ☐ No

Liaise with the emergency department pediatric emergency care coordinator

- ☐ Yes
- ☐ No

Promote family-centered care at the agency

- ☐ Yes
- ☐ No

Promote agency participation in pediatric research efforts

- ☐ Yes
- ☐ No

Other

- ☐ Yes
- ☐ No

You marked 'other' to the previous question. Please describe the 'other' activity(s) performed by the designated individual who coordinates pediatric emergency care at your agency._____

If you have any additional thoughts about pediatric emergency care coordination, please share them here:

EMSC 03 PERFORMANCE MEASURE **Revised for clarity and based on additional feedback** **Goal: Use of pediatric-specific equipment** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The percentage of EMS agencies in the state/territory that have a process or plan that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.
GOAL	By 2020, 30% of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of '6' or more on a 0-12 scale. By 2023: 60% of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of '6' or more on a 0-12 scale. By 2026: 90% of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of '6' or more on a 0-12 scale.
MEASURE	The percentage of EMS agencies in the state/territory that have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.
DEFINITION	**Numerator**: The number of EMS agencies in the state/territory that score a '6' or more on a 0-12 scale. **Denominator:** Total number of EMS agencies in the state/territory that provided data. **Units**: 100 **Text**: Percent **EMS**: Emergency Medical Services **EMS Agency**: An EMS agency is defined as an organization staffed with personnel who render medical care in response to a 911 or similar emergency call. Data will be gathered from both transporting and non-transporting agencies. **IOM**: Institute of Medicine **EMS Providers**: EMS providers are defined as people/persons who are certified or licensed to provide emergency medical services during a 911 or similar emergency call. There are four EMS personnel licensure levels: Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), and Paramedic. Reference the National Highway Traffic Safety Administration (NHTSA) National EMS Scope of Practice Model http://www.ems.gov/education/EMSScope.pdf

EMSC 03 PERFORMANCE MEASURE **Revised for clarity and based on additional feedback** **Goal: Use of pediatric-specific equipment** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The percentage of EMS agencies in the state/territory that have a process or plan that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.
HRSA STRATEGIC OBJECTIVE	**Goal I**: Improve Access to Quality Health Care and Services (by improving quality) or; **Goal II**: Strengthen the Health Workforce
GRANTEE DATA SOURCES	Survey of EMS agencies
SIGNIFICANCE	The Institute of Medicine (IOM) report "Emergency Care for Children: Growing Pains" reports that because EMS providers rarely treat seriously ill or injured pediatric patients, providers may be unable to maintain the necessary skill level to care for these patients. For example, Lammers et al reported that paramedics manage an adult respiratory patient once every 20 days compared to once every 625 days for teens, 958 days for children and once every 1,087 days for infants. As a result, skills needed to care for pediatric patients may deteriorate. Another study by Su et al found that EMS provider knowledge rose sharply after a pediatric resuscitation course, but when providers were retested six months later; their knowledge was back to baseline. Continuing education such as the Pediatric Advance Life Support (PALS) and Pediatric Education for Prehospital Professionals (PEPP) courses are vitally important for maintaining skills and are considered an effective remedy for skill atrophy. These courses are typically only required every two years. More frequent practice of skills using different methods of skill ascertainment are necessary for EMS providers to ensure their readiness to care for pediatric patients when faced with these infrequent encounters. These courses may be counted if an in-person skills check is required as part of the course. Demonstrating skills using EMS equipment is best done in the field on actual patients but in the case of pediatric patients this can be difficult given how infrequently EMS providers see seriously ill or injured children. Other methods for assessing skills include simulation, case scenarios and skill stations. In the absence of pediatric patient encounters in the field. There is not definitive evidence that shows that one method is more effective than another for demonstrating clinical skills. But, Miller's Model of Clinical Competence posits via the skills complexity triangle that performance assessment can be demonstrated by a combination of task training, integrated skills training, and integrated team performance. In the EMS environment this can be translated to task training at skill stations, integrated skills training during case scenarios, and integrated team performance while treating patients in the field.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 03

The percentage of EMS agencies in the state/territory that have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.

Numerator: The number of EMS agencies in the state/territory that score a '6' or more on a 0-12 scale.	
Denominator: Total number of EMS agencies in the state/territory that provided data.	
Percent:	

EMS agencies will be asked to select the frequency of each of three methods used to evaluate EMS providers' use of pediatric-specific equipment. The measure will be determined on a scale of 0 – 12. The following table shows the scoring rubric for responses. Achievement for the grantees will be reached when at least 90% of the EMS agencies in a state/territory report a combined score of '6' or higher from a combination of the methods.

