

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

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 3	Health Equity
CB 1	State Capacity for Advancing the Health of MCH Populations
CB 3	Impact Measurement
CB 4	Sustainability
CB 5	Scientific Publications
CB 6	Products
CB 8	Quality Improvement
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

Core 3 PERFORMANCE MEASURE	The percent of programs promoting and/ or facilitating improving health equity.
Goal: Health Equity	
Level: Grantee	
Domain: Capacity Building	
GOAL	To ensure MCHB grantees have established specific aims related to improving health equity.
MEASURE	The percent of MCHB funded projects with specific measurable aims related to promoting health equity.
DEFINITION	Tier 1: Are you promoting and/ or facilitating health equity in your program? € Yes € No Tier 2: Through which activity domains are you promoting and/or facilitating health equity with your program (check all that apply): € Creating and Supporting Collaborations and Partnerships with other health and non-health sectors that influence the well-being of individuals. Collaboration is necessary to address social determinants of health and can include family/community representatives as advisors or leaders. € Creating and Supporting a Culture of Equity by increasing organizational diversity and inclusion. € Creating and Supporting the Infrastructure and Capacity for Equity by improving data capacity, workforce knowledge and cultural competence, and promoting policies and procedures that advance equity. € Collecting and Using Data on race, ethnicity, etc. to measure and address equity. € Providing Services to individuals and communities in a manner that promotes equity. What type(s) of equity topics do your activities target? € Race/ ethnicity € Sex/ gender/ sexual orientation/ gender identity € Income/ socioeconomic status € Health status/ disability € Age € Language € Geography – rural/urban € Other: _____
	Tier 3: Implementation Has your program set stated goal/ objectives for health equity? Y/N If yes, what are those aims? _____ Tier 4: What are the related outcomes? Has your program made progress on your stated goals/ objectives around health equity? Y/N If yes, what progress has been made? _____

* Health equity exists when challenges and barriers have been

removed for those groups who experience greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

BENCHMARK DATA SOURCES

N/A

GRANTEE DATA SOURCES

Grantee self-reported.

SIGNIFICANCE

Health equity is achieved when every individual has the opportunity to attain his or her full health potential and no one is “disadvantaged from achieving this potential because of social position or socially determined consequences.” Achieving health equity is a top priority in the United States.

CB 1 PERFORMANCE MEASURE

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
 - € Developmental Disabilities

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

- € 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 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 o List of tools used o Specify Tools: _____ o Outcomes of qualitative assessment o # of participant surveys o # of clients whose level data collected o # of case reports Tier 4: What are the related outcomes in the reporting year? % of grantees that collect data on the impact of their grants on the field (and methods used to collect data) Numerator: # of grantees that collect data on the impact of their grants on the field Denominator: # of grantees How is data collected: _____ % of grantees that collect and analyze data on the impact of their grants on the field (and methods used to analyze data) Numerator: # of grantees that analyze data on the impact of their grants on the field Denominator: # of grantees How is data analyzed: _____
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	Impact as referenced here is a change in condition or status of life. This can include a change in health, social, economic or environmental condition. Examples may include improved health for a community/population or a reduction in disparities for a specific disease or increased adoption of a practice.

CB 4 PERFORMANCE MEASURE	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	
GOAL	To ensure sustainability of programs or initiatives over time, beyond the duration of MCHB funding.
MEASURE	The percent of MCHB funded initiatives working to promote sustainability of their programs or initiatives beyond the life of MCHB funding, and through what methods.
DEFINITION	Tier 1: Are you addressing sustainability in your program? € Yes € No Tier 2: Through what processes/ mechanisms are you addressing sustainability? € A written sustainability plan is in place within two years of the MCHB award with goals, objectives, action steps, and timelines to monitor plan progress € Staff and leaders in the organization engage and build partnerships with consumers, and other key stakeholders in the community, in the early project planning, and I sustainability planning and implementation processes € There is support for the MCHB-funded program or initiative within the parent agency or organization, including from individuals with planning and decision making authority € There is an advisory group or a formal board that includes family, community and state partners, and other stakeholders who can leverage resources or otherwise help to sustain the successful aspects of the program or initiative € The program's successes and identification of needs are communicated within and outside the organization among partners and the public, using various internal communication, outreach, and marketing strategies € The grantee identified, actively sought out, and obtained other funding sources and in-kind resources to sustain the entire MCHB-funded program or initiative € Policies and procedures developed for the successful aspects of the program or initiative are incorporated into the parent or another organization's system of programs and services € The responsibilities for carrying out key successful aspects of the program or initiative have begun to be transferred to permanent staff positions in other ongoing programs or organizations € The grantee has secured financial or in-kind support from within the parent organization or external organizations to sustain the successful aspects of the MCHB-funded program or initiative Tier 3: Implementation N/A Tier 4: What are the related outcomes?

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.

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

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

CB 8 PERFORMANCE MEASURE	The percent of programs engaging in quality improvement and through what means, and related outcomes.
Goal: Quality Improvement	
Level: Grantee	
Domain: Capacity Building	
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.

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 reached by the services provided (e.g., # of women receiving referrals or # of partners receiving TA). Report the number reached by each activity for each participant type. Only report a participant under one participant type (select the best category for the participant). For those services you do not provide, or segments you do not reach, please leave the cell blank.

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

WMH 1 PERFORMANCE MEASURE	The percent of programs promoting and/or facilitating timely prenatal care.
Goal: Prenatal Care	
Level: Grantee	
Domain: Women's/ Maternal Health	
GOAL	To ensure supportive programming for prenatal care.
MEASURE	The percent of MCHB funded projects addressing prenatal care. The percent of pregnant program participants who receive prenatal care beginning in the first trimester.
DEFINITION	Tier 1: Are you addressing prenatal care in your program? € Yes € No Tier 2: Through what processes/ mechanisms are you addressing prenatal care? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives Tier 3: How many are reached through those activities? (Report in Table 1: Activity Data Collection Form) # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives Tier 4: What are the related outcomes? % of pregnant women who receive prenatal care beginning in the first trimester Numerator: Number of pregnant program participants who began prenatal care in the first trimester of pregnancy. Denominator: Number of pregnant program participants who were enrolled prenatally, prior to their second trimester of pregnancy, during the reporting period.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 MICH Objective #08: Increase the proportion of pregnant women who receive early and adequate prenatal care. (Baseline: 76.4% in 2018, Target: 80.5%).
GRANTEE DATA SOURCES	Title V National Outcome Measure #1.
SIGNIFICANCE	

WMH 1 PERFORMANCE MEASURE

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

Goal: Prenatal Care

Level: Grantee

Domain: Women's/ Maternal Health

Early and continuous prenatal care is essential for identification of maternal disease and risks for complications of pregnancy or birth. This can help ensure that women with complex problems, chronic illness, or other risks are seen by specialists. Prenatal care can also provide important education and counseling on modifiable risks in pregnancy, including smoking, drinking, and inadequate or excessive weight gain.

WMH 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	
GOAL	To ensure supportive programming for postpartum care.
MEASURE	The percent of MCHB funded projects addressing postpartum care. The percent of pregnant women with a postpartum visit within 4-6 weeks of delivery
DEFINITION	Tier 1: Are you promoting and/ or facilitating timely postpartum care in your program? € Yes € No Tier 2: Through what processes/ mechanisms are you promoting and/ or facilitating postpartum care? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives Tier 3: How many are reached through those activities? (Report in Table 1: Activity Data Collection Form) # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives Tier 4: What are the related outcomes in the reporting year? % of pregnant women with a postpartum visit within 4 to 6 weeks after delivery⁰ Numerator: Number of women program participants who enrolled prenatally or within 30 days after delivery and received a postpartum visit within 4-6 weeks after delivery⁰ Denominator: Number of women program participants who enrolled prenatally or within 30 days after delivery during the reporting period Definition: 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.⁰ A participant who has a visit prior to 4-6

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

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

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

WMH 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	
	weeks must still have a visit between 4-6 weeks to meet the standard and be included in the numerator.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 MICH- D01: 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. ⁰ 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.

⁰ <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.⁰ Numerator: Number of 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: Number of 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

⁰ 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	An annual well-woman visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. The American College of Obstetrics and Gynecologists (ACOG) recommends an annual well-woman visit beginning in adolescence and continuing across the lifespan with any health care provider offering preventive well-woman care.

