

Health Resources and Services Administration  
Maternal and Child Health Bureau

Discretionary Grant Performance Measures

OMB No. 0915-0298

Expires: \_\_\_\_\_

Attachment B:  
Core Measures, Population Domain Measures,  
Program-Specific Measures (Detail Sheets)

OMB Clearance Package

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. 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 14N-39, Rockville, Maryland, 20857.

## Table of Contents

### Attachment B: Core Measures, Population Domain Measures, Program-Specific Measures (Detail Sheets)

Core Measures

Capacity Building Measures

Activity Data Collection Form for Selected Measures

#### **Population Domain Measures**

Women's/ Maternal Health

Perinatal Infant Health

Child Health

Children and Youth with Special Health Care Needs

Adolescent Health

Life Course/ Cross Cutting

#### Program-Specific Measures

Division of MCH Workforce Development

Div. of Child Adolescent, & Family Health – Emergency Medical Services for  
Children Program

Division of Healthy Start and Perinatal Services

Div. of Children with Special Health Needs – Family to Family Health Information Ctr  
Program

DGIS Performance Measures, Numbering by Domain	
Performance Measure	Topic
Core 1	Grant Impact
Core 2	Quality Improvement
Core 3	Health Equity
CB 1	State Capacity for Advancing the Health of MCH Populations
CB 2	Technical Assistance
CB 3	Impact Measurement
CB 4	Sustainability
CB 5	Scientific Publications
CB 6	Products
CB 7	Direct Annual Access to MCH Data
WMH 1	Prenatal Care
WMH 2	Perinatal/ Postpartum Care
WMH 3	Well Woman Visit/ Preventive Health Care
WMH 4	Depression Screening
PIH 1	Safe Sleep
PIH 2	Breastfeeding
PIH 3	Newborn Screening
CH 1	Well Child Visit
CH 2	Quality of Well Child Visit
CH 3	Developmental Screening
CH 4	Injury Prevention
CSHCN 1	Family Engagement
CSHCN 2	Access to and Use of Medical Home
CSHCN 3	Transition
AH 1	Adolescent Well Visit
AH 2	Injury Prevention
AH 3	Screening for Major Depressive Disorder
LC 1	Adequate Health Insurance Coverage
LC 2	Tobacco and eCigarette Use
LC 3	Oral Health

<b>Core 1 PERFORMANCE MEASURE</b>	The percent of programs meeting the stated aims of their grant at the end of the current grant cycle
<b>Goal: Grant Impact</b>	
<b>Level: Grantee</b>	
<b>Domain: Core</b>	
<b>GOAL</b>	To ensure that planned grant impact was met.
<b>MEASURE</b>	The percent of MCHB funded projects meeting their stated objectives.
<b>DEFINITION</b>	<b>Tier 1:</b> Have you met the planned objectives as stated at the beginning of the grant cycle? <i>Prepopulated with the objectives from NOFO:</i> <ul style="list-style-type: none"><li>• Did you meet objective 1_____? Y/N</li><li>• Did you meet objective 2_____? Y/N</li></ul>
<b>BENCHMARK DATA SOURCES</b>	N/A
<b>GRANTEE DATA SOURCES</b>	Grantee self-reported.
<b>SIGNIFICANCE</b>	

**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**

<p><b>Core 3 PERFORMANCE MEASURE</b></p> <p><b>Goal: Health Equity</b>  <b>Level: Grantee</b>  <b>Domain: Capacity Building</b></p>	<p>The percent of programs promoting and/ or facilitating improving health equity.</p>
<p><b>GOAL</b></p>	<p>To ensure MCHB grantees have established specific aims related to improving health equity.</p>
<p><b>MEASURE</b></p>	<p>The percent of MCHB funded projects with specific measurable aims related to promoting health equity.</p>
<p><b>DEFINITION</b></p>	<p><b>Tier 1:</b> Are you promoting and/ or facilitating health equity in your program?  <input type="checkbox"/> Yes  <input type="checkbox"/> No</p> <p><b>Tier 2:</b> Please select within which of the following domains your program addresses health equity (check all that apply):  <input type="checkbox"/> Income  <input type="checkbox"/> Race  <input type="checkbox"/> Ethnicity  <input type="checkbox"/> Language  <input type="checkbox"/> Socioeconomic Status  <input type="checkbox"/> Health Status  <input type="checkbox"/> Disability  <input type="checkbox"/> Sexual Orientation  <input type="checkbox"/> Sex  <input type="checkbox"/> Gender  <input type="checkbox"/> Age  <input type="checkbox"/> Geography – Rural/ Urban  <input type="checkbox"/> Other: _____</p> <p><b>Tier 3: Implementation</b>      Has your program set stated goal/ objectives for health equity? Y/N      If yes, what are those aims? _____</p> <p><b>Tier 4:</b> What are the related outcomes?      % of programs that met stated goals/ objectives around health equity  <b>Numerator:</b> # of programs that met stated specific aims around health equity  <b>Denominator:</b> # of programs that set specific aims around health equity</p> <p><i>* 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.</i></p>
<p><b>BENCHMARK DATA SOURCES</b></p>	<p>N/A</p>
<p><b>GRANTEE DATA SOURCES</b></p>	<p>Grantee self-reported.</p>
<p><b>SIGNIFICANCE</b></p>	<p>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</p>

position or socially determined consequences.” Achieving health equity is a top priority in the United States.

**CB 1 PERFORMANCE MEASURE**

The percent of programs promoting and facilitating state capacity for advancing the health of MCH populations.

**Goal: State capacity for advancing the health of MCH populations (for National programs)**

**Level: Grantee**

**Domain: Capacity Building**

**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



**CB 1 PERFORMANCE MEASURE**

The percent of programs promoting and facilitating state capacity for advancing the health of MCH populations.

**Goal: State capacity for advancing the health of MCH populations (for National programs)**

**Level: Grantee**

**Domain: Capacity Building**

- € Developmental Disabilities
- € Medicaid
- € Mental & Behavioral Health
- € 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**

The percent of programs providing technical assistance on MCH priority topics.

**Goal: Technical Assistance**

**Level: Grantee**

**Domain: Capacity Building**

**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) through 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 Assistance 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.*

**CB 2 PERFORMANCE MEASURE**

The percent of programs providing technical assistance on MCH priority topics.

**Goal: Technical Assistance**

**Level: Grantee**

**Domain: Capacity Building**

**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.

**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				
Nutrition				
Data Research and Evaluation				
Other (Specify: _____)				

**CB 3 PERFORMANCE MEASURE**

The percent of grantees that collect and analyze data on the impact of their grants on the field.

**Goal: Impact Measurement**

**Level: Grantee**

**Domain: Capacity Building**

**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

Specify Tools: \_\_\_\_\_

Outcomes of qualitative assessment

# of participant surveys

# of clients whose level data collected

# 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.

<b>CB 4 PERFORMANCE MEASURE</b>	The percent of MCHB funded initiatives working to promote sustainability of their programs or initiatives beyond the life of MCHB funding.
<b>Goal: Sustainability</b>	
<b>Level: Grantee</b>	
<b>Domain: Capacity Building</b>	

<b>GOAL</b>	To ensure sustainability of programs or initiatives over time, beyond the duration of MCHB funding.
<b>MEASURE</b>	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.
<b>DEFINITION</b>	<p><b>Tier 1:</b> Are you addressing sustainability in your program?</p> <ul style="list-style-type: none"><li>€ Yes</li><li>€ No</li></ul> <p><b>Tier 2:</b> Through what processes/ mechanisms are you addressing sustainability?</p> <ul style="list-style-type: none"><li>€ 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</li><li>€ 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</li><li>€ 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</li><li>€ 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</li><li>€ 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</li><li>€ The grantee identified, actively sought out, and obtained other funding sources and in-kind resources to sustain the entire MCHB-funded program or initiative</li><li>€ 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</li><li>€ 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</li><li>€ 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</li></ul> <p><b>Tier 3:</b> Implementation N/A</p> <p><b>Tier 4:</b> What are the related outcomes?</p>

**CB 4 PERFORMANCE MEASURE**

The percent of MCHB funded initiatives working to promote sustainability of their programs or initiatives beyond the life of MCHB funding.

**Goal: Sustainability**

**Level: Grantee**

**Domain: Capacity Building**

% of grants that have sustainability plans

**BENCHMARK DATA SOURCES**

N/A

**GRANTEE DATA SOURCES**

Grantee self-reported.

**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.

<b>CB 5 PERFORMANCE MEASURE</b>	The percent of programs supporting the production of scientific publications and through what means, and related outcomes.
<b>Goal: Scientific Publications</b>	
<b>Level: Grantee</b>	
<b>Domain: Capacity Building</b>	
<b>GOAL</b>	To ensure supportive programming for the production of scientific publications.
<b>MEASURE</b>	The percent of MCHB funded projects programs supporting the production of scientific publications.
<b>DEFINITION</b>	<p><b>Tier 1:</b> Are you supporting the production of scientific publications in your program?</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Yes</li><li><input type="checkbox"/> No</li></ul> <p><b>Tier 2:</b> Indicate the categories of scientific publication that have been produced with grant support (either fully or partially) during the reporting period.</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Submitted</li><li><input type="checkbox"/> In press</li><li><input type="checkbox"/> Published</li></ul> <p><b>Tier 3:</b> How many are reached through those activities? # of scientific/ peer-reviewed publications</p> <p><b>Tier 4:</b> How, if at all, have these publications been disseminated (check all that apply)?</p> <p><i>Note: research only; include this as Part B of publications form</i></p> <ul style="list-style-type: none"><li><input type="checkbox"/> TV/ Radio interview(s)</li><li><input type="checkbox"/> Newspaper interview(s)</li><li><input type="checkbox"/> Online publication interview(s)</li><li><input type="checkbox"/> Press release</li><li><input type="checkbox"/> Social Networking sites</li><li><input type="checkbox"/> Listservs</li><li><input type="checkbox"/> Presentation at conference (poster, abstract, presentation)</li><li><input type="checkbox"/> Websites</li></ul>
<b>GRANTEE DATA SOURCES</b>	Grantee self-reported.
<b>SIGNIFICANCE</b>	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.