	Two or more times per year	**At least once per year**	**At least once every two years**	**Less frequency than once every two years**
How often are your providers required to demonstrate skills via a SKILL STATION?	**4**	**2**	**1**	**0**
How often are your providers required to demonstrate skills via a SIMULATED EVENT?	**4**	**2**	**1**	**0**
How often are your providers required to demonstrate skills via a FIELD ENCOUNTER?	**4**	**2**	**1**	**0**

Proposed Survey Questions:

EMS runs involving pediatric patients are a small percentage of runs for most agencies. As a result, EMS providers rarely apply life-saving skills using pediatric equipment on children such as:

-
- Airway adjunct use/ventilation
- Clearing airway/suctioning
- CPR
- AED use/cardio-monitoring
- IV/IO insertion and administration of fluids
- Weight/length-based tape use
- Child safety restraint vehicle installation and pediatric patient restraint

In the next set of questions we are asking about the process or plan that your agency uses to evaluate your EMS providers' skills using pediatric-specific equipment.

While individual providers in your agency may take PEPP or PALS or other national training courses in pediatric emergency care, we are interested in learning more about the process or plans that your agency employs to evaluate skills on pediatric equipment.

We realize that there are multiple processes that might be used to assess correct use of pediatric equipment. Initial focus of this performance measure metrics is on he following three processes:

- At a skill station
- Within a simulated event
- During an actual pediatric patient encounter

At a *SKILL STATION* (not part of a simulated event), does your agency have a process or plan which *REQUIRES* your EMS providers to *PHYSICALLY DEMONSTRATE* the correct use of *PEDIATRIC- SPECIFIC* equipment?

- ☐ Yes
- ☐ No

How often is this process required for your EMS providers? (Choose one)

- ☐ Two or more times a year
- ☐ At least once a year
- ☐ At least once every two years
- ☐ Less frequently than once every two years

Within *A SIMULATED EVENT* (such as a case scenario or a mock incident), does your agency have a process or plan which *REQUIRES* your EMS providers to *PHYSICALLY DEMONSTRATE* the correct use of *PEDIATRIC- SPECIFIC* equipment?

- ☐ Yes
- ☐ No

How often is this process required for your EMS providers? (Choose one)

- ☐ Two or more times a year
- ☐ At least once a year
- ☐ At least once every two years
- ☐ Less frequently than once every two years

During an actual *PEDIATRIC PATIENT ENCOUNTER*, does your agency have a process or plan which *REQUIRES* your EMS providers to be observed by a *FIELD TRAINING OFFICER, MEDICAL DIRECTOR* or *SUPERVISOR* to ensure the correct use of *PEDIATRIC- SPECIFIC* equipment?

- ☐ Yes
- ☐ No

How often is this process required for your EMS providers? (Choose one)

- ☐ Two or more times a year
- ☐ At least once a year
- ☐ At least once every two years
- ☐ Less frequently than once every two years

If you have any additional thoughts about skill checking, please share them here:

EMSC 04 PERFORMANCE MEASURE **Goal: Emergency Department Preparedness** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric medical emergencies.
GOAL	By 2022: 25% of hospitals are recognized as part of a statewide, territorial, or regional standardized program that are able to stabilize and/or manage pediatric medical emergencies.
MEASURE	The percent of hospitals recognized through a statewide, territorial or regional program 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 program 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 of care provides a framework for collaboration across agencies, health care organizations/services, families, and youths for the purposes of improving access and expanding coordinated culturally and linguistically competent care for children and youth. The system is coordinated, accountable and includes a facility recognition program for pediatric medical emergencies. Recognizing the pediatric emergency care capabilities of hospitals supports the development of a system of care that is responsive to the needs of children and extends access to specialty resources when needed. **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	Ensure the operational capacity and infrastructure to provide pediatric emergency care. Develop a statewide, territorial, or regional program that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies..