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 tool⁰ 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.⁰ % of women who screened positive for depression who

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

⁰ <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	receive a referral for services
Level: Grantee	
Domain: Women's/ Maternal Health	
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 2030 MICH-D01Objective: (Developmental) Increase the proportion of women who are screened for postpartum depression at their postpartum checkup PRAMS (depression screening).
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	Postpartum depression (PPD) is common, affecting as many as 1 in 7 mothers.⁸ Symptoms may include depressed mood, loss of interest or pleasure in activities, sleep disturbance, appetite disturbance, loss of energy, feelings of worthlessness or guilt, diminished concentration, irritability, anxiety, and thoughts of suicide.⁹ PPD is associated with negative maternal physical and psychological health, relationship problems, and risky behaviors.⁹ PPD is also associated with poor maternal and infant bonding and may negatively influence child development. Infant consequences of PPD include less infant weight gain and stunting, problems with sleep, poor social, emotional, behavioral, cognitive, and language development.¹⁰ Universal screening and treatment for pregnant and postpartum women is recommended by the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the U.S. Preventive Services Task Force.⁸

⁸ Pearlstein T, Howard M, Salisbury A, Zlotnick C. Postpartum depression. American Journal of Obstetrics & Gynecology. 2009; 200(4): 357-364

⁹ Slomian J, Honvo G, Emonts P, Reginster JY, Bruyere O. Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. Women's Health. 2019; 15:1-55.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6492376/pdf/10.1177_1745506519844044.pdf

PIH 1 PERFORMANCE MEASURE	The percent of MCHB funded projects promoting and/ or facilitating 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 practices⁰ 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.⁰ Denominator: Total number of child program participants aged <12 months. A participant is considered to engage in safe sleep practices and included in the numerator if it is reported that the baby is ‘always’ or ‘most often’ 1) placed to sleep on their back, 2) always or often sleeps alone in his or her own crib or bed with no bed sharing, and 3) sleeps on a firm sleep surface (crib,

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

⁰ http://nccd.cdc.gov/PRAMStat/rdPage.aspx?rdReport=DRH_PRAMS.ExploreByTopic&isClassId=CLA8&isTopicId=TOP23&go=GO

PIH 1 PERFORMANCE MEASURE	The percent of MCHB funded projects promoting and/ or facilitating safe sleep practices.
Goal: Safe Sleep Level: Grantee Domain: Perinatal Infant Health	bassinet, pack and play, etc.) with no soft objects or loose bedding.⁰ 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 Healthy People 2030 MICH-04: Increase the proportion of infants placed to sleep on their backs (Baseline: 78.7% in 2016; Target: 88.9%); Healthy People 2030 MICH-D3: Increase the proportion of infants who are put to sleep in a safe sleep environment. (Developmental) Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 7, Question 48 (Sleep Position) and F1 (Bed Sharing). ⁰
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding.⁰

⁰ <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>

⁰ http://nccd.cdc.gov/PRAMStat/rdPage.aspx?rdReport=DRH_PRAMS.ExploreByTopic&islClassId=CLA8&islTopicId=TOP23&go=GO

⁰ American Academy of Pediatrics (AAP). Task Force on Sudden Infant Death Syndrome. SIDS and other sleep-related infant deaths: Updated 2016 recommendations for a safe infant sleeping environment. Pediatrics 2016. 138 (5):e20162938.

PIH 2 PERFORMANCE MEASURE	The percent of programs promoting and/ or facilitating breastfeeding.
Goal: Breastfeeding	
Level: Grantee	
Domain: Perinatal Infant Health	
GOAL	To ensure supportive programming for breastfeeding.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating breastfeeding.
DEFINITION	Tier 1: Are you promoting and/ or facilitating breastfeeding in your program? € Yes € No Tier 2: Through what activities are you promoting and/ or facilitating breastfeeding? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives Tier 3: How many are reached through those activities? (Report in Table 1: Activity Data Collection Form) # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives Tier 4: What are the related outcomes in the reporting year? % of child program participants ever breastfed⁰ Numerator: Total number of child program participants aged <12 months who were ever breastfed or fed pumped breast milk, and whose parent was enrolled prenatally. Denominator: Total number of child program participants aged <12 months whose parent was enrolled prenatally. Definition: A participant is considered to have ever breastfed and included in the numerator if the child received breast milk direct from the breast or expressed at any time in any amount. % of child program participants breastfed at 6 months⁰ Numerator: Total number of child program participants

⁰ 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.

⁰ 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	
	age 6 through 11 months that were breastfed or were fed pumped breast milk in any amount at 6 months of age, and whose parent was enrolled prenatally. Denominator: Total number of child program participants age 6 through 11 months whose parent was enrolled prenatally. 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	Related to Healthy People 2030 MICH-15: Increase the proportion of infants who are breastfed exclusively through 6 months (Baseline: 24.9% in 2015, Target: 42.4%); Related to Healthy People 2030 MICH-16: Increase the proportion of infants who are breastfed at 1 year (Baseline: 35.9% in 2015, Target: 54.1%).
GRANTEE DATA SOURCES	Grantee data systems.
SIGNIFICANCE	The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months, followed by continued breastfeeding as complementary foods are introduced for 1 year or longer. Exclusive breastfeeding for six months supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer, diabetes, hypertension, and heart disease.

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

PIH 3 PERFORMANCE MEASURE	Percent of programs promoting newborn screenings and follow-up.
Goal: Newborn Screening	
Level: Grantee	
Domain: Perinatal Infant Health	
GRANTEE DATA SOURCES	Title V National Outcome Measure #12 (Developmental)
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 of all results. Timely detection and follow-up with appropriate treatment prevents death or disability and enables children to reach their full potential. ⁰

⁰ Centers for Disease Control and Prevention. CDC Grand Rounds: Newborn Screening and Improved Outcomes. Morbidity and Mortality Weekly Report. 2012 June 1. 61(21): 390-93.

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 child program participants who received recommended well child visits.⁰ 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 AAP recommends children be seen by a healthcare

⁰ 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	
	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. ⁰ % 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: Total number of 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	Routine pediatrician visits are important to (1) prevent illness and injury through immunizations and anticipatory guidance, (2) track growth and development and refer for interventions as needed, (3) address parent concerns (e.g., behavior, sleep, eating, milestones), and (4) build trusting parent-provider relationships to support optimal physical, mental, and social health of a child. ⁰

⁰ https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

⁰ <https://www.aappublications.org/news/aapnewsmag/2015/12/15/WellChild121515.full.pdf>

CH 2 PERFORMANCE MEASURE	The percent of programs promoting and/ or facilitating quality of well-child visits.
Goal: Quality of Well Child Visit	
Level: Grantee	
Domain: Child Health	
GOAL	To ensure supportive programming for quality of well child visits.
MEASURE	The percent of MCHB funded projects promoting or facilitating quality of well child visits.
DEFINITION	Tier 1: Are you addressing the quality of well child visits in your program? € Yes € No Tier 2: Through what activities are you addressing quality of well child visits? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Quality improvement initiatives Tier 3: How many are reached through those activities? # receiving TA # receiving training # product disseminated # reached while guideline setting # peer-reviewed publications published # receiving information and education through outreach # participating in quality improvement initiatives <u>See data collection form.</u> Tier 4: What are the related outcomes in the reporting year? % providers trained in conducting a quality well-child visit Numerator: # of providers trained Denominator: # of providers targeted through the program
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	Comprehensive well-child visits include (1) complete history about birth; prior screenings; diet; sleep; dental care; and medical, surgical, family, and social histories, (2) head-to-toe examination and review of growth, (3) immunization review and delivery, (4) screening for postpartum depression in mothers of infants up to six months of age, (5) age-appropriate health and development screenings (e.g., developmental, vision, hearing, autism), (6) age-appropriate guidance to address parent questions/concerns and encouragement of positive parenting practices (e.g., screen time, nutrition, physical activity, sleep), and (7) developmentally appropriate injury prevention guidance (e.g., car seat safety, bicycle helmet, substance use).⁰ .