<b>CB 6 PERFORMANCE MEASURE</b>	The percent of programs supporting the development of informational products and through what means, and related outcomes.
<b>Goal: Products</b>	
<b>Level: Grantee</b>	
<b>Domain: Capacity Building</b>	
<b>GOAL</b>	To ensure supportive programming for the development of informational products.
<b>MEASURE</b>	The percent of MCHB funded projects supporting the development of informational products, and through what processes.
<b>DEFINITION</b>	<p><b>Tier 1:</b> Are you creating products as part of your MCHB-supported program?</p> <ul style="list-style-type: none"><li>€ Yes</li><li>€ No</li></ul> <p><b>Tier 2:</b> Indicate the categories of products that have been produced with grant support (either fully or partially) during the reporting period. <i>Count the original completed product, not each time it is disseminated or presented.</i></p> <ul style="list-style-type: none"><li>€ Books</li><li>€ Book chapters</li><li>€ Reports and monographs (including policy briefs, best practice reports, white papers)</li><li>€ Conference presentations and posters presented</li><li>€ Web-based products (website, blogs, webinars, newsletters, distance learning modules, wikis, RSS feeds, social networking sites) <i>Excluding video/ audio products that are posted online post-production</i></li><li>€ Audio/ Video products (podcasts, produced videos, video clips.CD-ROMs, CDs, or audio)</li><li>€ Press communications (TV/ Radio interviews, newspaper interviews, public service announcements, and editorial articles)</li><li>€ Newsletters (electronic or print)</li><li>€ Pamphlets, brochures, or fact sheets</li><li>€ Academic course development</li><li>€ Distance learning modules</li><li>€ Doctoral dissertations/ Master’s theses</li><li>€ Other: _____</li></ul> <p><b>Tier 3:</b> Implementation of products # products created in each category</p>
<b>GRANTEE DATA SOURCES</b>	Grantee self-reported.
<b>SIGNIFICANCE</b>	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** The percent of programs promoting and facilitating state capacity for direct annual access to MCH electronic health data

**Goal: Direct Annual Access to MCH Data**  
**Level: Grantee**  
**Domain: Capacity Building**

**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**

<b>Tier 1. State Capacity to Access MCH Data for Programming and/ or Reporting on a consistent, Direct and Timely Basis</b>						
	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>
<b>Data Sources</b>	<b>State Has Consistent Annual Access to Data Source<sup>0</sup></b>	<b>State Has Direct Access to an Electronic Database<sup>0</sup></b>	<b>State Has Consistent Annual and Direct Access to Data Source<sup>0</sup></b>	<b>Describe Periodicity<sup>0</sup> (if available more often than annually; does not need to be direct)</b>	<b>Describe Lag Length (for the most timely data available, annual or otherwise if more frequent)</b>	<b>Data Source Is Linked to Vital Records Birth</b>
<b>1. Vital Records Birth</b>				__ Quarterly __ Monthly __ More often than monthly	__# months <sup>0</sup> __ < 6mos <sup>0</sup>	
<b>2. Vital Records Death</b>				__ Quarterly __ Monthly __ More often than monthly	__# Months __ < 6mos	
<b>3. Medicaid</b>				__ Quarterly __ Monthly __ More often than monthly	__# Months __ < 6mos	
<b>4. WIC</b>				__ Quarterly __ Monthly __ More often than	__# Months __ <	

<sup>0</sup> Consistent Annual Access Yes = 1; No = 0

<sup>0</sup> Direct Access to an Electronic Database for Analysis Yes = 1; No = 0

<sup>0</sup> Consistent Annual and Direct Access Yes = 1; No = 0

<sup>0</sup> If Available More Often Than Annually, Indicate Most Frequent Availability Yes = 1; No = 0

<sup>0</sup> Indicate Lag Length for Most Timely Data Available in Number of Months

<sup>0</sup> Indicate Lag Lengths Less than 6 months Yes = 1; No = 0

				monthly	6mos	
<b>5. Newborn Bloodspot Screening</b>				__Quarterly __Monthly __More often than monthly	____# Months ____< 6mos	
<b>6. Newborn Hearing Screening</b>				__Quarterly __Monthly __More often than monthly	____# Months ____< 6mos	
<b>7. Hospital Discharge</b>				__Quarterly __Monthly __More often than monthly	____# Months ____< 6mos	
<b>8. PRAMS or PRAMS-like</b>				__Quarterly __Monthly __More often than monthly	____# Months ____< 6mos	
<b>9. Other:</b>						
<b>Sum<sup>0</sup>/N</b>	____/8	____/8	____/8	____/8	____/8	____/8
<b>Percentages<sup>0</sup></b>						

**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.

<sup>0</sup> Only Sum 1's; Include only Unshaded Cells in Sums  
<sup>0</sup> 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 women receiving referrals or # of partners receiving TA). For those services you do not provide, or segments you do not reach, please leave the cell blank.

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

<b>WHM 1 PERFORMANCE MEASURE</b>	The percent of programs promoting and/or facilitating timely prenatal care.
<b>Goal: Prenatal Care</b>	
<b>Level: Grantee</b>	
<b>Domain: Women's/ Maternal Health</b>	
<b>GOAL</b>	To ensure supportive programming for prenatal care.
<b>MEASURE</b>	The percent of MCHB funded projects addressing prenatal care. The percent of pregnant program participants who receive prenatal care beginning in the first trimester.
<b>DEFINITION</b>	<p><b>Tier 1:</b> Are you addressing prenatal care in your program?</p> <ul style="list-style-type: none"><li>€ Yes</li><li>€ No</li></ul> <p><b>Tier 2:</b> Through what processes/ mechanisms are you addressing prenatal care?</p> <ul style="list-style-type: none"><li>€ Technical Assistance</li><li>€ Training</li><li>€ Product Development</li><li>€ Research/ Peer-reviewed publications</li><li>€ Outreach/ Information Dissemination/ Education</li><li>€ Tracking/ Surveillance</li><li>€ Screening/ Assessment</li><li>€ Referral/ care coordination</li><li>€ Direct Service</li><li>€ Quality improvement initiatives</li></ul> <p><b>Tier 3:</b> How many are reached through those activities? <i>(Report in Table 1: Activity Data Collection Form)</i></p> <ul style="list-style-type: none"><li># receiving TA</li><li># receiving training</li><li># products developed</li><li># peer-reviewed publications published</li><li># receiving information and education through outreach</li><li># receiving screening/ assessment</li><li># referred/care coordinated</li><li># received direct service</li><li># participating in quality improvement initiatives</li></ul> <p><b>Tier 4:</b> What are the related outcomes?</p> <p>% of pregnant women who receive prenatal care beginning in the first trimester</p> <p><b>Numerator:</b> Pregnant program participants who began prenatal care in the first trimester of pregnancy.</p> <p><b>Denominator:</b> Pregnant program participants who were enrolled prenatally, prior to their second trimester of pregnancy.</p>
<b>BENCHMARK DATA SOURCES</b>	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%)
<b>GRANTEE DATA SOURCES</b>	Title V Ntnl Outcome Measure #1, Healthy People 2020 MICH-10
<b>SIGNIFICANCE</b>	Entry of prenatal care during the first trimester is important to

**WHM 1 PERFORMANCE MEASURE**

The percent of programs promoting and/or facilitating timely prenatal care.

**Goal: Prenatal Care**

**Level: Grantee**

**Domain: Women's/ Maternal Health**

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.

<b>WHM 2 PERFORMANCE MEASURE</b>	The percent of programs promoting and/or facilitating timely postpartum care.
<b>Goal: Perinatal/ Postpartum Care</b>	
<b>Level: Grantee</b>	
<b>Domain: Women's/ Maternal Health</b>	
<b>GOAL</b>	To ensure supportive programming for postpartum care.
<b>MEASURE</b>	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
<b>DEFINITION</b>	<b>Tier 1:</b> Are you promoting and/ or facilitating timely postpartum care in your program? € Yes € No <b>Tier 2:</b> 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 <b>Tier 3:</b> How many are reached through those activities? <a href="#">(Report in Table 1: Activity Data Collection Form)</a> # 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 <b>Tier 4:</b> What are the related outcomes in the reporting year? % of pregnant women with a postpartum visit within 4 to 6 weeks after delivery <sup>0</sup> <b>Numerator:</b> Women program participants who enrolled prenatally or within 30 days after delivery and received a postpartum visit within 4-6 weeks after delivery <sup>0</sup> <b>Denominator:</b> Women program participants who enrolled prenatally or within 30 days after delivery during the reporting period <b>Definition:</b> ACOG recommends that the postpartum visit occur between 4-6 weeks after delivery. ACOG suggests a 7-14 day postpartum visit for high-risk women. <sup>0</sup> A participant who has a visit prior to 4-6 weeks

<sup>0</sup> Consistent with Healthy Start Benchmark 3: The percent of Healthy Start women participants who receive a postpartum visit.

<sup>0</sup> PRAMS measures 4-6 weeks, a visit between 28-42 days of delivery.

<sup>0</sup> Note: ACOG suggests a 7-14 day postpartum visit for high-risk women.

**WHM 2 PERFORMANCE MEASURE**

The percent of programs promoting and/or facilitating timely postpartum care.

**Goal: Perinatal/ Postpartum Care**

**Level: Grantee**

**Domain: Women's/ Maternal Health**

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. <sup>0</sup>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.

<sup>0</sup> <http://www.aafp.org/afp/2005/1215/p2491.html>



**WMH 3 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating well woman visits/ preventive health care.

**Goal: Well Woman Visit/ Preventive Health Care**

**Level: Grantee**

**Domain: Women's/ Maternal Health**

**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.<sup>0</sup>

**Numerator:** Women program participants who received a well-woman or preventive visit (including prenatal or postpartum visit) in the past 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

<sup>0</sup> Consistent with Healthy Start Benchmark 5: The percent of Healthy Start women participants who have a well-woman visit.

**WMH 3 PERFORMANCE MEASURE** The percent of programs promoting and/ or facilitating well woman visits/ preventive health care.  
**Goal: Well Woman Visit/ Preventive Health Care**  
**Level: Grantee**  
**Domain: Women's/ Maternal Health**

within twelve months of her last contact with the Program in the reporting year. 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.<sup>0</sup>

<sup>0</sup> <http://www.acog.org/About-ACOG/ACOG-Departments/Annual-Womens-Health-Care/Well-Woman-Recommendations>

**WMH 4 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating depression screening.

**Goal: Depression Screening**

**Level: Grantee**

**Domain: Women's/ Maternal Health**

**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<sup>0</sup>

**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.

**Definition:** 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.<sup>0</sup>

<sup>0</sup> Consistent with Healthy Start Benchmark 12a and 12b: Percent of Healthy Start women participants who receive depression screening and referral.

<sup>0</sup> <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression>

**WMH 4 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating depression screening.

**Goal: Depression Screening**

**Level: Grantee**

**Domain: Women's/ Maternal Health**

% of women who screened positive for depression who receive a referral for services

**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.

**Definitions:** 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.<sup>0</sup>

<sup>0</sup> <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression>

**PIH 1 PERFORMANCE MEASURE** The percent of Healthy Start participants who engage in safe sleep practices.  
**Goal: Safe Sleep**  
**Level: Grantee**  
**Domain: Perinatal Infant Health**

**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<sup>0</sup>

**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.<sup>0</sup>

**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

<sup>0</sup> Consistent with Healthy Start Benchmark 6: Percent of Healthy Start participants who are placed to sleep following safe sleep behaviors.