EMSC 04 PERFORMANCE MEASURE **Goal: Emergency Department Preparedness** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric medical emergencies.
GRANTEE DATA SOURCES	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 medical emergencies.
SIGNIFICANCE	The performance measure emphasizes the importance of the existence of a standardized statewide, territorial, or regional system of care for children that includes a recognition program for hospitals capable of stabilizing and/or managing pediatric medical emergencies. A standardized recognition and/or designation program, based on compliance with the current published pediatric emergency/trauma care guidelines, contributes to the development of an organized system of care that assists hospitals in determining their capacity and readiness to effectively deliver pediatric emergency/trauma and specialty care. This measure helps to ensure essential resources and protocols are available in facilities where children receive care for medical and trauma emergencies. A recognition program can also facilitate EMS transfer of children to appropriate levels of resources. Additionally, a pediatric recognition program, that includes a verification process to identify facilities meeting specific criteria, has been shown to increase the degree to which EDs are compliant with published guidelines and improve hospital pediatric readiness statewide. In addition, Performance Measure EMSC 04 does not require that the recognition program be mandated. Voluntary facility recognition is accepted.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 04

The percent of hospitals with an Emergency Department (ED) that are recognized through a statewide, territorial or regional standardized program 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 program 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 facility recognition program for pediatric medical emergencies exists.						

0= No progress has been made towards developing a statewide, territorial, or regional program 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 being able to stabilize and/or manage pediatric medical emergencies 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

EMSC 05 PERFORMANCE MEASURE **Goal: Standardized System for Pediatric Trauma** **Level: Grantee** **Domain: Emergency Medical Services for Children**	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 trauma.
GOAL	By 2022: 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 trauma. **Denominator**: Total number of hospitals with an ED in the State/Territory. **Units**: 100 **Text**: Percent **Standardized system:** A system of care provides a framework for collaboration across agencies, health care organizations/services, families, and youths for the purposes of improving access and expanding coordinated culturally and linguistically competent care for children and youth. The system is coordinated, accountable and includes a facility recognition program for pediatric traumatic injuries. Recognizing the pediatric emergency care capabilities of hospitals supports the development of a system of care that is responsive to the needs of children and extends access to specialty resources when needed. **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	Ensure the operational capacity and infrastructure to provide pediatric emergency care. Develop a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies and trauma.

EMSC 05 PERFORMANCE MEASURE **Goal: Standardized System for Pediatric Trauma Level: Grantee** **Domain: Emergency Medical Services for Children**	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 trauma.
GRANTEE DATA SOURCES	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 pediatric trauma.
SIGNIFICANCE	The performance measure emphasizes the importance of the existence of a standardized statewide, territorial, or regional system of care for children that includes a recognition program for hospitals capable of stabilizing and/or managing pediatric trauma emergencies. A standardized recognition and/or designation program, based on compliance with the current published pediatric emergency/trauma care guidelines, contributes to the development of an organized system of care that assists hospitals in determining their capacity and readiness to effectively deliver pediatric emergency/trauma and specialty care. This measure addresses the development of a pediatric trauma recognition program. Recognition programs are based upon State-defined criteria and/or adoption of national current published pediatric emergency and trauma care consensus guidelines that address administration and coordination of pediatric care; the qualifications of physicians, nurses and other ED staff; a formal pediatric quality improvement or monitoring program; patient safety; policies, procedures, and protocols; and the availability of pediatric equipment, supplies and medications. Additionally, EMSC 05 does not require that the recognition program be mandated. Voluntary facility recognition is accepted. However, the preferred status is to have a program that is monitored by the State/Territory.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 05

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.

Numerator:	
Denominator:	
Percent	

Numerator: Number of hospitals with an ED recognized through a statewide, territorial or regional standardized system that have been validated/designated as being capable of stabilizing and/or managing pediatric trauma patients.

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

EMSC 06 PERFORMANCE MEASURE **Goal: Inter-facility transfer guidelines** **Level: Grantee** **Domain: Emergency Medical Services for Children**	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 2021: 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

Ensure the operational capacity and infrastructure to provide pediatric emergency care

Develop written pediatric inter-facility transfer guidelines for hospitals.

GRANTEE DATA SOURCE(S)

- 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.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 06

Performance Measure EMSC 06: 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

Hospitals with Inter-facility Transfer Guidelines that Cover Pediatric Patients:
You will be asked to enter a numerator and a denominator, not a percentage. ***NOTE:*** This measure only applies to hospitals with an Emergency Department (ED).

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.

EMSC 07 PERFORMANCE MEASURE **Goal: Inter-facility Transfer Agreements** **Level: Grantee** **Domain: Emergency Medical Services for Children**	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 2021: 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	Ensure the operational capacity and infrastructure to provide pediatric emergency care. 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.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 07

Performance Measure EMSC 07: The percentage of hospitals in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.