⁰ <https://www.aafp.org/afp/2018/0915/p347.html>

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

CH 3 PERFORMANCE MEASURE	Percent of programs promoting developmental screenings and follow-up for children.
Goal: Developmental Screening	
Level: Grantee	
Domain: Child Health	
GOAL	To ensure supportive programming for developmental screenings.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating developmental screening and follow-up for children.
DEFINITION	Tier 1: Are you promoting and/or facilitating developmental screening and follow-up in your program? € Yes € No Tier 2: Through what processes/ mechanisms are you promoting or facilitating developmental screening and follow-up? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives Tier 3: How many are reached through those activities? (Report in Table 1: Activity Data Collection Form) # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives Tier 4: What are the related outcomes in the reporting year? % of children 9 through 35 months receiving a developmental screening using a parental-completed tool? Numerator: Children of program participants aged 9 to 35 months who have received a developmental screening using a parent/ caretaker-completed tool Denominator: Children, aged 9 to 35 months, of program participants
BENCHMARK DATA SOURCES	Related to Healthy People 2030 MICH-17: Increase the proportion of children who receive a developmental screening. (Baseline: 31.1% in 2016-17, Target: 35.8%).
GRANTEE DATA SOURCES	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. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests at the 9, 18, and 24 or 30 month visit. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP. ⁰

⁰ Council on Children With Disabilities; Section on Developmental Behavioral Pediatrics; Bright Futures Steering Committee; Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. Pediatrics. 2006 Jul;118(1):405-20. Reaffirmed November 2014. <http://pediatrics.aappublications.org/content/118/1/405>

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? <i>See data collection form.</i> € 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 <i>See data collection form.</i> Tier 4: What are the related outcomes in the reporting year? Rate of injury-related hospitalization to children ages 1-9. Numerator: Injury-related hospitalizations to children ages 1-9 Denominator: Children ages 1-9 in the target population Target Population: _____ Percent of children ages 6-11 missing 5 or more days of school because of illness or injury. Numerator: # of children ages 6-11 missing 5 or more days of school Denominator: Total number of children ages 6-11 represented in National Survey of Children's Health

CH 4 PERFORMANCE MEASURE	The percent of programs promoting and/ or facilitating injury prevention among children.
Goal: Injury Prevention Level: Grantee Domain: Child Health	
	results Dataset reporting from: _____
BENCHMARK DATA SOURCES	Related to HP2030 IVP-02: Reduce emergency department (ED) visits for nonfatal injuries. (Baseline: 9,349.5 ED visits per 100,000 population in 2017 (age adjusted to the year 2000 standard population), Target: 7,738.2 ED visits per 100,000 population).
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	Unintentional injury is the leading cause of child and adolescent mortality, from age 1 through 19. ⁰ Homicide and suicide, violent or intentional injury, are the second and third leading causes of death for adolescents ages 15 through 19. ⁴ The total death rate for persons aged 10-19 years decreased 33% between 1999 and 2013, then increased 12% between 2013 and 2016 due to an increase in injury deaths. ⁰ For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.

⁰ Heron M. Deaths: Leading Causes for 2017. National Vital Statistics Reports. 2019 June 24. 68(6).
https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_06-508.pdf

⁰ Curtin SC, Heron M, Minino AM, Warner M. Recent Increases in Injury Mortality Among Children and Adolescents Aged 10-19 years in the United States: 1999-2016. National Vital Statistics Reports. 67 (4)
https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_04.pdf.

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 recipients received those services. Please use the space provided for notes to specify the recipients of each type of service.

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

CSHCN 1 PERFORMANCE MEASURE	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: <u>Family Engagement</u> 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. <u>Family and Youth Leaders</u> 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. <u>Meaningful [Support] Roles</u> 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	N/A
GRANTEE DATA SOURCES	Title V National Outcome Measure #17.2
SIGNIFICANCE	Children and youth live within the context of families, who are the ultimate decision-makers and health enablers for their children.

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	
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 aspects of pediatric care.

CSHCN 2 PERFORMANCE MEASURE Goal: Access to and Use of Medical Home Level: Grantee Domain: CSHCN	The percent of programs promoting and/ or facilitating medical home access and use among children and youth with special health care needs.
BENCHMARK DATA SOURCES	Related to HP2030 MICH-19: Increase the proportion of children and adolescents who receive care in a medical home. (Baseline: 48.6% in 2016-17, Target: 53.6%)
GRANTEE DATA SOURCES	Title V National Performance Measure #11
SIGNIFICANCE	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions.

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

CSHCN 3 PERFORMANCE MEASURE

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

Numerator: Number of Grantees promoting transition planning early in adolescence

Denominator: Total number of grantees reporting transition performance measure

% of grantees linking transition efforts with medical home initiatives

Numerator: Number of Grantees promoting transition as part of routine medical home care

Denominator: Total number of grantees reporting transition performance measure

% of grantees linking transition efforts with adolescent preventive care efforts

Numerator: Number of grantees promoting transition as part of routine adolescent preventive care

Denominator: Total number of grantees reporting transition performance measure

Definitions: The terms “assessed for readiness” and “deemed ready” used here refer to language utilized by gottransition.org.

Health care transition: is the process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.

Transition Readiness: Assessing youth’s transition readiness and self-care skills is the third element in these health care transition quality recommendations. Use of a standardized transition assessment tool is helpful in engaging youth and families in setting health priorities; addressing self-care needs to prepare them for an adult approach to care at age 18, and navigating the adult health care system, including health insurance. Providers can use the results to jointly develop a plan of care with youth and families. Transition readiness assessment should begin at age 14 and continue through adolescence and young adulthood, as needed.

BENCHMARK DATA SOURCES

Related to HP2030 AH-02: Increase the proportion of adolescents who speak privately with a physician or other health care provider during a preventive medical visit. (Baseline: 38.4% in 2016-17, Target: 43.3%). Related to HP2030 AH-R01: Increase the proportion of adolescents (aged 12 to 17 years) with and without special health care needs who receive services to support their transition to adult health care. (Research)

GRANTEE DATA SOURCES

Title V National Performance Measure #12.

SIGNIFICANCE

Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college, or be employed. Health and health care are cited as two of the major barriers to making successful transitions. The transition of youth to adulthood,

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

including moving from a child to adult healthcare, is a national priority as evidenced by the 2011 clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families.⁰

⁰

White PH, Cooley WC. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*. 2018; 142 (5): e20182587. <https://doi.org/10.1542/peds.2018-2587>

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	HP2030 AH-01: Increase the proportion of adolescents who received a preventive health care visit in the past year. (Baseline:

AH 1 PERFORMANCE MEASURE	The percent of programs promoting and/ or facilitating adolescent well visits.
Goal: Adolescent Well Visit	
Level: Grantee	
Domain: Adolescent Health	
	78.7% in 2016-17, Target: 82%)
GRANTEE DATA SOURCES	Title V National Performance Measure #10, National Vital Statistics System (NVSS) Birth File.
SIGNIFICANCE	As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors, such as unsafe sexual activity, unsafe driving, and substance use, is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. An annual preventive well visit may help adolescents adopt or maintain healthy habits and behaviors, avoid health-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? <i>See data collection form.</i> ☐ 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 <i>See data collection form.</i> Tier 4: What are the related outcomes in the reporting year? Rate of injury-related hospitalization to children ages 10-19. Numerator: # of injury-related hospitalizations to children ages 10-19 Denominator: # of children ages 10-19 in the target population Target Population: _____

AH 2 PERFORMANCE MEASURE	The percent of programs promoting and/ or facilitating adolescent injury prevention.
Goal: Injury Prevention Level: Grantee Domain: Adolescent Health	
	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 2030 Injury and Violence Prevention (IVP) objectives 1-7, 9-24 and Injury and Violence Developmental (IV-D) objectives 1-5.
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 and 12-17 year old survey, Question G1.
SIGNIFICANCE	Unintentional injury is the leading cause of child and adolescent mortality, from age 1 through 19. Homicide and suicide, violent or intentional injury are the second and third leading causes of death for adolescents ages 15 through 19. ⁴ The total death rate for persons aged 10-19 years decreased 33% between 1999 and 2013, then increased 12% between 2013 and 2016 due to an increase in injury deaths. For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.

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 recipients received those services. Please use the space provided for notes to specify the recipients of each type of service.