<sup>0</sup> [http://nccd.cdc.gov/PRAMStat/rdPage.aspx?rdReport=DRH\\_PRAMS.ExploreByTopic&isClassId=CLA8&isTopicId=TOP23&go=GO](http://nccd.cdc.gov/PRAMStat/rdPage.aspx?rdReport=DRH_PRAMS.ExploreByTopic&isClassId=CLA8&isTopicId=TOP23&go=GO)

**PIH 1 PERFORMANCE MEASURE**

The percent of Healthy Start participants who engage in safe sleep practices.

**Goal: Safe Sleep**

**Level: Grantee**

**Domain: Perinatal Infant Health**

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.<sup>0</sup>

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).<sup>0</sup>

**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.<sup>0</sup>

<sup>0</sup> <https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/aap-expands-guidelines-for-infant-sleep-safety-and-sids-riskreduction.aspx#sthash.1nnEJQwk.dpuf>

<sup>0</sup> [http://nccd.cdc.gov/PRAMStat/rdPage.aspx?rdReport=DRH\\_PRAMS.ExploreByTopic&islClassId=CLA8&islTopicId=TOP23&go=GO](http://nccd.cdc.gov/PRAMStat/rdPage.aspx?rdReport=DRH_PRAMS.ExploreByTopic&islClassId=CLA8&islTopicId=TOP23&go=GO)

<sup>0</sup> <http://nappss.org/plan/background.php>

<b>PIH 2 PERFORMANCE MEASURE</b>	The percent of programs promoting and/ or facilitating breastfeeding.
<b>Goal: Breastfeeding</b>	
<b>Level: Grantee</b>	
<b>Domain: Perinatal Infant Health</b>	
<b>GOAL</b>	To ensure supportive programming for breastfeeding.
<b>MEASURE</b>	The percent of MCHB funded projects promoting and/ or facilitating breastfeeding.
<b>DEFINITION</b>	<p><b>Tier 1:</b> Are you promoting and/ or facilitating breastfeeding in your program?</p> <ul style="list-style-type: none"><li>€ Yes</li><li>€ No</li></ul> <p><b>Tier 2:</b> Through what activities are you promoting and/ or facilitating breastfeeding?</p> <ul style="list-style-type: none"><li>€ Technical Assistance</li><li>€ Training</li><li>€ Product Development</li><li>€ Research/ Peer-reviewed publications</li><li>€ Outreach/ Information Dissemination/ Education</li><li>€ Tracking/ Surveillance</li><li>€ Screening/ Assessment</li><li>€ Referral/ care coordination</li><li>€ Direct Service</li><li>€ Quality improvement initiatives</li></ul> <p><b>Tier 3:</b> How many are reached through those activities? <i>(Report in Table 1: Activity Data Collection Form)</i></p> <ul style="list-style-type: none"><li># receiving TA</li><li># receiving training</li><li># products developed</li><li># peer-reviewed publications published</li><li># receiving information and education through outreach</li><li># receiving screening/ assessment</li><li># referred/care coordinated</li><li># received direct service</li><li># participating in quality improvement initiatives</li></ul> <p><b>Tier 4:</b> What are the related outcomes in the reporting year?</p> <p>% of child program participants ever breastfed<sup>0</sup></p> <p><b>Numerator:</b> Total number of HS child participants aged &lt;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.</p> <p><b>Denominator:</b> Total number of HS child participants aged &lt;12 months whose parent was enrolled prenatally or at the time of delivery.</p> <p><b>Definition:</b> 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.</p> <p>% of child program participants breastfed at 6 months<sup>0</sup></p>

<sup>0</sup> 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.

<sup>0</sup> 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**

The percent of programs promoting and/ or facilitating breastfeeding.

**Goal: Breastfeeding**

**Level: Grantee**

**Domain: Perinatal Infant Health**

**Numerator:** Total number of HS child participants age 6 through 11 months whose parent was enrolled 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.<sup>0</sup>

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.<sup>0</sup>

<sup>0</sup> [http://www.babycenter.com/0\\_how-breastfeeding-benefits-you-and-your-baby\\_8910.bc](http://www.babycenter.com/0_how-breastfeeding-benefits-you-and-your-baby_8910.bc)

<sup>0</sup> <http://www.nichd.nih.gov/health/topics/breastfeeding/conditioninfo/Pages/benefits.aspx>



<b>PIH 3 PERFORMANCE MEASURE</b>	Percent of programs promoting newborn screenings and follow-up.
<b>Goal: Newborn Screening</b>	
<b>Level: Grantee</b>	
<b>Domain: Perinatal Infant Health</b>	

<b>GOAL</b>	To ensure supportive programming for newborn screenings.
<b>MEASURE</b>	The percent of MCHB funded projects promoting and/ or facilitating newborn screening and follow-up.
<b>DEFINITION</b>	<p><b>Tier 1:</b> Are you promoting and/or facilitating newborn screening and follow-up in your program?</p> <ul style="list-style-type: none"> <li>€ Yes</li> <li>€ No</li> </ul> <p><b>Tier 2:</b> Through what processes/ mechanisms are you promoting or facilitating newborn screening and follow-up?</p> <ul style="list-style-type: none"> <li>€ Technical Assistance</li> <li>€ Training</li> <li>€ Product Development</li> <li>€ Research/ Peer-reviewed publications</li> <li>€ Outreach/ Information Dissemination/ Education</li> <li>€ Tracking/ Surveillance</li> <li>€ Screening/ Assessment</li> <li>€ Referral/ care coordination</li> <li>€ Direct Service</li> <li>€ Quality improvement initiatives</li> </ul> <p><b>Tier 3:</b> How many are reached through those activities?  <i>(Report in Table 1: Activity Data Collection Form)</i></p> <ul style="list-style-type: none"> <li># receiving TA</li> <li># receiving training</li> <li># products developed</li> <li># peer-reviewed publications published</li> <li># receiving information and education through outreach</li> <li># receiving screening/ assessment</li> <li># referred/care coordinated</li> <li># received direct service</li> <li># participating in quality improvement initiatives</li> </ul> <p><b>Tier 4:</b> What are the related outcomes in the reporting year?</p> <p>% of eligible newborns screened with timely notification for out of range screens</p> <p><b>Numerator:</b> # of eligible newborns screened with out of range results whose caregivers receive timely notification</p> <p><b>Denominator:</b> # of eligible newborns screened with out of range results</p> <p>% of eligible newborns screened with timely notification for out of range screens who are followed up in a timely manner</p> <p><b>Numerator:</b> # of eligible newborns screened with out of range results whose caregivers receive timely notification and receive timely follow up</p> <p><b>Denominator:</b> # of eligible newborns screened with out of range results whose caregivers receive timely notification</p>

<b>BENCHMARK DATA SOURCES</b>	Objective # MICH-32: Increase appropriate newborn-blood spot
-------------------------------	--

**PIH 3 PERFORMANCE MEASURE**

Percent of programs promoting newborn screenings and follow-up.

**Goal: Newborn Screening**

**Level: Grantee**

**Domain: Perinatal Infant Health**

screening and follow-up testing (Baseline: 98.3% in 2006, Target: 100%)

**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** The percent of programs promoting and/ or facilitating well-child visits.

**Goal: Well Child Visit**  
**Level: Grantee**  
**Domain: Child Health**

**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.<sup>0</sup>

**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.

**Definition:** 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

<sup>0</sup> Consistent with Healthy Start Benchmark 11: The percent of Healthy Start child participants who receive well child visits.

**CH 1 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating well-child visits.

**Goal: Well Child Visit**

**Level: Grantee**

**Domain: Child Health**

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 thereafter.<sup>0</sup>

% 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.

<sup>0</sup> [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf)

<b>CH 2 PERFORMANCE MEASURE</b>	The percent of programs promoting and/ or facilitating quality of well-child visits.
<b>Goal: Quality of Well Child Visit</b>	
<b>Level: Grantee</b>	
<b>Domain: Child Health</b>	
<b>GOAL</b>	To ensure supportive programming for quality of well child visits.
<b>MEASURE</b>	The percent of MCHB funded projects promoting or facilitating quality of well child visits.
<b>DEFINITION</b>	<p><b>Tier 1:</b> Are you addressing the quality of well child visits in your program?</p> <ul style="list-style-type: none"><li>€ Yes</li><li>€ No</li></ul> <p><b>Tier 2:</b> Through what activities are you addressing quality of well child visits?</p> <ul style="list-style-type: none"><li>€ Technical Assistance</li><li>€ Training</li><li>€ Product Development</li><li>€ Research/ Peer-reviewed publications</li><li>€ Outreach/ Information Dissemination/ Education</li><li>€ Quality improvement initiatives</li></ul> <p><b>Tier 3:</b> How many are reached through those activities?</p> <ul style="list-style-type: none"><li># receiving TA</li><li># receiving training</li><li># product disseminated</li><li># reached while guideline setting</li><li># peer-reviewed publications published</li><li># receiving information and education through outreach</li><li># participating in quality improvement initiatives</li></ul> <p><i>See data collection form below.</i></p> <p><b>Tier 4:</b> What are the related outcomes in the reporting year?</p> <ul style="list-style-type: none"><li>% providers trained in conducting a quality well-child visit</li></ul> <p><b>Numerator:</b> # of providers trained <b>Denominator:</b> # of providers targeted through the program</p>
<b>BENCHMARK DATA SOURCES</b>	N/A
<b>GRANTEE DATA SOURCES</b>	Grantee self-reported.
<b>SIGNIFICANCE</b>	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.

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

<b>CH 3 PERFORMANCE MEASURE</b>	Percent of programs promoting developmental screenings and follow-up for children.
<b>Goal: Developmental Screening</b>	
<b>Level: Grantee</b>	
<b>Domain: Child Health</b>	
<b>GOAL</b>	To ensure supportive programming for developmental screenings.
<b>MEASURE</b>	The percent of MCHB funded projects promoting and/ or facilitating developmental screening and follow-up for children.
<b>DEFINITION</b>	<p><b>Tier 1:</b> Are you promoting and/or facilitating developmental screening and follow-up in your program?</p> <ul style="list-style-type: none"> <li>€ Yes</li> <li>€ No</li> </ul> <p><b>Tier 2:</b> Through what processes/ mechanisms are you promoting or facilitating developmental screening and follow-up?</p> <ul style="list-style-type: none"> <li>€ Technical Assistance</li> <li>€ Training</li> <li>€ Product Development</li> <li>€ Research/ Peer-reviewed publications</li> <li>€ Outreach/ Information Dissemination/ Education</li> <li>€ Tracking/ Surveillance</li> <li>€ Screening/ Assessment</li> <li>€ Referral/ care coordination</li> <li>€ Direct Service</li> <li>€ Quality improvement initiatives</li> </ul> <p><b>Tier 3:</b> How many are reached through those activities?  <i>(Report in Table 1: Activity Data Collection Form)</i></p> <ul style="list-style-type: none"> <li># receiving TA</li> <li># receiving training</li> <li># products developed</li> <li># peer-reviewed publications published</li> <li># receiving information and education through outreach</li> <li># receiving screening/ assessment</li> <li># referred/care coordinated</li> <li># received direct service</li> <li># participating in quality improvement initiatives</li> </ul> <p><b>Tier 4:</b> What are the related outcomes in the reporting year?</p> <p>% of children 9 through 71 months receiving a developmental screening using a parental-completed tool?</p> <p><b>Numerator:</b> Children of program participants aged 9 to 71 months who have received a developmental screening using a parent/ caretaker-completed tool</p> <p><b>Denominator:</b> Children, aged 9 to 71 months, of program participants</p>
<b>BENCHMARK DATA SOURCES</b>	National Survey of Children's Health Indicator 4.16: Developmental screening during health care visit, age 10 months-5 years (2011/2012)
<b>GRANTEE DATA SOURCES</b>	Title V National Performance Measure #6, Title V National Outcome Measure #12

**CH 3 PERFORMANCE MEASURE**

Percent of programs promoting developmental screenings and follow-up for children.