Hospitals with Inter-facility Transfer Agreements that Cover Pediatric Patients:
You will be asked to enter a numerator and a denominator, not a percentage.
NOTE: *This measure only applies to hospitals with an Emergency Department (ED).*

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.

EMSC 08 PERFORMANCE MEASURE **Goal: EMSC Permanence** **Level: Grantee** **Domain: Emergency Medical Service for Children**	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. • Pediatric representation incorporated on the State/Territory EMS Board. • The State/Territory require pediatric representation on the EMS Board. • One full time EMSC Manager is dedicated solely to the EMSC Program. **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	Establish permanence of EMSC in each State/Territory EMS system. Establish an EMSC Advisory Committee within each State/Territory Incorporate pediatric representation on the State/Territory EMS Board Establish one full-time equivalent EMSC manager that is dedicated solely to the EMSC Program.
GRANTEE DATA SOURCES	Attached data collection form to be completed by grantee.

EMSC 08 PERFORMANCE MEASURE **Goal: EMSC Permanence** **Level: Grantee** **Domain: Emergency Medical Service for Children**	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system.
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: EMSC 08

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)_____

EMSC 09 PERFORMANCE MEASURE **Goal: Integration of EMSC priorities** **Level: Grantee** **Domain: Emergency Medical Services for Children**	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 2027, 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: 1. EMS agencies are required to submit NEMSIS compliant data to the State EMS Office. 2. EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency are. 3. EMS agencies in the state/territory have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment. 4. 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 *(continued on next page)*
DEFINITION (continued)	5. 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 6. Hospitals in the State/Territory have written inter-facility

EMSC 09 PERFORMANCE MEASURE **Goal: Integration of EMSC priorities** **Level: Grantee** **Domain: Emergency Medical Services for Children**	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.
	transfer agreements that cover pediatric patients. 7. BLS and ALS pre-hospital provider agencies in the State/Territory are required to have on-line and off-line pediatric medical direction available. 8. 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. 9. Requirements adopted by the State/Territory that requires pediatric continuing education prior to the renewal of BLS/ALS licensing/certification.
EMSC STRATEGIC OBJECTIVE	Establish permanence of EMSC in each State/Territory EMS system.
GRANTEE DATA SOURCES	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: EMSC 09

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 that requires the submission of NEMSIS compliant data to the state EMS office		
2. There is a statute/regulation that assures an individual is designated to coordinate pediatric emergency care.		
3. There is a statute/regulation that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.		
4. There is a statute/regulation for a hospital recognition program 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 pediatric on-line medical direction for ALS and BLS pre-hospital provider agencies.		
9. There is a statute/regulation for pediatric off-line medical direction for ALS and BLS pre-hospital provider agencies.		
10. There is a statute/regulation for pediatric equipment for BLS and ALS patient care units.		
11. There is a statute/regulation for the adoption of requirements for continuing pediatric education piror to recertification/relicensing of BLS and ALS providers.		

Yes = 1
No = 0

Total number of elements your grant program has established (possible 0-11 score)_____

DIVISION OF HEALTHY START AND PERINATAL SERVICES

PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

Performance Measure	New/Revised Measure	Prior PM Number (if applicable)	Topic
HS 01	New		Reproductive Life Plan
HS 02	Revised	17, 20	Usual Source of Care
HS 03	New		Interconception Planning
HS 04	New		Intimate Partner Violence Screening
HS 05	New		Father/ Partner Involvement during Pregnancy
HS 06	New		Father and/or Partner Involvement with Child 0-24 Months
HS 07	New		Daily Reading
HS 08	New		CAN implementation
HS 09	New		CAN Participation

HS 01 PERFORMANCE MEASURE **Edited for Clarity and Consistency** **Goal: Reproductive Life Plan** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start participants that have a documented reproductive life plan.[32]
GOAL	To increase the proportion of Healthy Start women participants who have a documented reproductive life plan to 90%.
MEASURE	The percent of Healthy Start women participants that have a documented reproductive life plan.
DEFINITION	**Numerator:** Number of Healthy Start (HS) women participants with a documented reproductive life plan in the reporting period. **Denominator:** Number of HS women participants in the reporting period. There is no formal written format for a reproductive life plan. A participant is considered to have a reproductive life plan and included in the numerator if there is documentation in the participant's record of an annually updated statement to include: 1) goals for having or not having children; and 2) plans for how to achieve those goals. Participants with permanent birth control are included in both the denominator and numerator. If a participant completes the Reproductive Life Plan questions within the Healthy Start Screening tools during the reporting period, then they are considered to have a documented Reproductive Life Plan.
BENCHMARK DATA SOURCES	Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 8, Question 14
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	A reproductive life plan reduces the risk of unintended pregnancy, identifies unmet reproductive health care needs, and increases the number of women who plan their pregnancies and engage in healthy behaviors *before* becoming pregnant.[33]