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

AH 3 PERFORMANCE MEASURE	The percent of programs promoting and/ or facilitating screening for major depressive disorder.
Goal: Screening for Major Depressive Disorder Level: Grantee Domain: Adolescent Health	
GOAL	To ensure supportive programming for screening for major depressive disorder.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating screening for major depressive disorder for adolescents and through what processes.
DEFINITION	Tier 1: Are you promoting and/ or facilitating screening major depressive disorder for adolescents in your program? € Yes € No Tier 2: Through what processes/ mechanisms are you addressing screening for major depressive disorder for adolescents? € 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? <i>(Report in Table 1: Activity Data Collection Form)</i> # 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 12-17 year olds screened for major depressive disorder (MDD) in the past year in community level or school health settings Numerator: Adolescents involved with your program in the reporting year who were screened for MDD in a community-level or school health setting. Denominator: Adolescents involved with your program in the reporting year. % of adolescent well care visits that include screening for MDD Numerator: Adolescents involved with your program in the reporting year that had a well-child that included a screening for MDD, in the reporting year. Denominator: Adolescents involved with your program in the reporting year that had a well-child visit

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	in the reporting year. % of adolescents identified with a MDD that receive treatment 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 2030 MHMD-08: Increase the proportion of primary care office visits where adolescents and adults are screened for depression (Baseline 8.5% of primary care office visits included screening for depression in persons aged 12 years and over in 2016, Target: 13.5%). Healthy People 2030 MHMD-06: Increase the proportion of adolescents with major depressive episodes (MDEs) who receive treatment (Baseline: 41.4% of adolescents aged 12 to 17 years with MDEs received treatment in the past 12 months, in 2018; Target: 46.4%).
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	Depression is under recognized and undertreated in adolescents, with an estimated 75% of depressed adolescents not receiving treatment. Untreated depression in adolescence is associated with debilitating immediate and long-term psychological and physical outcomes, as well as increased risk of suicide. Validated screening instruments and effective treatment are available. Routine depression screening for all adolescents helps reduce the challenges of case-finding due to stigma, parental/patient denial and common assumptions about “typical teenage” behavior.⁰

⁰ Maslow GR, Dunlap K, Chung RJ. Depression and Suicide in Children and Adolescents. Pediatrics. 2015, 36(7): 299-310. <https://pedsinreview-aappublications-org.ezproxyhhs.nihlibrary.nih.gov/content/36/7/299#sec-7>

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? <i>See data LC 1 Data Collection Form.</i> Tier 4: What are the related outcomes? % with health insurance⁰ Numerator: Number of program participants with health insurance as of the last assessment during the reporting period Denominator: Number of program participants during the reporting period Participants are identified as not insured if they report not having any of the following: private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), State-sponsored or other government-sponsored health plan, or military plan at the time of the interview. A participant is also defined as uninsured if he or she reported having only Indian Health Service coverage, or only a private plan that paid for one type of service such as family planning, accidents, or dental care. For more information regarding health insurance questions please refer to Section VII (page 35) of the 2014 National Health Interview Survey (NHIS) Survey Description % with adequate health insurance in the reporting year Numerator: Program participants who reported having adequate insurance coverage during the reporting period Denominator: Program participants during the reporting period
BENCHMARK DATA SOURCES	Related to HP2030 AHS-01: Increase the proportion of people

⁰ 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	
	with health insurance (Baseline: 89.0% of persons under 65 years had medical insurance in 2018; Target: 92.1%)
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Inadequately insured children are more likely to have delayed or forgone care, lack a medical home, be less likely to receive needed referrals and care coordination, and receive family-centered care. ⁰ Approximately 27% of American children were not adequately insured in 2018-2019. ⁰

⁰ Kogan MD, Newacheck PW, Blumberg SJ, Ghandour RM, Singh GK, Strickland BB, van Dyck PC. Underinsurance among children in the United States. N Engl J Med. 2010 Aug 26;363(9):841-51. <http://www.nejm.org/doi/full/10.1056/NEJMsa0909994>

⁰ Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 11/09.2021 from <https://www.childhealthdata.org/browse/survey/results?q=7888&r=1>.

Data Collection form for #LC 1

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

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

LC 2 PERFORMANCE MEASURE	The percent of programs promoting and/ or facilitating tobacco and eCigarette cessation.
Goal: Tobacco and eCigarette Use	
Level: Grantee	
Domain: Life Course/ Cross Cutting	
GOAL	To ensure supportive programming promoting and/ or facilitating tobacco and eCigarette cessation.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating tobacco and eCigarette cessation, and through what processes.
DEFINITION	Tier 1: Are you addressing tobacco and eCigarette cessation in your program? € Yes € No Tier 2: Through what activities are you promoting and/ or facilitating tobacco and eCigarette cessation? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral/ care coordination € Direct Service € Quality improvement initiatives Tier 3: How many are reached through those activities? <i>See data LC 2 Data Collection Form.</i> Tier 4: What are the related outcomes in the reporting year? % of prenatal program participants who abstain from smoking Numerator: Number of prenatal program participants who do not smoke cigarettes as of their last contact in the reporting year. Denominator: Number of prenatal program participants during the reporting year. % of prenatal program participants that abstain from smoking cigarettes in their third trimester. Numerator: Number of prenatal program participants who abstained from using any tobacco products during the last 3 months (third trimester) of pregnancy. Denominator: Total number of prenatal program participants who were enrolled at least 90 days before delivery. Smoking includes all tobacco products and e-cigarettes.
BENCHMARK DATA SOURCES	Related to HP2030 MICH-10: Increase abstinence from cigarette smoking among pregnant women. (Baseline: 93.5% in 2018, Target: 95.7%). Related to HP2030 TU-15: Increase smoking cessation success during pregnancy among females. (Baseline: 20.2% in 2018, Target 24.4%)

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	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Adverse effects of parental smoking on children have been a clinical and public health concern for decades. ⁰ Children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections; and SIDS.

⁰ U.S. Department of Health and Human Services. The Health Consequences of Smoking: 50 Years of Progress. A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2014. Printed with corrections, January 2014.
https://www.ncbi.nlm.nih.gov/books/NBK179276/pdf/Bookshelf_NBK179276.pdf

Data Collection form for #LC 2

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

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

LC 3 PERFORMANCE MEASURE	The percent of programs promoting and/ or facilitating oral health.
Goal: Oral Health	
Level: Grantee	
Domain: Life Course/ Cross Cutting	
GOAL	To ensure supportive programming for oral health.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating oral health, and through what activities.
DEFINITION	Tier 1: Are you promoting and/ or facilitating oral health in your program? € Yes € No Tier 2: Through what activities are you promoting and/ or facilitating oral health? € Technical Assistance € Training € Product Development € Research/ Peer-reviewed publications € Outreach/ Information Dissemination/ Education € Tracking/ Surveillance € Screening/ Assessment € Referral € Direct Service € Quality improvement initiatives Tier 3: How many from each population are reached through each of the activities? <i>See data LC 3 Data Collection Form.</i> Tier 4: What are the related outcomes in the reporting year? % of program participants receiving an oral health risk assessment Numerator: Number of program participants who received an oral health risk assessment in the reporting year Denominator: All program participants % of women in program population who had a dental visit during pregnancy Numerator: Program participants who were pregnant during the reporting year who had a dental visit Denominator: Program participants who were pregnant during the reporting year % of those aged 1 through 17 who had preventative oral health visit during the last year Numerator: Infants and children involved with the program who received a preventative oral health visit in the reporting year Denominator: Infants and children involved with the program during the reporting year.
BENCHMARK DATA SOURCES	Related to HP2030 OH-8: Increase the proportion of children, adolescents, and adults who use the oral health care system (Baseline: 43.3% in 2016; Target: 45.0%). Related to HP2030 OH-9: Increase the proportion of low income youth who have a preventive dental visit (Baseline: 78.8% of children aged 1

LC 3 PERFORMANCE MEASURE	The percent of programs promoting and/ or facilitating oral health.
Goal: Oral Health	
Level: Grantee	
Domain: Life Course/ Cross Cutting	
	through 17 years who reside in households with income less than 200 percent of the federal poverty level received a preventive dental service in 2016-17; Target: 82.7%).
GRANTEE DATA SOURCES	Title V National Performance Measure #13
SIGNIFICANCE	Oral health is a vital component of overall health and oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. To prevent tooth decay and oral infection, the American Academy of Pediatric Dentistry (AAPD) recommends preventive dental care for all children after the eruption of the first tooth or by 12 months of age, usually at intervals of every 6 months.⁰ Preventive dental care in pregnancy is also recommended by the American College of Obstetricians and Gynecologists (ACOG) to improve lifelong oral hygiene habits and dietary behavior for women and their families.⁰

⁰ American Academy of Pediatric Dentistry. Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Health Treatment for Infants, Children, and Adolescents. 2018. Reference Manual of Pediatric Dentistry. https://www.aapd.org/globalassets/media/policies_guidelines/bp_periodicity.pdf

⁰ National Maternal and Child Oral Health Resource Center. Oral Health During Pregnancy: A National Consensus Statement. (n.d.) https://www.mchoralhealth.org/materials/consensus_statement.php

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 reached by the services provided (i.e. number of children receiving referrals), for those that you do not, please leave blank.