**Goal: Developmental Screening**

**Level: Grantee**

**Domain: Child Health**

**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**

The percent of programs promoting and/ or facilitating injury prevention among children.

**Goal: Injury Prevention**  
**Level: Grantee**  
**Domain: Child Health**

**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

**CH 4 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating injury prevention among children.

**Goal: Injury Prevention**

**Level: Grantee**

**Domain: Child Health**

**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.

**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										
<b>Notes:</b>										

**CSHCN 1 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating family engagement among children and youth with special health care needs.

**Goal: Family Engagement**

**Level: Grantee**

**Domain: CSHCN**

**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:** 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

**Tier 4:** What are the related outcomes?

% 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

**CSHCN 1 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating family engagement among children and youth with special health care needs.

**Goal: Family Engagement**

**Level: Grantee**

**Domain: CSHCN**

**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

**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.

<b>CSHCN 2 PERFORMANCE MEASURE</b> <b>Goal: Access to and Use of Medical Home</b> <b>Level: Grantee</b> <b>Domain: CSHCN</b>	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?

% 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

**CSHCN 2 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating medical home access and use among children and youth with special health care needs.

**Goal: Access to and Use of Medical Home**

**Level: Grantee**

**Domain: CSHCN**

aspects of pediatric care.

**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.

<b>CSHCN 3 PERFORMANCE MEASURE</b>	The percent of programs promoting and/or facilitating transition to adult health care for youth with special health care needs.
<b>Goal: Transition Level: Grantee Domain: CSHCN</b>	
<b>GOAL</b>	To ensure supportive programming for transition to adult health care for youth with special health care needs.
<b>MEASURE</b>	The percent of MCHB funded projects promoting and/or facilitating transition to adult health care for youth with special health care needs.
<b>DEFINITION</b>	<p><b>Tier 1:</b> Are you addressing the transitional needs to adult health care for youth with special health care needs in your program?</p> <ul style="list-style-type: none"><li>€ Yes</li><li>€ No</li></ul> <p><b>Tier 2:</b> Through what activities are you promoting or facilitating the transition to adult health care for youth with special health care needs?</p> <ul style="list-style-type: none"><li>€ Technical Assistance</li><li>€ Training</li><li>€ Product Development</li><li>€ Research/ Peer-reviewed publications</li><li>€ Outreach/ Information Dissemination/ Education</li><li>€ Tracking/ Surveillance</li><li>€ Screening/ Assessment</li><li>€ Referral/ care coordination</li><li>€ Direct Service</li><li>€ Quality improvement initiatives</li></ul> <p><b>Tier 3:</b> How many are reached through those activities? <i>(Report in Table 1: Activity Data Collection Form)</i></p> <ul style="list-style-type: none"><li># receiving TA</li><li># receiving training</li><li># products developed</li><li># peer-reviewed publications published</li><li># receiving information and education through outreach</li><li># receiving screening/ readiness assessment</li><li># referred/ care coordinated</li><li># received direct service</li><li># participating in quality improvement initiatives</li></ul> <p><b>Tier 4:</b> What are the related outcomes?</p> <p>% of grantees promoting an evidence-informed framework and clinical recommendations for transition from pediatric to adult health care.</p> <p><b>Numerator:</b> Number of Grantees promoting an evidence informed framework</p> <p><b>Denominator:</b> Total Number of grantees reporting transition performance measure</p> <p>% of grantees involving both pediatric and adult providers/systems in transition efforts</p> <p><b>Numerator:</b> Number of pediatric and adult providers involved in grantee transition efforts</p> <p><b>Denominator:</b> Total number of transition practices sponsored by grantee</p> <p>% of grantees initiating or encouraging transition planning</p>



**CSHCN 3 PERFORMANCE MEASURE**

The percent of programs promoting and/or facilitating transition to adult health care for youth with special health care needs.

**Goal: Transition**  
**Level: Grantee**  
**Domain: CSHCN**

early in adolescence

**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](http://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**

The percent of programs promoting and/ or facilitating adolescent well visits.

**Goal: Adolescent Well Visit**  
**Level: Grantee**  
**Domain: Adolescent Health**

**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

**AH 1 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating adolescent well visits.

**Goal: Adolescent Well Visit**

**Level: Grantee**

**Domain: Adolescent Health**

proportion of adolescent who have had a wellness checkup in the past 12 months Baseline: 68.7%, Target: 75.6%).

**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**

The percent of programs promoting and/ or facilitating adolescent injury prevention.

**Goal: Injury Prevention**

**Level: Grantee**

**Domain: Adolescent Health**

**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

**AH 2 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating adolescent injury prevention.

**Goal: Injury Prevention**

**Level: Grantee**

**Domain: Adolescent Health**

**Target Population:** \_\_\_\_\_

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

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

<b>AH 3 PERFORMANCE MEASURE</b>	The percent of programs promoting and/ or facilitating screening for major depressive disorder.
<b>Goal: Screening for Major Depressive Disorder</b>	
<b>Level: Grantee</b>	
<b>Domain: Adolescent Health</b>	
<b>GOAL</b>	To ensure supportive programming for screening for major depressive disorder.
<b>MEASURE</b>	The percent of MCHB funded projects promoting and/ or facilitating screening for major depressive disorder for adolescents and through what processes.
<b>DEFINITION</b>	<p><b>Tier 1:</b> Are you promoting and/ or facilitating screening major depressive disorder for adolescents in your program?</p> <ul style="list-style-type: none"><li>€ Yes</li><li>€ No</li></ul> <p><b>Tier 2:</b> Through what processes/ mechanisms are you addressing injury prevention?</p> <ul style="list-style-type: none"><li>€ Technical Assistance</li><li>€ Training</li><li>€ Product Development</li><li>€ Research/ Peer-reviewed publications</li><li>€ Outreach/ Information Dissemination/ Education</li><li>€ Tracking/ Surveillance</li><li>€ Screening/ Assessment</li><li>€ Referral/ care coordination</li><li>€ Direct Service</li><li>€ Quality improvement initiatives</li></ul> <p><b>Tier 3:</b> How many are reached through those activities? <i>(Report in Table 1: Activity Data Collection Form)</i></p> <ul style="list-style-type: none"><li># receiving TA</li><li># receiving training</li><li># products developed</li><li># peer-reviewed publications published</li><li># receiving information and education through outreach</li><li># receiving screening/ assessment training</li><li># referred/ care coordinated</li><li># received direct service</li><li># participating in quality improvement initiatives</li></ul> <p><b>Tier 4:</b> What are the related outcomes in the reporting year?</p> <p>% of 12-17 year olds screened for MDD in the past year in community level or school health settings</p> <p><b>Numerator:</b> Adolescents involved with your program in the reporting year who were screened for MDD in a community-level or school health setting.</p> <p><b>Denominator:</b> Adolescents involved with your program in the reporting year.</p> <p>% of adolescent well care visits that include screening for MDD</p> <p><b>Numerator:</b> Adolescents involved with your program in the reporting year that had a well-child that included a screening for MDD, in the reporting year.</p> <p><b>Denominator:</b> Adolescents involved with your program in the reporting year that had a well-child visit in the reporting year.</p> <p>% of adolescents identified with a MDD that receive treatment</p>



**AH 3 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating screening for major depressive disorder.

**Goal: Screening for Major Depressive Disorder**

**Level: Grantee**

**Domain: Adolescent Health**

**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**

The percent of programs promoting and/ or facilitating adequate health insurance coverage.

**Goal: Adequate Health Insurance Coverage**

**Level: Grantee**

**Domain: Life Course/ Cross Cutting**

**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?

% with health insurance<sup>0</sup>

**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

<sup>0</sup> Consistent with Healthy Start Benchmark 1: The percent of Healthy Start women and child participants with health insurance.

**LC 1 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating adequate health insurance coverage.

**Goal: Adequate Health Insurance Coverage**

**Level: Grantee**

**Domain: Life Course/ Cross Cutting**

**BENCHMARK DATA SOURCES**

Related to HP2020 Access to Health Services Objective 1: Increase the proportion of persons with health insurance. (Baseline: 83.2% persons had medical insurance in 2008, Target: 100%); National Survey of Children's Health (Children's Average 94.5%, 2011/2012),<sup>0</sup> National Health Interview Survey<sup>0</sup>

**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.

<sup>0</sup> <http://childhealthdata.org/browse/survey/results?q=2197&r=1>

<sup>0</sup> <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.