[32] Consistenty with Healthy Start Benchmark 2.
[33] http://www.cdc.gov/preconception/documents/reproductivelifeplan-worksheet.pdf

HS 02 PERFORMANCE MEASURE **Edited for Clarity and Consistency** **Goal: Usual Source of Care** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start women and child participants that have a usual source of care.[34]
GOAL	To increase the percent of Healthy Start women and child participants who have a usual source of care to 80%.
MEASURE	The percent of Healthy Start women and child participants that have a usual source of care.
DEFINITION	**a.** **Numerator:** Total number of Healthy Start (HS) women participants that report having a usual source of care as of the last assessment in the reporting period. **Denominator:** Total number of women HS participants in the reporting period. **b.** **Numerator:** Total number of Healthy Start (HS) child participants whose parent/ caregiver reports that they have a usual source of care as of the last assessment in the reporting period. **Denominator:** Total number of child HS participants in the reporting period. A participant is considered to have a usual source of care and included in the numerator if the participant identifies a regular place where they can go for routine and sick care other than an emergency room. A participant receiving regular prenatal care from a prenatal provider is considered to have a usual source of care.
BENCHMARK DATA SOURCES	National Survey of Children's Health (Children 0-5 with a Usual Source of Care 91.7%, 2011-2012); National Health Interview Survey (Children 0-4 with a Usual Source of Care: 97.5%, 2012-2014; Women 18-44 with a Usual Source of Care 81.8%, 2012-2014)
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Having a usual source of medical care has been shown to improve care quality as well as access to and receipt of preventative services.[35] Further, patients having a usual source of care reduce overall costs to patients, employers, and health plans by reducing emergency department visits, hospital readmissions, and inpatient visits. [36]

[34] Consistent with Healthy Start Benchmark 4

[35] Blewett LA, Johnson PJ, Lee B, Scal PB. When a usual source of care and usual provider matter: adult prevention and screening services. J Gen Intern Med. September 2008 [Epub Ahead of Print May 28, 2008];23(9):1354-60.

[36] https://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home

HS 03 PERFORMANCE MEASURE **Edited for Clarity and Consistency** **Goal: Interconception Planning** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start women participants who conceive within 18 months of a previous birth.[37]
GOAL	To reduce the proportion of Healthy Start women participants who conceive within 18 months of a previous birth to 30%.
MEASURE	The percent of Healthy Start women participants who conceive within 18 months of a previous birth.
DEFINITION	**Numerator**: Number of Healthy Start (HS) women participants whose pregnancy during the reporting period was conceived within 18 months of the previous live birth. **Denominator:** Total number of HS women participants enrolled before the current pregnancy in the reporting period who had a prior pregnancy that ended in live birth. The interval between the most recent pregnancy and previous birth is derived from the delivery date of the birth and the date of conception for the most recent pregnancy.
BENCHMARK DATA SOURCES	CDC National Survey of Family Growth, Healthy People 2020 Family Planning Goal 5; Vital Statistics[38]
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Family planning is important to ensure spacing pregnancies at least 18 months apart to reduce health risks for both mother and baby. Pregnancy within 18 months of giving birth is associated with increased risk for the baby including low birth weight, small size for gestational age, and preterm birth. Additionally, the mother needs time to fully recovering from the previous birth.[39].

[37] Consistent with Healthy Start Benchmark 10
[38] http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_03.pdf
[39] http://www.mayoclinic.org/healthy-lifestyle/getting-pregnant/in-depth/family-planning/art-20044072

HS 04 PERFORMANCE MEASURE **Edited for Clarity and Consistency** **Goal: Intimate Partner Violence Screening** **Level: Grantee** **Domain: Healthy Start**	The percent of HS women participants who receive intimate partner violence screening.[40]
GOAL	To increase proportion of Healthy Start women participants who receive intimate partner violence (IPV) screening to 100%.
MEASURE	The percent of Healthy Start women participants who receive intimate partner violence screening.
DEFINITION	**Numerator**: Number of Healthy Start (HS) women participants who received intimate partner violence screening using a standardized screening tool during the reporting period. **Denominator:** Total number of HS women participants in the reporting period. A participant is considered to have been screened and included in the denominator if a standardized screening tool which is appropriately validated for her circumstances is used. A number of screening tools have been validated for IPV screening. Intimate Partner Violence is a pattern of assaultive behavior and coercive behavior that may include physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion. These behaviors are committed by someone who is, was, or wishes to be involved in an intimate relationship with the participant.[41]
BENCHMARK DATA SOURCES	PRAMS
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Intimate Partner Violence is a substantial yet preventable public health problem that affects women across the world. Research shows that intimate partner violence screening differs among health care specialties and is overall relatively low. The U.S. Department of Health and Human Services recommends that IPV screening and counseling to be a core part of a women's well visit. [42]