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

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

Performance Measure	Topic
Training 01	MCH Training Program and Healthy Tomorrows Family Member/Youth/Community Member participation
Training 02	MCH Training Program and Healthy Tomorrows Cultural Responsiveness
Training 03	Healthy Tomorrows Title V Collaboration
Training 04	Title V Collaboration
Training 05	Policy
Training 06	Racial and Ethnic Diversity of Long-Term Trainees
Training 07	MCH LEAP Program – Work with MCH populations
Training 08	MCH LEAP Program – Work with populations that are underserved or have been marginalized
Training 09	MCH LEAP - Graduate Program Enrollment
Training 10	Leadership
Training 11	Work with MCH Populations
Training 12	Interdisciplinary Practice
Training 14	Medium-Term Trainees Skill and Knowledge (PPC-Specific)
Training 15	Teleconsultation and Training for Mental and Behavioral Health

Training 01 PERFORMANCE MEASURE	
Goal: Family/ Youth/ Community Engagement in MCH Training and Healthy Tomorrows Programs Level: Grantee Domain: MCH Workforce Development	
GOAL	The percent of MCHB training and Healthy Tomorrows programs that ensure family, youth, and community member participation in program and policy activities.
MEASURE	To increase family, youth, and/or community member participation in MCH Training and Healthy Tomorrows programs.
DEFINITION	The percent of MCHB training and Healthy Tomorrows programs that ensure family/ youth/ community member participation in program and policy activities.
BENCHMARK DATA SOURCES	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.
GRANTEE 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
SIGNIFICANCE	Attached data collection form to be completed by grantee.
	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 responsive 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,

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.

community-based, family-centered, culturally/linguistically responsive, and coordinated care. Healthy Tomorrows projects are required to incorporate family members/youth/community members as project staff, advisors, volunteers, and partners. This performance measure directly relates to MCHB Strategic Plan Objective 1.3: Ensure family and consumer leadership and partnership in efforts to improve health and strengthen MCH systems of care.

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	Yes 1	No 0
Participatory Planning Family members/youth/community members participate in and provide feedback on the planning, implementation and/or evaluation of the training or Healthy Tomorrows program’s activities (e.g., strategic planning, program planning, materials development, program activities, and performance measure reporting).		
Cultural Diversity Culturally diverse family members/youth/community members facilitate the training or Healthy Tomorrows program’s ability to meet the needs of the populations served.		
Leadership Opportunities Within your training or Healthy Tomorrows program, family members/youth/community members are offered training, mentoring, and/or opportunities for leadership roles on advisory committees or task forces.		
Compensation Family members/youth/community members who participate in the MCH Training or Healthy Tomorrows program are paid faculty, staff, consultants, or compensated for their time and expenses.		
Train MCH/CSHCN staff Family members/youth/community members work with their training or Healthy Tomorrows program to provide training (pre-service, in-service and professional development) to MCH/CSHCN faculty/staff, students/trainees, and/or providers.		

NOTES/COMMENTS:

Training 02 PERFORMANCE MEASURE	The percent of MCHB training and Healthy Tomorrows programs that have incorporated cultural and linguistic responsiveness elements into their policies, guidelines, and training.
Goal: Cultural Responsiveness in MCH Training and Healthy Tomorrows Programs	
Level: Grantee	
Domain: MCH Workforce Development	
GOAL	To increase the percentage of MCH Training and Healthy Tomorrows programs that have integrated cultural and linguistic responsiveness into their policies, guidelines, and training.
MEASURE	The percent of MCHB training and Healthy Tomorrows programs that have integrated cultural and linguistic responsiveness into their policies, guidelines, and training.
DEFINITIONS	Attached is a checklist of 6 elements that demonstrate cultural and linguistic responsiveness. 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 responsiveness 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. 'Responsiveness' 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.georgetow.edu/foundations/frameworks.html)) Linguistic responsiveness 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 responsiveness requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. (Goode, T. and W. Jones, 2004. National Center for Cultural Competence; http://www.nccccurricula.info/linguisticcompetence.html) Cultural and linguistic responsiveness is a process that occurs along a developmental continuum. A culturally and linguistically responsive program is characterized by elements including the following: written strategies for advancing cultural responsiveness; cultural and linguistic

Training 02 PERFORMANCE MEASURE	The percent of MCHB training and Healthy Tomorrows programs that have incorporated cultural and linguistic responsiveness elements into their policies, guidelines, and training.
Goal: Cultural Responsiveness in MCH Training and Healthy Tomorrows Programs	
Level: Grantee	
Domain: MCH Workforce Development	
	responsiveness policies and practices; cultural and linguistic responsiveness 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 responsiveness; and periodic assessment of trainees' progress in developing cultural and linguistic responsiveness.
BENCHMARK DATA SOURCES	Related to the following HP2030 Objectives: PHI-RO3: Increase the use of core and discipline-specific competencies to drive workforce development PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education. PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education
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 responsiveness 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 responsiveness objectives have been: (1) incorporated into the Division of MCH Workforce Development priorities; 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 responsiveness through development of curricula, research, learning and practice environments. This performance measure directly relates to MCHB Strategic Plan Objective 3.2: Support training and educational opportunities to create a diverse an culturally responsive MCH workforce, including professionals, community-based workers, and families.

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

Please indicate if your MCH Training or Healthy Tomorrows program has incorporated the following cultural/linguistic responsiveness elements into your policies, guidelines, and training.

Please use the space provided for notes to provide additional details about the elements, as applicable.

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

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, and other MCH or MCH-related programs.
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-DO9: Increase core clinical prevention and population health education in medical schools. ECBP-D10: Increase core clinical prevention and population health education in nursing schools. ECBP-D11: Increase core clinical prevention and population health education in physician assistant training programs. ECBP-D12: Increase core clinical prevention and population health education in pharmacy schools. ECBP-D13: Increase core clinical prevention and population health education in dental schools. PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education. PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education. PHI-DO1: Increase the proportion of tribal public health agencies that use core competencies in continuing education.
GRANTEE DATA SOURCES	The Healthy Tomorrows program completes the attached table which describes the categories of collaborative activity.
SIGNIFICANCE	As a SPRANS grantee, a Healthy Tomorrows program enhances the Title V State block grants that support MCHB Strategic Plan Goal 1: to assure access to high-quality and equitable health services to optimize health and well-being for all MCH populations. Interactive collaboration between a Healthy Tomorrows program

Training 03 PERFORMANCE MEASURE

Goal: Healthy Tomorrow's Partnership

Level: Grantee

Domain: MCH Workforce Development

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

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 2030 objectives;
- 2) make the needs of MCH populations more visible to decision-makers and help states achieve best practice standards for their systems of care;
- 3) internally use these data to assure a full scope of these program elements in all regions.

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

Indicate the degree to which the Healthy Tomorrows program collaborates with State Title V (MCH Block Grant) agencies and other MCH or MCH-related programs^{1,2} by entering the following values:

0= Does not collaborate on this element

1= Does collaborate on this element.

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

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

¹State Title V programs include State Block Grant funded or supported activities.