	<b>Pregnant/ Perinatal Women (Col 1)</b>	<b>Infants (Col 2)</b>	<b>Children (Col3)</b>	<b>CSHCN (Col 4)</b>	<b>Adolescents (Col 5)</b>	<b>Non-pregnant Adults (Col 5)</b>	<b>Providers/ Health Care Professionals (Col 6)</b>	<b>Community/ Local Partners (Col 7)</b>	<b>State or National Partners (Col 8)</b>	<b>Other Specify____ (Col 9)</b>
<b>Technical Assistance</b>										
<b>Training</b>										
<b>Product Development</b>										
<b>Research/ Peer-reviewed publications</b>										
<b>Outreach/ Information Dissemination/ Education</b>										
<b>Tracking/ Surveillance</b>										
<b>Screening/ Assessment</b>										
<b>Referral</b>										
<b>Direct Service</b>										
<b>Quality improvement initiatives</b>										

<b>LC 2 PERFORMANCE MEASURE</b>	The percent of programs promoting and/ or facilitating tobacco and eCigarette cessation.
<b>Goal: Tobacco and eCigarette Use</b>	
<b>Level: Grantee</b>	
<b>Domain: Life Course/ Cross Cutting</b>	
<b>GOAL</b>	To ensure supportive programming promoting and/ or facilitating tobacco and eCigarette cessation.
<b>MEASURE</b>	The percent of MCHB funded projects promoting and/ or facilitating tobacco and eCigarette cessation, and through what processes.
<b>DEFINITION</b>	<p><b>Tier 1:</b> Are you addressing tobacco and eCigarette cessation in your program?</p> <ul style="list-style-type: none"><li>€ Yes</li><li>€ No</li></ul> <p><b>Tier 2:</b> Through what activities are you promoting and/ or facilitating tobacco and eCigarette cessation?</p> <ul style="list-style-type: none"><li>€ Technical Assistance</li><li>€ Training</li><li>€ Product Development</li><li>€ Research/ Peer-reviewed publications</li><li>€ Outreach/ Information Dissemination/ Education</li><li>€ Tracking/ Surveillance</li><li>€ Screening/ Assessment</li><li>€ Referral/ care coordination</li><li>€ Direct Service</li><li>€ Quality improvement initiatives</li></ul> <p><b>Tier 3:</b> How many are reached through those activities? <i>See data LC 2 Data Collection Form.</i></p> <p><b>Tier 4:</b> What are the related outcomes in the reporting year?</p> <p>% of prenatal women who abstain from smoking</p> <p><b>Numerator:</b> Number of program participants who do not smoke cigarettes as of their last contact in the reporting year.</p> <p><b>Denominator:</b> Number of program participants.</p> <p>% of prenatal program participants that abstain from smoking cigarettes in their third trimester.</p> <p><b>Numerator:</b> Number of Healthy Start prenatal women participants who abstained from using any tobacco products during the last 3 months of pregnancy.</p> <p><b>Denominator:</b> Total number of Healthy Start prenatal women participants who were enrolled at least 90 days before delivery.</p> <p>Smoking includes all tobacco products and e-cigarettes.</p>
<b>BENCHMARK DATA SOURCES</b>	Healthy People 2020 (Baseline 89.6%, 2007), Pregnancy Risk Assessment Monitoring System (PRAMS) (89.8%, 2011); Vital Statistics (94.4%, 2014)
<b>GRANTEE DATA SOURCES</b>	Grantee data systems
<b>SIGNIFICANCE</b>	Research shows that smoking in pregnancy is directly linked to problems including premature birth, certain birth defects,

**LC 2 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating tobacco and eCigarette cessation.

**Goal: Tobacco and eCigarette Use**

**Level: Grantee**

**Domain: Life Course/ Cross Cutting**

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.

	<b>Pregnant/ Perinatal Women (Col 1)</b>	<b>Infants (Col 2)</b>	<b>Children (Col3)</b>	<b>CSHCN (Col 4)</b>	<b>Adolescents (Col 5)</b>	<b>Non-pregnant Adults (Col 5)</b>	<b>Providers/ Health Care Professionals (Col 6)</b>	<b>Community/ Local Partners (Col 7)</b>	<b>State or National Partners (Col 8)</b>	<b>Other Specify____ (Col 9)</b>
<b>Technical Assistance</b>										
<b>Training</b>										
<b>Product Development</b>										
<b>Research/ Peer-reviewed publications</b>										
<b>Outreach/ Information Dissemination/ Education</b>										
<b>Tracking/ Surveillance</b>										
<b>Screening/ Assessment</b>										
<b>Referral</b>										
<b>Direct Service</b>										
<b>Quality improvement initiatives</b>										

<b>LC 3 PERFORMANCE MEASURE</b>	The percent of programs promoting and/ or facilitating oral health.
<b>Goal: Oral Health</b> <b>Level: Grantee</b> <b>Domain: Life Course/ Cross Cutting</b>	
<b>GOAL</b>	To ensure supportive programming for oral health.
<b>MEASURE</b>	The percent of MCHB funded projects promoting and/ or facilitating oral health, and through what activities.
<b>DEFINITION</b>	<p><b>Tier 1:</b> Are you promoting and/ or facilitating oral health in your program?</p> <ul style="list-style-type: none"><li>€ Yes</li><li>€ No</li></ul> <p><b>Tier 2:</b> Through what activities are you promoting and/ or facilitating oral health?</p> <ul style="list-style-type: none"><li>€ Technical Assistance</li><li>€ Training</li><li>€ Product Development</li><li>€ Research/ Peer-reviewed publications</li><li>€ Outreach/ Information Dissemination/ Education</li><li>€ Tracking/ Surveillance</li><li>€ Screening/ Assessment</li><li>€ Referral</li><li>€ Direct Service</li><li>€ Quality improvement initiatives</li></ul> <p><b>Tier 3:</b> How many from each population are reached through each of the activities? <i>See data LC 3 Data Collection Form.</i></p> <p><b>Tier 4:</b> What are the related outcomes in the reporting year?</p> <p>% of program participants receiving an oral health risk assessment</p> <p><b>Numerator:</b> Number of program participants who received an oral health risk assessment in the reporting year</p> <p><b>Denominator:</b> All program participants</p> <p>% of women in program population who had a dental visit during pregnancy</p> <p><b>Numerator:</b> Program participants who were pregnant during the reporting year who had a dental visit</p> <p><b>Denominator:</b> Program participants who were pregnant during the reporting year</p> <p>% of those aged 1 through 17 who had preventative oral health visit during the last year</p> <p><b>Numerator:</b> Infants and children involved with the program who received a preventative oral health visit in the reporting year</p> <p><b>Denominator:</b> Infants and children involved with the program during the reporting year.</p>
<b>BENCHMARK DATA SOURCES</b>	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



**LC 3 PERFORMANCE MEASURE**

The percent of programs promoting and/ or facilitating oral health.

**Goal: Oral Health**

**Level: Grantee**

**Domain: Life Course/ Cross Cutting**

low-income children and adolescents who receive any preventive dental service during the past year (Baseline: 30.2%, Target: 33.2%).

**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.

	<b>Pregnant/ Perinatal Women (Col 1)</b>	<b>Infants (Col 2)</b>	<b>Children (Col3)</b>	<b>CSHCN (Col 4)</b>	<b>Adolescents (Col 5)</b>	<b>Non-pregnant Adults (Col 5)</b>	<b>Providers/ Health Care Professionals (Col 6)</b>	<b>Community/ Local Partners (Col 7)</b>	<b>State or National Partners (Col 8)</b>	<b>Other Specify____ (Col 9)</b>
<b>Technical Assistance</b>										
<b>Training</b>										
<b>Product Development</b>										
<b>Research/ Peer-reviewed publications</b>										
<b>Outreach/ Information Dissemination/ Education</b>										
<b>Tracking/ Surveillance</b>										
<b>Screening/ Assessment</b>										
<b>Referral</b>										
<b>Direct Service</b>										
<b>Quality improvement initiatives</b>										

**DIVISION OF MCH WORKFORCE DEVELOPMENT:  
PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE**

<b>Performance Measure</b>	<b>Topic</b>
<b>Training 01</b>	MCH Training Program and Healthy Tomorrows Family Member/Youth/Community Member participation
<b>Training 02</b>	MCH Training Program and Healthy Tomorrows Cultural Competence
<b>Training 03</b>	Healthy Tomorrows Title V Collaboration
<b>Training 04</b>	Title V Collaboration
<b>Training 05</b>	Policy
<b>Training 06</b>	Diversity of Long-Term Trainees
<b>Training 07</b>	MCH Pipeline Program – Work with MCH populations
<b>Training 08</b>	MCH Pipeline Program – Work with underserved or vulnerable populations
<b>Training 09</b>	MCH Pipeline - Graduate Program Enrollment
<b>Training 10</b>	Leadership
<b>Training 11</b>	Work with MCH Populations
<b>Training 12</b>	Interdisciplinary Practice
<b>Training 13</b>	Diverse Adolescent Involvement (LEAH-specific)
<b>Training 14</b>	Medium-Term Trainees Skill and Knowledge (PPC-Specific)

**Training 01 PERFORMANCE MEASURE**

The percent of MCHB training and Healthy Tomorrows programs that ensure family, youth, and community member participation in program and policy activities.

**Goal: Family/ Youth/ Community Engagement in MCH Training and Healthy Tomorrows Programs**

**Level: Grantee**

**Domain: MCH Workforce Development**

**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,

**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.

culturally/linguistically competent, and coordinated care. Healthy Tomorrows projects are required to incorporate 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
<p><b>Participatory Planning</b></p> <p>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).</p>		
<p><b>Cultural Diversity</b></p> <p>Culturally diverse family members/youth/community members facilitate the training or Healthy Tomorrows program’s ability to meet the needs of the populations served.</p>		
<p><b>Leadership Opportunities</b></p> <p>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.</p>		
<p><b>Compensation</b></p> <p>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.</p>		
<p><b>Train MCH/CSHCN staff</b></p> <p>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.</p>		

**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>)

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.ncccricula.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

**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.

competency policies and practices; cultural and linguistic competence knowledge and skills building efforts; research data on populations served according to racial, ethnic, and linguistic groupings; 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. <b>Written Guidelines</b> 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. <b>Training</b> Cultural and linguistic competence knowledge and skills building are included in training aspects of your program.		
3. <b>Data</b> 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. <b>Staff/faculty diversity</b> MCH Training Program or Healthy Tomorrows staff and faculty reflect cultural and linguistic diversity of the significant populations served.		
5. <b>Professional development</b> MCH Training Program or Healthy Tomorrows staff and faculty participate in professional development activities to promote their cultural and linguistic competence.		
6. <b>Measure progress Measurement of Progress</b> 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**

The degree to which the Healthy Tomorrows Partnership for Children program collaborates with State Title V agencies, other MCH or MCH-related programs.

**Goal: Healthy Tomorrow's Partnership**

**Level: Grantee**

**Domain: MCH Workforce Development**

**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**

The degree to which the Healthy Tomorrows Partnership for Children program collaborates with State Title V agencies, other MCH or MCH-related programs.

**Goal: Healthy Tomorrow's Partnership**

**Level: Grantee**

**Domain: MCH Workforce Development**

**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.



<b>Training 04 PERFORMANCE MEASURE</b>	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs.
<b>Goal: Collaborative Interactions</b>	
<b>Level: Grantee</b>	
<b>Domain: MCH Workforce Development</b>	
<b>GOAL</b>	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.
<b>MEASURE</b>	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs and other professional organizations.
<b>DEFINITION</b>	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.'
<b>BENCHMARK DATA SOURCES</b>	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
<b>GRANTEE DATA SOURCES</b>	The training program completes the attached table which describes the categories of collaborative activity.
<b>SIGNIFICANCE</b>	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,

**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.

and culturally-sensitive systems of health care that serve the diverse needs of all families within their own communities. Interactive collaboration between a training program and Federal, Tribal, State and local agencies dedicated to improving the health of MCH populations will increase active involvement of many disciplines across public and private sectors and increase the likelihood of success in meeting the goals of relevant stakeholders.