[40] Consistent with Healthy Start Benchmark 13
[41] http://mchb.hrsa.gov/whusa09/hstat/hi/pages/226ipv.html
[42] http://aspe.hhs.gov/report/screening-domestic-violence-health-care-settings/prevalence-screening

HS 05 PERFORMANCE MEASURE **Edited for Clarity and Consistency** **Goal: Father/ Partner Involvement during pregnancy** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy.[43]
GOAL	To increase proportion of Healthy Start women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) to 90%.
MEASURE	The percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy.
DEFINITION	**Numerator:** Number of Healthy Start (HS) prenatal participants who report supportive father and/or partner involvement (e.g., attend appointments, classes, etc.) in the reporting period **Denominator:** Total number HS prenatal participants in the reporting period. A participant is considered to have support and included in the numerator if she self- reports a partner who has a significant and positive role in the participant's pregnancy. Involvement during pregnancy may include, but is not limited to: • Attending prenatal appointments • Attending prenatal classes • Assisting in preparing the home for the baby e.g,, putting together a crib • Providing economic support
BENCHMARK DATA SOURCES	Child Trend Research Brief, CDC National Health Statistics Report
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Research suggests that paternal involvement has been recognized to have an impact on both pregnancy and infant outcomes. Father involvement during pregnancy has shown to reduce negative maternal health behaviors, risk of preterm birth, low birth weight, and fetal growth restrictions.

[43] Consistent with Healthy Start Benchmark 14

HS 06 PERFORMANCE MEASURE **Edited for Clarity and Consistency** **Goal: Father and/or Partner Involvement with child <24 Months** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start women participants that demonstrate father and/or partner involvement with child <24 months.[44]
GOAL	To increase proportion of HS women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) with child <24 months to 80%.
MEASURE	The percent of Healthy Start women participants that demonstrate father and/or partner involvement with child <24 months.
DEFINITION	**Numerator:** Number of Healthy Start (HS) child participants whose mother reports supportive father and/or partner involvement (e.g., attend appointments, classes, child care, etc.) during the reporting period **Denominator:** Total number of Healthy Start women participants with a child participant <2 years of age. A participant is considered to have support and included in the numerator if she self- reports a partner who has a significant and positive role for the child. Involvement includes, but is not limited to:[45] • Engagement or direct interaction with the child, including taking care of, playing with, or teaching the child • Accessibility or availability, which includes monitoring behavior from the next room or nearby and allowing direct interaction if necessary • Responsibility for the care of the child, which includes making plans and arrangements for care • Economic support or breadwinning • Attending postpartum and well child visits • Other meaningful support
BENCHMARK DATA SOURCES	None
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Research suggests that paternal involvement has been recognized to have an impact on both pregnancy and infant outcomes

[44] Consistent with Healthy Start Benchmark 15
[45] http://www.cdc.gov/nchs/data/nhsr/nhsr071.pdf

HS 07 PERFORMANCE MEASURE **Edited for Clarity and Consistency** **Goal: Daily Reading** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start child participants age 6 through 23 months who are read to 3 or more times per week, on average. [46]
GOAL	To increase the proportion of Healthy Start child participants age 6 through 23 months who are read to 3 or more times per week to 50%
MEASURE	The percent of Healthy Start child participants age 6 through 23 months who are read to by a family member 3 or more times per week, on average.
DEFINITION	**Numerator:** Number of Healthy Start children participants whose parent/ caregiver reports that they were read to by a family member on 3 or more days during the past week during the reporting period. **Denominator:** Total number of Healthy Start child participants 6 through 23 months of age during the reporting period. Reading by a family member may include reading books, picture books, or telling stories.
BENCHMARK DATA SOURCES	National Survey of Children's Health (2011-2012)
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Reading to a child teaches them about communication, introduces concepts such as numbers, letters, colors, and shapes, builds listening, memory, and vocabulary skills, and gives them information about the world around them. [47] The American Academy of Pediatrics (AAP) promotes reading aloud as a daily fun family activity to promote early literacy development as an important evidence-based intervention beginning in infancy and continuing at least until the age of school entry. [48]