²Other maternal and child health-related programs (both MCHB-funded and funded from other sources) include, but are not limited to:

- State Health Department
- State Adolescent Health
- Social Service Agency
- Medicaid Agency
- Education
- Juvenile Justice
- Early Intervention
- Home Visiting
- Professional Organizations/Associations
- Family and/or Consumer Group
- Self-Advocacy Groups
- Foundations
- Clinical Program/Hospitals
- Local and state division of mental health
- Developmental disability agencies
- Tribal governments and organizations
- School-based programs, including health centers
- City and County Health Departments
- Health care organizations
- Behavioral health disorder support and advocacy organizations
- College/University programs
- Faith-based programs
- Other programs working with maternal and child health populations

Training 04 PERFORMANCE MEASURE	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs.
Goal: Collaborative Interactions	
Level: Grantee	
Domain: MCH Workforce Development	
GOAL	To assure that a training program has collaborative interactions related to training, technical assistance, continuing education, and other capacity-building services with relevant national, state and local programs, agencies and organizations.
MEASURE	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs and other professional organizations.
DEFINITION	Attached is a list of the 6 elements that describe activities carried out by training programs for or in collaboration with State Title V and other agencies on a scale of 0 to 1. If a value of '1' is selected, provide the number of activities for the element. The total score for this measure will be determined by the sum of those elements noted as '1.'
BENCHMARK DATA SOURCES	ECBP-DO9: Increase core clinical prevention and population health education in medical schools. ECBP-D10: Increase core clinical prevention and population health education in nursing schools. ECBP-D11: Increase core clinical prevention and population health education in physician assistant training programs. ECBP-D12: Increase core clinical prevention and population health education in pharmacy schools. ECBP-D13: Increase core clinical prevention and population health education in dental schools. PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education. PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education. PHI-DO1: Increase the proportion of tribal public health agencies that use core competencies in continuing education.
GRANTEE DATA SOURCES	The training program completes the attached table which describes the categories of collaborative activity.
SIGNIFICANCE	As a SPRANS grantee, a training program enhances the Title V State block grants that support the MCHB Strategic Plan Goal 1: to assure access to high-quality and equitable health services to optimize health and well-being for all MCH populations. Interactive collaboration

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.

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 and Healthy People 2030 objectives;
- 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 these data to assure a full scope of these program elements in all regions.

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

Indicate the degree to which your training program collaborates with State Title V (MCH Block Grant) agencies and other MCH-related programs* by entering the following values:

0= Does not collaborate on this element

1= Does collaborate on this element.

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

Element	State Title V programs ¹			Other MCH-related programs ²		
	0	1	Total number of activities	0	1	Total number of activities
Service* Examples might include: Clinics run by the training program and/or in collaboration with other agencies						
Training Examples might include: Training in Bright Futures; Workshops related to adolescent health practice; and Community-based practices. It would not include clinical supervision of long-term trainees.						
Continuing Education Examples might include: Conferences; Distance learning; and Computer-based educational experiences. It would not include formal classes or seminars for long-term trainees.						
Technical Assistance Examples might include: Conducting needs assessments with State programs; policy development; grant writing assistance; identifying best-practices; and leading collaborative groups. It would not include conducting needs assessments of consumers of the training program services.						
Product Development Examples might include: Collaborative development of journal articles and training or informational videos.						
Research Examples might include: Collaborative submission of research grants, research teams that include Title V or other MCH-program staff and the training program's faculty.						
Total						

¹State Title V programs include State Block Grant funded or supported activities.

²Other maternal and child health-related programs (both MCHB-funded and funded from other sources) include, but are not limited to:

- State Health Department
- State Adolescent Health
- Social Service Agency
- Medicaid Agency
- Education
- Juvenile Justice
- Early Intervention
- Home Visiting
- Professional Organizations/Associations
- Family and/or Consumer Group
- Self-Advocacy Groups
- Foundations
- Clinical Program/Hospitals
- Local and state division of mental health
- Developmental disability agencies
- Tribal governments and organizations
- School-based programs, including health centers
- City and County Health Departments
- Health care organizations
- Behavioral health disorder support and advocacy organizations
- College/University programs
- Faith-based programs
- Other programs working with maternal and child health populations

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

Training 05 PERFORMANCE MEASURE	The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.
Goal: Policy Development Level: Grantee Domain: MCH Workforce Development	
GOAL	To increase the number of MCH long-term training programs that actively promote the transfer and utilization of MCH knowledge and research to the policy arena through the work of faculty, trainees, alumni, and collaboration with Title V.
MEASURE	The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.
DEFINITION	Attached is a list of six elements that demonstrate policy engagement. Please check yes or no to indicate which the elements have been implemented. Please keep the completed checklist attached. Policy development, implementation and evaluation in the context of MCH training programs relates to the process of translating research to policy and training for leadership in the core public health function of policy development.
BENCHMARK DATA SOURCES	PHI-R02: Expand public health pipeline programs that include service or experiential learning. PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development.
GRANTEE DATA SOURCES	Attached data collection form to be completed by grantee. Data will be collected from competitive and continuation applications as part of the grant application process and annual reports. The elements of training program engagement in policy development, implementation, and evaluation need to be operationally defined with progress noted on the attached list with an example described more fully in the narrative application.
SIGNIFICANCE	Policy development is one of the three core functions of public health as defined by the Institute of Medicine in The Future of Public Health (National Academy Press, Washington DC, 2015). In this landmark report by the IOM, the committee recommends that “every public health agency exercise its responsibility to serve the public interest in the development of comprehensive public health policies by promoting use of the scientific knowledge base in decision-making about public health and by leading in developing public health policy.” Academic institutions such as schools of public health and research universities have the dual responsibility to develop knowledge and to produce well-trained professional practitioners. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce in MCH.

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

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

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

Training 06 PERFORMANCE MEASURE	
Goal: Long Term Training Programs	
Level: Grantee	
Domain: MCH Workforce Development	
GOAL	To increase the percentage of trainees participating in MCHB long-term training programs who are from racial and ethnic groups who are underrepresented in the MCH workforce.
MEASURE	The percentage of participants in MCHB long-term training programs who are from racial and ethnic groups who are underrepresented in the MCH workforce.
DEFINITION	Ethnicity Numerator: Total number of long-term trainees (≥ 300 contact hours) participating in MCHB training programs reported to be from ethnic groups that are underrepresented in the MCH workforce. (Include MCHB-supported and non-supported trainees.) Denominator: Total number of long-term trainees (≥ 300 contact hours) participating in MCHB training programs. (Include MCHB-supported and non-supported trainees.) Units: 100 Text: Percentage Hispanic or Latino is defined as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. People who identify as Hispanic, Latino, or Spanish may be any race. Race Numerator: Total number of long term trainees (≥ 300 contact hours) participating in MCHB training programs reported to be from racial groups that are underrepresented in the MCH workforce. (Include MCHB-supported and non-supported trainees.) Denominator: Total number of long term trainees (≥ 300 contact hours) participating in MCHB training programs. (Include MCHB-supported and non-supported trainees.) Units: 100 Text: Percentage .
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objectives: AHS-R01: Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it. AHS-R02: Increase the use to telehealth to improve access to health services.

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	
GRANTEE DATA SOURCES	Data will be collected annually from grantees about their trainees. MCHB does not maintain a master list of all trainees who are supported by MCHB long-term training programs. References supporting Workforce Diversity: ● In the Nation’s Compelling Interest: Ensuring Diversity in the Healthcare Workforce (2004). Institute of Medicine. ● Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2002). Institute of Medicine.
SIGNIFICANCE	HRSA’s MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. Training an ethnically and racially 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 responsive and effective services. This performance measure provides the necessary data to report on HRSA’s initiatives to reduce health disparities. This national performance measure relates directly to MCHB Strategic Plan Objective 3.2: Support training and educational opportunities to create a diverse and culturally responsive MCH workforce, including professionals, community-based workers, and families.