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

- 1) collaborate with State Title V and other agencies (at a systems level) to support achievement of 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.



\*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.)



<b>Training 05 PERFORMANCE MEASURE</b>	The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.
<b>Goal: Policy Development</b>	
<b>Level: Grantee</b>	
<b>Domain: MCH Workforce Development</b>	
<b>GOAL</b>	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.
<b>MEASURE</b>	The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.
<b>DEFINITION</b>	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.
<b>BENCHMARK DATA SOURCES</b>	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.
<b>GRANTEE DATA SOURCES</b>	<ul style="list-style-type: none"><li>• Attached data collection form to be completed by grantee.</li><li>• 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.</li></ul>
<b>SIGNIFICANCE</b>	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

**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.

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  <b>If Yes, check all that apply:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Write a policy brief about an emerging local MCH public health issue</li> <li><input type="checkbox"/> Attend a meeting of a local MCH stakeholder group, provide a written summary of their approach</li> <li><input type="checkbox"/> Attend a professional association meeting and actively participate on a committee</li> <li><input type="checkbox"/> Educate Policymakers</li> <li><input type="checkbox"/> Provide written and/or oral testimony to the state legislature</li> <li><input type="checkbox"/> Write an article on an MCH topic for a lay audience</li> <li><input type="checkbox"/> Observe a legislative hearing on CSPAN, or if possible, attend a legislative hearing on an MCH topic</li> <li><input type="checkbox"/> Track a bill over the Internet over the course of a legislative session</li> <li><input type="checkbox"/> 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</li> <li><input type="checkbox"/> Other, please describe _____</li> </ul>		
3. A pre/post assessment is in place to measure increased policy knowledge and skills of <b>long-term</b> 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
<p>4. Trainees, faculty and/or staff contribute to the development of guidelines, regulation, legislation <b>or</b> other public policy at the local, state, and/or national level.</p> <p>If yes, indicate all policy arenas to which they have contributed:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Local</li> <li><input type="checkbox"/> State</li> <li><input type="checkbox"/> National</li> </ul>		
<p>5. Trainees, faculty and/or staff participate in local, state and/or national MCH advocacy networks and initiatives</p> <p>If yes, indicate all policy arenas to which they have contributed :</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Local</li> <li><input type="checkbox"/> State</li> <li><input type="checkbox"/> National</li> </ul>		
<p>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.</p> <p>If yes, indicate all policy arenas to which they have contributed:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Local</li> <li><input type="checkbox"/> State</li> <li><input type="checkbox"/> National</li> </ul>		

<b>Training 06 PERFORMANCE MEASURE</b>	The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups.
<b>Goal: Long Term Training Programs</b>	
<b>Level: Grantee</b>	
<b>Domain: MCH Workforce Development</b>	
<b>GOAL</b>	To increase the percentage of trainees participating in MCHB long-term training programs who are from underrepresented racial and ethnic groups.
<b>MEASURE</b>	The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups.
<b>DEFINITION</b>	<p><b>Numerator:</b> Total number of long-term trainees (<math>\geq 300</math> contact hours) participating in MCHB training programs reported to be from underrepresented racial and ethnic groups. (Include MCHB-supported and non-supported trainees.)</p> <p><b>Denominator:</b> Total number of long-term trainees (<math>\geq 300</math> contact hours) participating in MCHB training programs. (Include MCHB-supported and non-supported trainees.)</p> <p><b>Units:</b> 100</p> <p><b>Text:</b> Percentage</p> <p>The definition of “underrepresented racial and ethnic groups” is based on the categories from the U.S. Census.</p>
<b>BENCHMARK DATA SOURCES</b>	<p>Related to Healthy People 2020 Objectives:</p> <p>AHS-4: Increase the number of practicing primary care providers</p> <p>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</p>
<b>GRANTEE DATA SOURCES</b>	<p>Data will be collected annually from grantees about their trainees.</p> <p>MCHB does not maintain a master list of all trainees who are supported by MCHB long-term training programs.</p> <p>References supporting Workforce Diversity:</p> <ul style="list-style-type: none"><li>● In the Nation’s Compelling Interest: Ensuring Diversity in the Healthcare Workforce (2004). Institute of Medicine.</li><li>● Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2002). Institute of Medicine.</li></ul>

**Training 06 PERFORMANCE MEASURE**

The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups.

**Goal: Long Term Training Programs**

**Level: Grantee**

**Domain: MCH Workforce Development**

---

**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:**

<b>Training 07 PERFORMANCE MEASURE</b>	The percent of MCHB Pipeline Program graduates who have been engaged in work focused on MCH populations.
<b>Goal: MCH Pipeline Programs</b>	
<b>Level: Grantee</b>	
<b>Domain: MCH Workforce Development</b>	
<b>GOAL</b>	To increase the percent of graduates of MCH Pipeline Programs who have been/are engaged in work focused on MCH populations.
<b>MEASURE</b>	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.
<b>DEFINITION</b>	<p><b>Numerator:</b> Number of pipeline graduates reporting they have been engaged in work focused on MCH populations since graduating from the MCH Pipeline Training Program.</p> <p><b>Denominator:</b> The total number of trainees responding to the survey</p> <p><b>Units:</b> 100</p> <p><b>Text:</b> Percent</p> <p>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</p> <p><b>MCH Populations:</b> Includes women, infants and children, adolescents, young adults, and their families including fathers, and children and youth with special health care needs</p>
<b>BENCHMARK DATA SOURCES</b>	<p>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</p> <p>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</p>
<b>GRANTEE DATA SOURCES</b>	<p>A pipeline program follow-up survey will be used to collect these data.</p> <p>Data Sources Related to Training and Work Settings/Populations: Rittenhouse Diane R, George E. Fryer, Robert L. Phillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps</p>



**Training 07 PERFORMANCE MEASURE**

The percent of MCHB Pipeline Program graduates who have been engaged in work focused on MCH populations.

**Goal: MCH Pipeline Programs**

**Level: Grantee**

**Domain: MCH Workforce Development**

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**

The percent of MCH Pipeline Program graduates who have been engaged in work with populations considered to be underserved or vulnerable.

**Goal: MCH Pipeline Program**

**Level: Grantee**

**Domain: MCH Workforce Development**

**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

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>

**BENCHMARK DATA SOURCES**

Related to Healthy People 2020:

**Training 08 PERFORMANCE MEASURE**

The percent of MCH Pipeline Program graduates who have been engaged in work with populations considered to be underserved or vulnerable.

**Goal: MCH Pipeline Program**

**Level: Grantee**

**Domain: MCH Workforce Development**

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. Phillips 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 \_\_\_\_\_

<b>Training 09 PERFORMANCE MEASURE</b>	The percent of pipeline graduates that enter graduate programs preparing them to work with the MCH population.
<b>Goal: Graduate Program Enrollment Level: Grantee Domain: MCH Workforce Development</b>	
<b>GOAL</b>	To increase the number of pipeline graduates that enter graduate programs preparing them to work with the MCH population.
<b>MEASURE</b>	The percent of pipeline graduates that enter graduate programs preparing them to work with the MCH population.
<b>DEFINITION</b>	<p><b>Numerator:</b> 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.</p> <p>*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.</p> <p><b>Denominator:</b> Total number of MCH Pipeline Trainees who graduated from the MCH pipeline program 2 or 5 years previously.</p>
<b>BENCHMARK DATA SOURCES</b>	<p>Related to Healthy People 2020 Objectives:</p> <p>ECBP-12: Increase the inclusion of core clinical preventive and population health content in M.D.-granting medical schools</p> <p>ECBP-13: Increase the inclusion of core clinical preventive and population health content in D.O.-granting medical schools</p> <p>ECBP-14: Increase the inclusion of core clinical preventive and population health content in undergraduate nursing</p> <p>ECBP-15: Increase the inclusion of core clinical preventive and population health content in nurse practitioner training</p> <p>ECBP-16: Increase the inclusion of core clinical preventive and population health content in physician assistant training</p> <p>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</p>
<b>GRANTEE DATA SOURCES</b>	Attached data collection form to be completed by grantees.

**Training 09 PERFORMANCE MEASURE**

The percent of pipeline graduates that enter graduate programs preparing them to work with the MCH population.

**Goal: Graduate Program Enrollment**

**Level: Grantee**

**Domain: MCH Workforce Development**

**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.



<b>Training 10 PERFORMANCE MEASURE</b>	The percent of long term trainees that have demonstrated field leadership after completing an MCH training program.
<b>Goal: Field Leadership</b>	
<b>Level: Grantee</b>	
<b>Domain: MCH Workforce Development</b>	
<b>GOAL</b>	To increase the percentage of long term trainees that have demonstrated field leadership two and five years after completing their MCH Training Program.
<b>MEASURE</b>	The percentage of long-term trainees that have demonstrated field leadership after completing an MCH Training Program.
<b>DEFINITION</b>	<p>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.</p> <p>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.</p> <p>“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.</p> <p>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.</p>
<b>BENCHMARK DATA SOURCES</b>	<p>Related to Healthy People 2020 Objectives:</p> <p>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</p> <p>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</p>
<b>GRANTEE DATA SOURCES</b>	Attached data collection form to be completed by grantees.
<b>SIGNIFICANCE</b>	An MCHB trained workforce is a vital participant in clinical, administrative, policy, public health and

**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.

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:**

<b>Training 11 PERFORMANCE MEASURE</b> <b>Goal: Long-term trainees working with MCH populations</b> <b>Level: Grantee</b> <b>Domain: MCH Workforce Development</b>	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-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

**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.

**Training 11 PERFORMANCE MEASURE**

The percentage of long-term trainees who are engaged in work focused on MCH populations after completing their MCH Training Program.