[46] Consistent with Healthy Start Benchmark 16
[47] http://kidshealth.org/parent/positive/all_reading/reading_babies.html
[48] http://pediatrics.aappublications.org/content/pediatrics/134/2/404.full.pdf

HS 08 PERFORMANCE MEASURE **Edited number, clarified content** **Goal: CAN implementation** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN). [49]
GOAL	To increase the proportion of HS grantees with a fully implemented Community Action Network (CAN) to 100%.
MEASURE	The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN).
DEFINITION	**Two benchmarks are calculated to capture Community Action Network (CAN) implementation and progress towards achieving collective impact:** **Numerator**: Number of related CAN measure components implemented by the CAN in which the Healthy Start grantee participates. **Denominator**: 3 (representing total of CAN components) This is a scaled measure which reports progress towards full implementation of a CAN. A "yes" answer is scored 1 point; a "no" answer receives no point. To meet the standard of "fully implemented" for this measure, the HS grantee must answer "yes" to all three core elements listed below: 1. Does your CAN have regularly scheduled meetings? (Regular scheduled is minimally defined as every quarter during the reporting period). This can be documented by using sign in sheets. Yes = 1 No = 0 2. Does your CAN have members from three or more community sectors? (e.g., individuals with lived experience, Healthy Start consumer, faith based, hospital, school setting, community based organizations, government, business, medical provider(s), child care provider(s)). Yes = 1 No = 0 3. Does your CAN have a twelve month work plan? This work plan should outline the CAN's goals, objectives, activities, entities responsible for completing, and timelines. Yes = 1 No = 0

[49] Consistent with Healthy Start Benchmark 17

HS 08 PERFORMANCE MEASURE **Edited number, clarified content** **Goal: CAN implementation** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN).
	1. Does your CAN have a common agenda developed? All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions. This can be documented by using a theory of change, logic model, work plan template that captures this information, and/or a charter. Yes = 2 In Process = 1 Not started = 0 2. Does your CAN have Shared Measurement Systems? The CAN has identified a common set of indicators that tracks progress/action related to the common agenda, collects data across partners, presents data on a consistent basis, and uses data to make informed decisions and to hold each other accountable. Yes = 2 In Process = 1 Not started = 0 3. Does your CAN engage in Mutually Reinforcing Activities? Participant activities are differentiated while still being coordinated through a mutually reinforcing plan of action. This plan of action can be included on the work plan noted above and should include at least two to three activities, a description of how it is believed that the activities will impact the common agenda, how the activities will be measured, who/what organization will take the lead, and the timeline for implementation. Yes = 2 In Process = 1 Not started = 0 4. Does your CAN have Continuous Communication? Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and appreciate common motivation. A communication plan agreed upon by stakeholders should be included as a part of the work plan noted above. Yes = 2 In Process = 1 Not started = 0 5. Does your CAN have a backbone infrastructure in place? Creating and managing collective impact requires a dedicated staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies. Documentation is shared with CAN members describing roles and responsibilities, and skills required for staff of the entity(ies) supporting the backbone infrastructure. Yes = 2 In Process = 1 Not started = 0
BENCHMARK DATA SOURCES	None
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	A Community Action Network, or CAN, is an existing, formally organized

HS 08 PERFORMANCE MEASURE **Edited number, clarified content** **Goal: CAN implementation** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN).
	partnership of organizations and individuals. The CAN represents consumers and appropriate agencies which unite in an effort to collectively apply their resources to the implementation of one or more commons strategies to achieve a common goal within that project area.