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 a racial/ethnic group (i.e., Hispanic or Latino, American Indian or Alaskan Native, Asian, Black or African-American, Native Hawaiian or Pacific Islander, more than one race (OMB) that is underrepresented in the MCH workforce. 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 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 more than one race

Notes/Comments:

Training 07 PERFORMANCE MEASURE	The percent of MCHB LEAP Program graduates who have been engaged in work focused on MCH populations.
Goal: MCH Pipeline Programs	
Level: Grantee	
Domain: MCH Workforce Development	
GOAL	To increase the percent of graduates of MCH Leadership, Education and Advancement in Undergraduate Pathways (LEAP) Programs who have been/are engaged in work focused on MCH populations.
MEASURE	The percent of MCHB LEAP Program graduates who have been engaged in work focused on MCH populations since graduating from the MCH LEAP Training Program.
DEFINITION	Numerator: Number of LEAP graduates reporting they have been engaged in work focused on MCH populations since graduating from the MCH LEAP Training Program. Denominator: The total number of trainees responding to the survey Units: 100 Text: Percent MCH LEAP trainees are defined as undergraduate students from underserved or underrepresented backgrounds, including trainees from racially and ethnically underrepresented groups who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related health professions. MCH Populations: Includes women, infants and children, adolescents, young adults, and their families including fathers, and children and youth with special health care needs
BENCHMARK DATA SOURCES	Related to Healthy People 2030: AHS-R01: Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it. AHS-R02: Increase the use to telehealth to improve access to health services. PHI-R02: Expand public health pipeline programs that include service or experiential learning. PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development
GRANTEE DATA SOURCES	A LEAP 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. <i>Ann Fam Med</i> 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 <i>JAMA</i>.

Training 07 PERFORMANCE MEASURE	The percent of MCHB LEAP Program graduates who have been engaged in work focused on MCH populations.
Goal: MCH Pipeline Programs	
Level: Grantee	
Domain: MCH Workforce Development	

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. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce for MCH.

DATA COLLECTION FORM FOR DETAIL SHEET: Training 07 - MCH LEAP Program

MCH Leadership, Education and Advancement in Undergraduate Pathways (LEAP) 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 LEAP program.

NOTE: Each LEAP trainee should be counted once.

2 YEARS AFTER GRADUATING FROM MCH LEAP 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 LEAP Training Program _____
- E. Percent of respondents who report working with an MCH population Since graduating from the MCH LEAP Training Program _____

5 YEARS AFTER GRADUATING FROM MCH LEAP 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 LEAP Training Program _____
- E. Percent of respondents who report working with an MCH population since graduating from the MCH LEAP Training Program _____

Training 08 PERFORMANCE MEASURE	The percent of MCH LEAP Program graduates who have been engaged in work with populations that are underserved or have been marginalized.
Goal: MCH LEAP Program	
Level: Grantee	
Domain: MCH Workforce Development	
GOAL	To increase the percent of graduates of MCH Leadership, Education and Advancement in Undergraduate Pathways (LEAP) Programs who have been engaged in work with populations that are underserved or have been marginalized.
MEASURE	The percent of MCH LEAP Program graduates who have been engaged in work with populations that are underserved or have been marginalized since graduating from the MCH LEAP Training Program.
DEFINITION	Numerator: Number of LEAP graduates reporting they have been engaged in work with populations that are underserved or have been marginalized since graduating from the MCH LEAP Training Program. Denominator: The total number of trainees responding to the survey Units: 100 Text: Percent MCH LEAP trainees are defined as undergraduate students from underserved or underrepresented backgrounds, including trainees from racially and ethnically underrepresented groups who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related fields. Populations that are underserved or have been marginalized refers to groups of individuals at higher risk for health disparities by virtue of their race or ethnicity, socioeconomic status, geography, gender, age, disability status, or other risk factors including those associated with sex and gender.
BENCHMARK DATA SOURCES	Related to Healthy People 2030: AHS-R01: Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it. AHS-R02: Increase the use of telehealth to improve access to health services. PHI-R02: Expand public health pipeline programs that include service or experiential learning. PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development.
GRANTEE DATA SOURCES	A LEAP 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

Training 08 PERFORMANCE MEASURE	The percent of MCH LEAP Program graduates who have been engaged in work with populations that are underserved or have been marginalized.
Goal: MCH LEAP Program Level: Grantee Domain: MCH Workforce Development	Service Corps Participation. <i>Ann Fam Med</i> 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 <i>JAMA</i> . 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. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce for MCH.

DATA COLLECTION FORM FOR DETAIL SHEET: Training 08 - MCH LEAP Program

MCH Leadership, Education and Advancement in Undergraduate Pathways (LEAP) Program graduates who have worked with populations that are underserved or have been marginalized 2 years and 5 years after graduating from their MCH LEAP program.

NOTE: Each LEAP trainee should be counted once.

2 YEARS AFTER GRADUATING FROM MCH LEAP 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 that are underserved or have been marginalized since graduating from the MCH LEAP Training Program _____
- E. Percent of respondents who have worked with populations that are underserved or have been marginalized since graduating from the MCH LEAP Training Program _____

5 YEARS AFTER GRADUATING FROM MCH LEAP 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 that are underserved or have been marginalized since graduating from the MCH LEAP Training Program _____
- E. Percent of respondents who have worked with populations that are underserved or have been marginalized since graduating from the MCH LEAP Training Program _____

Training 09 PERFORMANCE MEASURE	The percent of LEAP graduates that enter graduate programs preparing them to work with the MCH population.
Goal: Graduate Program Enrollment Level: Grantee Domain: MCH Workforce Development	
GOAL	To increase the number of Leadership, Education and Advancement in Undergraduate Pathways (LEAP) graduates that enter graduate programs preparing them to work with the MCH population.
MEASURE	The percent of LEAP graduates that enter graduate programs preparing them to work with the MCH population.
DEFINITION	Numerator: Total number of MCH LEAP 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 LEAP program. Denominator: Total number of MCH LEAP Trainees who graduated from the MCH LEAP program 2 or 5 years previously.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objectives: ECBP-DO9: Increase core clinical prevention and population health education in medical schools. ECBP-D10: Increase core clinical prevention and population health education in nursing schools. ECBP-D11: Increase core clinical prevention and population health education in physician assistant training programs. ECBP-D12: Increase core clinical prevention and population health education in pharmacy schools. ECBP-D13: Increase core clinical prevention and population health education in dental schools. PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development. PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education. PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education. PHI-DO1: Increase the proportion of tribal public health agencies that use core competencies in continuing education
GRANTEE DATA SOURCES	Attached data collection form to be completed by grantees.
SIGNIFICANCE	MCHB training programs assist in developing a public health workforce that addresses key MCH issues and fosters field leadership in the MCH arena. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and

Training 09 PERFORMANCE MEASURE	The percent of LEAP graduates that enter graduate programs preparing them to work with the MCH population.
Goal: Graduate Program Enrollment	
Level: Grantee	
Domain: MCH Workforce Development	
	workforce for MCH.

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

2 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

A. The total number of LEAP 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. Total number of respondents that are enrolled in or have completed graduate Programs preparing them work with the MCH population _____

Specify the number of respondents that are enrolled in or have completed the following graduate programs:

Medicine (e.g. Pediatric, Ob/Gyn, Primary Care): _____

Public health: _____

Nutrition: _____

Social work: _____

Nursing: _____

Pediatric dentistry: _____

Psychology: _____

Pediatric occupational/physical therapy: _____

Speech language pathology: _____

Other MCH-related health profession (specify): _____

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

F. Number of LEAP trainees who indicate MCH LEAP Training Program helped in admission to and/or being successful in a graduate program _____

G. Percent of LEAP trainees who indicate MCH LEAP Training Program helped in admission to and/or being successful in a graduate program _____

5 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

A. The total number of LEAP 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 _____

Training 10 PERFORMANCE MEASURE	
Goal: Field Leadership	
Level: Grantee	
Domain: MCH Workforce Development	
GOAL	The percent of long-term trainees that have demonstrated field leadership after completing an MCH training program.
MEASURE	To increase the percentage of long-term trainees that have demonstrated field leadership two and five years after completing their MCH Training Program.
DEFINITION	The percentage of long-term trainees that have demonstrated field leadership after completing an MCH Training Program. Attached is a checklist of four elements that demonstrate field leadership. For each element, identify the number of long-term trainees that have demonstrated field leadership two and five years after program completion. Please keep the completed checklist attached. Long-term trainees are defined as those who have completed a long-term (greater than or equal to 300 contact hours) MCH training program, including those who received MCH funds and those who did not. “Field leadership” refers to but is not limited to providing MCH leadership within the clinical, advocacy, academic, research, public health, public policy or governmental realms. Refer to attachment for complete definition.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objectives: ECBP-DO9: Increase core clinical prevention and population health education in medical schools. ECBP-D10: Increase core clinical prevention and population health education in nursing schools. ECBP-D11: Increase core clinical prevention and population health education in physician assistant training programs. ECBP-D12: Increase core clinical prevention and population health education in pharmacy schools. ECBP-D13: Increase core clinical prevention and population health education in dental schools. PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development. PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education. PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education. PHI-DO1: Increase the proportion of tribal public health agencies that use core competencies in continuing education.