**Goal: Long-term trainees working with MCH populations**

**Level: Grantee**

**Domain: MCH Workforce Development**

Data Sources Related to Training and Work Settings/Populations: Rittenhouse Diane R, George E. Fryer, Robert L. Phillips 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 \_\_\_\_\_

---

**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 \_\_\_\_\_



<b>Training 12 PERFORMANCE MEASURE</b>	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.).
<b>Goal: Long-term Trainees</b>	
<b>Level: Grantee</b>	
<b>Domain: MCH Workforce Development</b>	
<b>GOAL</b>	To increase the percent of long-term trainees who, upon completing their training, work in an interdisciplinary manner to serve the MCH population.
<b>MEASURE</b>	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.
<b>DEFINITION</b>	<p><b>Numerator:</b> The number of long-term trainees indicating that they have worked in an interdisciplinary manner serving the MCH population.</p> <p><b>Denominator:</b> The total number of long-term trainees responding to the survey</p> <p><b>Units:</b> 100                      <b>Text:</b> Percent</p> <p>In addition, data on the total number of the long-term trainees and the number of non-respondents for each year will be collected.</p> <p>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.</p>
<b>BENCHMARK DATA SOURCES</b>	<p>Related to Healthy People 2020 Objectives:</p> <p>ECBP-12: Increase the inclusion of core clinical preventive and population health content in M.D.-granting medical schools</p> <p>ECBP-13: Increase the inclusion of core clinical preventive and population health content in D.O.-granting medical schools</p> <p>ECBP-14: Increase the inclusion of core clinical preventive and population health content in undergraduate nursing</p> <p>ECBP-15: Increase the inclusion of core clinical preventive and population health content in nurse practitioner training</p> <p>ECBP-16: Increase the inclusion of core clinical preventive and population health content in physician assistant training</p> <p>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</p> <p>MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems</p>
<b>GRANTEE DATA SOURCES</b>	The trainee follow-up survey is used to collect these data.
<b>SIGNIFICANCE</b>	Leadership education is a complex interdisciplinary field that

**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.).

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 \_\_\_\_\_%

<b>Training 13 PERFORMANCE MEASURE</b>	The degree to which the LEAH program incorporates adolescents and parents from diverse ethnic and cultural backgrounds as advisors and participants in program activities.
<b>Goal: Diverse Adolescent Involvement</b>	
<b>Level: Grantee</b>	
<b>Domain: MCH Workforce Development</b>	
<b>GOAL</b>	To increase appropriate involvement of adolescents and parents as consumers of LEAH program activities.
<b>MEASURE</b>	The degree to which adolescents and parents are incorporated as consumers of LEAH program activities.
<b>DEFINITION</b>	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.
<b>BENCHMARK DATA SOURCES</b>	Related to Objective HC/HIT-2: Increase the proportion of persons who report that their health care providers have satisfactory communication skills.
<b>GRANTEE DATA SOURCES</b>	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.
<b>SIGNIFICANCE</b>	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

<b>Element</b>	<b>0</b>	<b>1</b>
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) \_\_\_\_\_**

<b>Training 14 PERFORMANCE MEASURE</b>	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 .
<b>Goal: Medium-Term Trainees Skill and Knowledge</b>	
<b>Level: Grantee</b>	
<b>Domain: MCH Workforce Development</b>	
<b>GOAL</b>	To increase the percentage of medium term trainees (MTT) who report increased knowledge or skills related to MCH core competencies.
<b>MEASURE</b>	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.
<b>DEFINITION</b>	<b>Numerator:</b> 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. <b>Denominator:</b> The total number of medium term trainees responding to the survey. <u>Medium Term trainees:</u> Level I MTT complete 40-149 hours of training. Level II MTT complete 150–299 hours of training.
<b>BENCHMARK DATA SOURCES</b>	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.
<b>GRANTEE DATA SOURCES</b>	End of training survey is used to collect these data.
<b>SIGNIFICANCE</b>	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**

<b>Performance Measure</b>	<b>Topic</b>
<b>EMSC 01</b>	Using NEMESIS Data to Identify Pediatric Patient Care Needs.
<b>EMSC 02</b>	Pediatric Emergency Care Coordination
<b>EMSC 03</b>	Use of pediatric-specific equipment
<b>EMSC 04</b>	Pediatric medical emergencies
<b>EMSC 05</b>	Pediatric traumatic emergencies
<b>EMSC 06</b>	Written inter-facility transfer guidelines that contain all the components as per the implementation manual.
<b>EMSC 07</b>	Written inter-facility transfer agreements that covers pediatric patients.
<b>EMSC 08</b>	Established permanence of EMSC
<b>EMSC 09</b>	Established permanence of EMSC by integrating EMSC priorities into statutes/regulations.

**EMSC 01 PERFORMANCE MEASURE**

**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 or 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.

**EMSC 01 PERFORMANCE MEASURE**

**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 or higher data to the State EMS Office.

NHTSA – National Highway Traffic Safety Administration

**HRSA STRATEGIC OBJECTIVE**

Improve Access to Quality Health Care and Services by 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

**EMSC 01 PERFORMANCE MEASURE**

**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 or higher data to the State EMS Office.

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 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
<p><b>Numerator:</b> 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</p>	
<p><b>Denominator:</b> Total number of EMS agencies in the state/territory actively responding to 911 requests for assistance.</p>	
<p><b>Percent:</b></p>	

**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:***

<b>Year</b>	<b>Target</b>
2018	Baseline data
2019	10%
2020	50%
2021	80%

**EMSC 02 PERFORMANCE MEASURE**

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

**Goal: Pediatric Emergency Care**

**Coordination Level: Grantee**

**Domain: Emergency Medical Services for Children**

**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

**GRANTEE DATA SOURCES**

Survey of EMS agencies

**EMSC 02 PERFORMANCE MEASURE**

**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.

**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.

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

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.

<b>Which statement best defines your agency?</b>	<b>Scale</b>
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
- 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; it can be an individual already in place who assumes this role as part of their existing duties. The individual may be located at your agency, county or region.

**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:**

- 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**

**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>

**Goal I:** Improve Access to Quality Health Care and Services (by improving quality) or;

**Goal II:** Strengthen the Health Workforce

**HRSA STRATEGIC OBJECTIVE**

**EMSC 03 PERFORMANCE MEASURE**

**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.

**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.

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

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.

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

***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 the 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** 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**

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: Emergency Department Preparedness  
Level: Grantee**

**Domain: Emergency Medical Services for Children**

**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.

**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



**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.

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

<b>EMSC 05 PERFORMANCE MEASURE</b>	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.
<b>Goal: Standardized System for Pediatric Trauma</b>	
<b>Level: Grantee</b>	
<b>Domain: Emergency Medical Services for Children</b>	
<b>GOAL</b>	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.
<b>MEASURE</b>	The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
<b>DEFINITION</b>	<p><b>Numerator:</b> 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.</p> <p><b>Denominator:</b> Total number of hospitals with an ED in the State/Territory.</p> <p><b>Units:</b> 100                      <b>Text:</b> Percent</p> <p><b>Standardized system:</b> 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.</p> <p><b>Hospital:</b> 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.</p>
<b>EMSC STRATEGIC OBJECTIVE</b>	<p>Ensure the operational capacity and infrastructure to provide pediatric emergency care.</p> <p>Develop a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies and trauma.</p>
<b>GRANTEE DATA SOURCES</b>	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.

**EMSC 05 PERFORMANCE MEASURE**

**Goal: Standardized System for Pediatric Trauma**

**Level: Grantee**

**Domain: Emergency Medical Services for Children**

**SIGNIFICANCE**

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.

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

**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.

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.



<b>EMSC 07 PERFORMANCE MEASURE</b>	The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
<b>Goal: Inter-facility Transfer Agreements</b> <b>Level: Grantee</b> <b>Domain: Emergency Medical Services for Children</b>	
<b>GOAL</b>	By 2021: 90% of hospitals in the State/Territory have written inter-facility transfer agreements that cover pediatric patients.
<b>MEASURE</b>	The percentage of hospitals in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
<b>DEFINITION</b>	<p><b>Numerator:</b> Number of hospitals with an ED that have written inter-facility transfer agreements that cover pediatric patients according to the data collected.</p> <p><b>Denominator:</b> Total number of hospitals with an ED that provided data.</p> <p><b>Units:</b> 100                      <b>Text:</b> Percent</p> <p><b>Pediatric:</b> Any person 0 to 18 years of age.</p> <p><b>Inter-facility transfer agreements:</b> 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.</p>
<b>EMSC STRATEGIC OBJECTIVE</b>	<p>Ensure the operational capacity and infrastructure to provide pediatric emergency care.</p> <p>Develop written pediatric inter-facility transfer agreements to facilitate timely movement of children to appropriate facilities.</p>
<b>DATA SOURCE(S) AND ISSUES</b>	<ul style="list-style-type: none"><li>• Surveys of hospitals with an emergency department.</li><li>• Hospital licensure rules and regulations</li></ul>
<b>SIGNIFICANCE</b>	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.

<b>EMSC 08 PERFORMANCE MEASURE</b>	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system.
<b>Goal: EMSC Permanence</b> <b>Level: Grantee</b> <b>Domain: Emergency Medical Service for Children</b>	
<b>GOAL</b>	To increase the number of States/Territories that have established permanence of EMSC in the State/Territory EMS system.
<b>MEASURE</b>	The degree to which States/Territories have established permanence of EMSC in the State/Territory EMS system.
<b>DEFINITION</b>	<p>Permanence of EMSC in a State/Territory EMS system is defined as:</p> <ul style="list-style-type: none"><li>• The EMSC Advisory Committee has the required members as per the implementation manual.</li><li>• The EMSC Advisory Committee meets at least four times a year.</li><li>• Pediatric representation incorporated on the State/Territory EMS Board.</li><li>• The State/Territory require pediatric representation on the EMS Board.</li><li>• One full time EMSC Manager is dedicated solely to the EMSC Program.</li></ul> <p><b>EMSC:</b> 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.</p> <p><b>EMS system:</b> 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.</p>
<b>EMSC STRATEGIC OBJECTIVE</b>	<ul style="list-style-type: none"><li>• Establish permanence of EMSC in each State/Territory EMS system.</li><li>• Establish an EMSC Advisory Committee within each State/Territory</li><li>• Incorporate pediatric representation on the State/Territory EMS Board</li><li>• Establish one full-time equivalent EMSC manager that is dedicated solely to the EMSC Program.</li></ul>
<b>GRANTEE DATA SOURCES</b>	<ul style="list-style-type: none"><li>• Attached data collection form to be completed by grantee.</li></ul>

**EMSC 08 PERFORMANCE MEASURE**

The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system.

**Goal: EMSC Permanence**

**Level: Grantee**

**Domain: Emergency Medical Service for Children**

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.

<b>Element</b>	<b>Yes</b>	<b>No</b>
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**

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: Integration of EMSC priorities**  
**Level: Grantee**  
**Domain: Emergency Medical Services for Children**

**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.

**EMSC 09 PERFORMANCE MEASURE**

The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.

**Goal: Integration of EMSC priorities**  
**Level: Grantee**  
**Domain: Emergency Medical Services for Children**

**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 care.
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
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 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.

**EMSC 09 PERFORMANCE MEASURE**

The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.