HS 09 PERFORMANCE MEASURE **Edited number, no content revision** **Goal: CAN participation** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start grantees with at least 25% community members and Healthy Start program participants serving as members of their CAN. [50]
GOAL	To increase the proportion of Healthy Start grantees with at least 25% community members and Healthy Start program participants serving as members of their CAN to 100%.
MEASURE	The percent of Healthy Start grantees with at least 25% community members and Healthy Start program participants serving as members of their CAN.
DEFINITION	**Numerator:** Number of community members and Healthy Start (HS) program participants serving as members of the CAN. **Denominator:** Total number of individual members serving on the CAN. Community Member: an individual who has lived experience that is representative of the project's Healthy Start target population. Community members may include former Healthy Start participants, fathers and/or partners of Healthy Start participants, males and family members. Program Participant: an individual having direct contact with Healthy Start staff or subcontractors and receiving Healthy Start services on an ongoing systematic basis to improve perinatal and infant health. Specifically, program participants are pregnant women and women of reproductive age and children up to age 2. A Community Action Network, or CAN, is an existing, formally organized partnership of organizations and individuals. The CAN represents consumers and appropriate agencies which unite in an effort to collectively apply their resources to the implementation of one or more commons strategies to achieve a common goal within that project area.
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Consumer involvement in setting the community agenda and informing efforts to effectively meet the community's needs is critical to the effectiveness of the CAN.

[50] Consistent with Healthy Start Benchmark 18

DIVISION OF CHILDREN WITH SPECIAL HEALTH NEEDS

Family to Family Health Information Center Program
PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

Performance Measure	New/Revised Measure	Previous Performance Measure Number	Topic
F2F 1	Revised	70	Provide National Leadership for families with children with special health needs

F2F 1 Performance Measure **Goal: Provide National Leadership for families with children with special health needs** **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 number of families that can be reasonably served with provided federal grant funds. **Units:** 100 **Text:** Percent
BENCHMARK DATA SOURCES	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
GRANTEE DATA SOURCES	Progress reports from Family-To-Family Health Care Information and Education Centers, National Survey for Children's Health (NSCH), Title V Information System
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 #F2F 1

A. PROVIDING INFORMATION, EDUCATION, AND/OR TRAINING

The number of families that can be reasonably served with provided federal grant funds: _____

1. The total number of families served is based solely on "one-to-one" service conducted by the F2F.

a. Total number of families served/trained: _____

b. Of the total number of families served/trained, how many families identified themselves as

Ethnicity

1. Hispanic
2. Non-Hispanic

Race

1. White
2. Black or African American
3. Asian
4. Native Hawaiian or Pacific Islander
5. Native American/American Indian or Alaskan Native
6. Some other Race
7. Multiple races
8. Unknown

c. Total instances of service/training provided (this will be a duplicated count): _____

d. Of the total instances of service, how many provided

1. Individualized assistance (Includes one-on-one instruction, consultation, counseling, case management, and mentoring) _____
2. Basic contact information and referrals _____
3. Group training opportunities _____
4. Meetings/Conferences and Public Events (includes outreach events and presentations) _____

e. Of the total number of families served/trained, how many instances of service 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 for CSHCN.

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

b. Total instances of service/training provided (this will be a duplicated count): _____

c. Of the total number of professionals/providers served/trained, how many instances of service were used to provide 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 conducted communication and outreach to families and other appropriate entities through a variety of methods.

a. Select the modes of how print/media information and resources are disseminated. (Select all that apply).
   - ☐ Electronic newsletters and listservs
   - ☐ Hardcopy
   - ☐ Public television/radio
   - ☐ Social media (Specify platform): _____
   - ☐ Text messaging

4. 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:

a. State level Commissions, Task Forces, etc.
b. MCH/CSHCN
c. Genetics/newborn screening
d. Early Hearing Detection and Intervention/Newborn Hearing screening
e. Emergency Medical Services for Children
f. LEND Programs
g. Oral Health
h. NICHQ Learning Collaboratives
i. Developmental Disabilities
j. Medicaid (CMS),SCHIP
k. Private Insurers
l. Case Managers
m. SAMHSA/Mental & Behavioral Health
n. Federation of Families for Children's Mental Health
o. HUD/housing
p. Early Intervention/Head Start
q. Education
r. Child Care
s. Juvenile Justice/Judicial System
t. Foster Care/Adoption agencies
u. Other (Specify): _____
v. None

B. MODELS OF FAMILY ENGAGEMENT COLLABORATION

1. 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
- Children's hospitals
- 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

2. Family-to-Family Health Information Center goals/objectives were accomplished through formal and informal partnership strategies and practices.

a. Number of agreements with partners (from partners identified in items 3 and 4). Total _____

b. Indicate the type of partnership agreements that were in place during the reporting period:
- Subcontract
- Memorandum of Understanding/Agreement
- Letter of Invitation/Acceptance/Support
- Informal/Verbal Arrangement
- Other (Specify): _____

9. Our organization is staffed by families with expertise in Federal and State public and private health care systems.

a. Number of Family-to-Family FTE _____

b. Number of FTE who are family/have a disability _____