**Goal: Integration of EMSC priorities**

**Level: Grantee**

**Domain: Emergency Medical Services for Children**

**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 prior 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**

<b>Performance Measure</b>	<b>Topic</b>
<b>HS 01</b>	Reproductive Life Plan
<b>HS 02</b>	Usual Source of Care
<b>HS 03</b>	Interconception Planning
<b>HS 04</b>	Early Elective Delivery
<b>HS 05</b>	Intimate Partner Violence Screening
<b>HS 06</b>	Father/ Partner Involvement during Pregnancy
<b>HS 07</b>	Father and/or Partner Involvement with Child 0-24 Months
<b>HS 08</b>	Daily Reading
<b>HS 09</b>	CAN implementation
<b>HS 10</b>	CAN Participation

<b>HS 01 PERFORMANCE MEASURE</b>	The percent of Healthy Start participants that have a documented reproductive life plan. <sup>0</sup>
<b>Goal: Reproductive Life Plan</b>	
<b>Level: Grantee</b>	
<b>Domain: Healthy Start</b>	
<b>GOAL</b>	To increase the proportion of Healthy Start women participants who have a documented reproductive life plan to 90%.
<b>MEASURE</b>	The percent of Healthy Start women participants that have a documented reproductive life plan.
<b>DEFINITION</b>	<p><b>Numerator:</b> Number of Healthy Start (HS) women participants with a documented reproductive life plan in the reporting period.</p> <p><b>Denominator:</b> Number of HS women participants in the reporting period.</p> <p>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 <u>annually updated</u> statement to include: 1) goals for having or not having children; and 2) plans for how to achieve those goals.</p> <p>Participants with permanent birth control are included in both the denominator and numerator.</p> <p>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.</p>
<b>BENCHMARK DATA SOURCES</b>	Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 8, Question 14
<b>GRANTEE DATA SOURCES</b>	Grantee data systems
<b>SIGNIFICANCE</b>	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 <i>before</i> becoming pregnant. <sup>0</sup>

<sup>0</sup> Consistent with Healthy Start Benchmark 2.

<sup>0</sup> <http://www.cdc.gov/preconception/documents/reproductivelifeplan-worksheet.pdf>

**HS 02 PERFORMANCE MEASURE**

The percent of Healthy Start women and child participants that have a usual source of care.<sup>0</sup>

**Goal: Usual Source of Care**  
**Level: Grantee**  
**Domain: Healthy Start**

**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 and child 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.<sup>0</sup> 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.<sup>0</sup>

<sup>0</sup> Consistent with Healthy Start Benchmark 4.

<sup>0</sup> 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.

---

<sup>0</sup> <https://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home>

<b>HS 03 PERFORMANCE MEASURE</b>	The percent of Healthy Start women participants who conceive within 18 months of a previous birth. <sup>0</sup>
<b>Goal: Interconception Planning</b>	
<b>Level: Grantee</b>	
<b>Domain: Healthy Start</b>	
<b>GOAL</b>	To reduce the proportion of Healthy Start women participants who conceive within 18 months of a previous birth to 30%.
<b>MEASURE</b>	The percent of Healthy Start women participants who conceive within 18 months of a previous birth.
<b>DEFINITION</b>	<p><b>Numerator:</b> Number of Healthy Start (HS) women participants whose current pregnancy during the reporting period was conceived within 18 months of the previous birth.</p> <p><b>Denominator:</b> Total number of HS women participants enrolled before the current pregnancy in the reporting period who had a prior pregnancy that ended in a live birth.</p> <p>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.</p>
<b>BENCHMARK DATA SOURCES</b>	CDC National Survey of Family Growth, Healthy People 2020 Family Planning Goal 5; Vital Statistics <sup>0</sup>
<b>GRANTEE DATA SOURCES</b>	Grantee data systems
<b>SIGNIFICANCE</b>	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 recover from the previous birth. <sup>0</sup>

<sup>0</sup> Consistent with Healthy Start Benchmark 10.

<sup>0</sup> [http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64\\_03.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_03.pdf)

<sup>0</sup> <http://www.mayoclinic.org/healthy-lifestyle/getting-pregnant/in-depth/family-planning/art-20044072>

<b>HS 04 PERFORMANCE MEASURE</b>	The percent of HS women participants who receive intimate partner violence screening. <sup>0</sup>
<b>Goal: Intimate Partner Violence Screening</b>	
<b>Level: Grantee</b>	
<b>Domain: Healthy Start</b>	
<b>GOAL</b>	To increase proportion of Healthy Start women participants who receive intimate partner violence (IPV) screening to 100%.
<b>MEASURE</b>	The percent of Healthy Start women participants who receive intimate partner violence screening.
<b>DEFINITION</b>	<p><b>Numerator:</b> Number of Healthy Start (HS) women participants who received intimate partner violence screening using a standardized screening tool during the reporting period.</p> <p><b>Denominator:</b> Total number of HS women participants in the reporting period.</p> <p>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.</p> <p>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.<sup>0</sup></p>
<b>BENCHMARK DATA SOURCES</b>	PRAMS
<b>GRANTEE DATA SOURCES</b>	Grantee data systems
<b>SIGNIFICANCE</b>	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. <sup>0</sup>

<sup>0</sup> Consistent with Healthy Start Benchmark 13.

<sup>0</sup> <http://mchb.hrsa.gov/whusa09/hstat/hi/pages/226ipv.html>

<sup>0</sup> <http://aspe.hhs.gov/report/screening-domestic-violence-health-care-settings/prevalence-screening>

<b>HS 05 PERFORMANCE MEASURE</b>	The percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy. <sup>0</sup>
<b>Goal: Father/ Partner Involvement during pregnancy</b>	
<b>Level: Grantee</b>	
<b>Domain: Healthy Start</b>	
<b>GOAL</b>	To increase proportion of Healthy Start women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) to 90%.
<b>MEASURE</b>	The percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy.
<b>DEFINITION</b>	<p><b>Numerator:</b> 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.</p> <p><b>Denominator:</b> Total number HS prenatal participants in the reporting period.</p> <p>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.</p> <p>Involvement during pregnancy may include, but is not limited to:</p> <ul style="list-style-type: none"><li>• Partnership; social/ emotional support</li><li>• Attending prenatal appointments</li><li>• Attending prenatal classes</li><li>• Assisting in preparing the home for the baby (e.g., putting together a crib)</li><li>• Providing economic support</li></ul>
<b>BENCHMARK DATA SOURCES</b>	Child Trend Research Brief, CDC National Health Statistics Report
<b>GRANTEE DATA SOURCES</b>	Grantee data systems
<b>SIGNIFICANCE</b>	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.

<sup>0</sup> Consistent with Healthy Start Benchmark 14.



<b>HS 06 PERFORMANCE MEASURE</b>	The percent of Healthy Start women participants that demonstrate father and/or partner involvement with child <24 months. <sup>0</sup>
<b>Goal: Father and/or Partner Involvement with child &lt;24 Months</b>	
<b>Level: Grantee</b>	
<b>Domain: Healthy Start</b>	
<b>GOAL</b>	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%.
<b>MEASURE</b>	The percent of Healthy Start women participants that demonstrate father and/or partner involvement with child <24 months.
<b>DEFINITION</b>	<p><b>Numerator:</b> 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.</p> <p><b>Denominator:</b> Total number of Healthy Start women participants with a child participant &lt;24 months.</p> <p>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.</p> <p>Involvement includes, but is not limited to:<sup>0</sup></p> <ul style="list-style-type: none"><li>• Engagement or direct interaction with the child, including taking care of, playing with, or teaching the child</li><li>• Accessibility or availability, which includes monitoring behavior from the next room or nearby and allowing direct interaction if necessary</li><li>• Responsibility for the care of the child, which includes making plans and arrangements for care</li><li>• Economic support or breadwinning</li><li>• Attending postpartum and well child visits</li><li>• Other meaningful support</li></ul>
<b>BENCHMARK DATA SOURCES</b>	None
<b>GRANTEE DATA SOURCES</b>	Grantee data systems
<b>SIGNIFICANCE</b>	Research suggests that paternal involvement has been recognized to have an impact on both pregnancy and infant outcomes

<sup>0</sup> Consistent with Healthy Start Benchmark 15.  
<sup>0</sup> <http://www.cdc.gov/nchs/data/nhsr/nhsr071.pdf>

<b>HS 07 PERFORMANCE MEASURE</b>	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. <sup>0</sup>
<b>Goal: Daily Reading</b>	
<b>Level: Grantee</b>	
<b>Domain: Healthy Start</b>	
<b>GOAL</b>	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%.
<b>MEASURE</b>	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.
<b>DEFINITION</b>	<p><b>Numerator:</b> 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.</p> <p><b>Denominator:</b> Total number of Healthy Start child participants 6 through 23 months of age during the reporting period.</p> <p>Reading by a family member may include reading books, picture books, or telling stories.</p>
<b>BENCHMARK DATA SOURCES</b>	National Survey of Children’s Health (2011-2012)
<b>GRANTEE DATA SOURCES</b>	Grantee data systems
<b>SIGNIFICANCE</b>	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. <sup>0</sup> 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. <sup>0</sup>

<sup>0</sup> Consistent with Healthy Start Benchmark 16.

<sup>0</sup> [http://kidshealth.org/parent/positive/all\\_reading/reading\\_babies.html](http://kidshealth.org/parent/positive/all_reading/reading_babies.html)

<sup>0</sup> <http://pediatrics.aappublications.org/content/pediatrics/134/2/404.full.pdf>

<b>HS 08 PERFORMANCE MEASURE</b>	The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN). <sup>0</sup>
<b>Goal: CAN implementation</b>	
<b>Level: Grantee</b>	
<b>Domain: Healthy Start</b>	

**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

-----  
**Numerator:** Number of related Collective Impact (CI) measure components implemented by the CAN in which the Healthy Start grantee participates.

**Denominator:** 10 (representing total points for 5 CI measure components)

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

<sup>0</sup> Consistent with Healthy Start Benchmark 17.

**HS 08 PERFORMANCE MEASURE**

The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN).

**Goal: CAN implementation**

**Level: Grantee**

**Domain: Healthy Start**

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 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 9 PERFORMANCE MEASURE**

The percent of Healthy Start grantees with at least 25% community members and Healthy Start program participants serving as members of their CAN.<sup>0</sup>

**Goal: CAN participation**  
**Level: Grantee**  
**Domain: Healthy Start**

**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 common 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.

<sup>0</sup> 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**

<b>Performance Measure</b>	<b>Topic</b>
F2F 1	Provide National Leadership for families with children with special health needs

<b>F2F 1 Performance Measure</b> <b>Goal: Provide National Leadership for families with children with special health needs</b> <b>Level: Grantee</b> <b>Category: Family Participation</b>	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.
<b>GOAL</b>	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.
<b>MEASURE</b>	The percent of families with CSHCN that have been provided information, education and/or training by Family-to-Family Health Information Centers.
<b>DEFINITION</b>	<b>Numerator:</b> 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. <b>Denominator:</b> The number of families that can be reasonably served with provided federal grant funds. <b>Units:</b> 100 <b>Text:</b> Percent
<b>BENCHMARK DATA SOURCES</b>	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
<b>GRANTEE DATA SOURCES</b>	Progress reports from Family-To-Family Health Care Information and Education Centers, National Survey for Children’s Health (NSCH), Title V Information System
<b>SIGNIFICANCE</b>	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 \_\_\_\_\_