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.

GRANTEE DATA SOURCES

Attached data collection form to be completed by grantees.

SIGNIFICANCE

An MCHB trained workforce is a vital participant in clinical, administrative, policy, public health and various other arenas. MCHB long term training programs assist in developing a public health workforce that addresses MCH concerns and fosters field leadership in the MCH arena. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce for MCH.

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 MCHB 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 long-term trainees, 2 years post program completion, 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 their 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 their 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 or 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 long-term trainees, **5 years** post program completion, 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 their 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 their 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 or other funding in MCH areas
- Conducted strategic planning or program evaluation
- Conducted research or quality improvement on MCH issues
- Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
- Participated in public policy development activities (e.g., Participated in community engagement or coalition building efforts, written policy or guidelines, provided testimony, educated policymakers , etc.)

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

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

NOTES/COMMENTS:

Training 11 PERFORMANCE MEASURE	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	
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. 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 Healthy People 2030 objectives: PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development. PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education. PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education. PHI-DO1: Increase the proportion of tribal public health agencies that use core competencies in continuing education
GRANTEE DATA SOURCES	A trainee follow-up survey that incorporates the new form for collecting data on the involvement of those completing an MCH training program in work related to MCH populations will be used to collect these data. Data Sources Related to Training and Work Settings/Populations: Rittenhouse Diane R, George E. Fryer, Robert L. Phillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps

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	
	Participation. <i>Ann Fam Med</i> 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 <i>JAMA</i> .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. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce for MCH.

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

Training 12 PERFORMANCE MEASURE	
Goal: Long-term Trainees Level: Grantee Domain: MCH Workforce Development	The percent of long-term trainees who, at 2, 5 and 10 years post training, have worked in an interdisciplinary manner to serve the MCH population (e.g., individuals with disabilities and their families, adolescents and their families, etc.).
GOAL	To increase the percent of long-term trainees who, upon completing their training, work in an interdisciplinary manner to serve the MCH population.
MEASURE	The percent of long-term trainees who, at 2, 5 and 10 years post training have worked in an interdisciplinary manner to serve the MCH population.
DEFINITION	Numerator: The number of long-term trainees indicating that they have worked in an interdisciplinary manner serving the MCH population. Denominator: The total number of long-term trainees responding to the survey Units: 100 Text: Percent In addition, data on the total number of the long-term trainees and the number of non-respondents for each year will be collected. Long-term trainees are defined as those who have completed a long-term (300+ hours) MCH Training program, including those who received MCH funds and those who did not. Individuals working in an interdisciplinary manner value the skills and expertise of team members from different disciplines, including a variety of professionals, MCH populations, and community partners, are acknowledged and seen as essential and synergistic. Input from each team member is elicited and valued in making collaborative, outcome-driven decisions to address individual, community-level, or systems-level problems.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objectives: ECBP-DO9: Increase core clinical prevention and population health education in medical schools. ECBP-D10: Increase core clinical prevention and population health education in nursing schools. ECBP-D11: Increase core clinical prevention and population health education in physician assistant training programs. ECBP-D12: Increase core clinical prevention and population health education in pharmacy schools. ECBP-D13: Increase core clinical prevention and population health education in dental schools. PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education. PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education. PHI-DO1: Increase the proportion of tribal public health agencies that use core competencies in continuing education. MICH-20: Increase the proportion of children and adolescents with special health care needs who have a system

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

of care.

GRANTEE DATA SOURCES

The trainee follow-up survey is used to collect these data.

SIGNIFICANCE

Leadership education is a complex interdisciplinary field that must meet the needs of MCH populations. This measure addresses one of a training program's core values and its unique role to prepare professionals for comprehensive systems of care/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. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce for MCH.

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 below.

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 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 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 information** to develop a coordinated, prioritized plan across disciplines to address a need in your work _____%
- Established decision-making** procedures in an interdisciplinary group. _____%
- Collaborated** with various disciplines across agencies/entities? _____%
- Advanced policies & programs** that promote collaboration with other disciplines or professions _____%

Training 14 PERFORMANCE MEASURE	
Goal: Medium-Term Trainees Skill and Knowledge	
Level: Grantee	
Domain: MCH Workforce Development	
GOAL	To increase the percentage of medium-term trainees (MTT) who report increased knowledge or skills related to MCH core competencies.
MEASURE	The percentage of Level I medium-term trainees who report an increase in knowledge and the percentage of Level II medium-term trainees who report an increase in knowledge or skills related to MCH core competencies.
DEFINITION	Numerator: The number of Level I medium-term trainees who report an increase in knowledge and Level II medium-term trainees who report an increase in knowledge or skills related to MCH core competencies. Denominator: The total number of medium-term trainees responding to the survey. <u>Medium Term trainees:</u> Level I MTT complete 40-149 hours of training. Level II MTT complete 150–299 hours of training.
BENCHMARK DATA SOURCES	ECBP-DO9: Increase core clinical prevention and population health education in medical schools. ECBP-D10: Increase core clinical prevention and population health education in nursing schools. ECBP-D11: Increase core clinical prevention and population health education in physician assistant training programs. ECBP-D12: Increase core clinical prevention and population health education in pharmacy schools. ECBP-D13: Increase core clinical prevention and population health education in dental schools. PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education. PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education. PHI-DO1: Increase the proportion of tribal public health agencies that use core competencies in continuing education. MICH-20: Increase the proportion of children and adolescents with special health care needs who have a system of care.
GRANTEE DATA SOURCES	End of training survey is used to collect these data.
SIGNIFICANCE	Medium-Term trainees comprise a significant proportion of training efforts. These trainees impact the provision of care to MCH populations nationally. The impact of this training must be measured and evaluated. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce for MCH.

TA 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 _____

Training 15 PERFORMANCE MEASURE

Goal: Consultation and Training for Mental and Behavioral Health

Level: Grantee

Domain: MCH Workforce Development

GOAL	Increase the availability and accessibility of consultation services to providers caring for individuals with behavioral or mental health conditions.
MEASURE	Number of providers participating in consultation and care coordination support services.
DEFINITION	Total number of providers participating in consultation (teleconsultation and in-person) and care coordination support services provided by the Pediatric Mental Health Care Access (PMHCA) program and the Screening for Maternal Depression and Related Behavioral Disorders (MDRBD) program.
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	PMHCA and MDRBD awardees report using the data collection form.
SIGNIFICANCE	Mental and behavioral health issues are prevalent among children and adolescents, and pregnant and postpartum women in the United States. However, due to shortages in the number of psychiatrists, developmental-behavioral providers, and other behavioral health clinicians, access to mental and behavioral health services is lacking. Research indicates that telehealth can improve access to care, reduce health care costs, improve health outcomes, and address workforce shortages in underserved areas. Telehealth strategies that connect primary care providers with specialty mental and behavioral health care providers can be an effective means of increasing access to mental and behavioral health services for children and pregnant and postpartum women, especially those living in rural and other underserved areas.

Training 15 Data Collection Form

A. Provider Consultation and Training

1. Consultation:

Provider Type		Number enrolled (if applicable) ⁰	Number participating ⁰	Number enrolled AND participating (if applicable) ⁰
Primary Care Providers (non-specialty)	Pediatrician			
	Family Medicine			
	OB/GYN			
	Internal Medicine			
	Advanced Practice Nurse/Nurse Practitioner			
	Certified Nurse Midwife			
	Physician Assistant			
Others	Psychiatrist			
	Developmental-Behavioral Pediatrician			
	Nurse			
	Behavioral Health Clinician (e.g. psychologist, therapist, counselor)			
	Care Coordinator/ Patient Navigator			
	Other Specialist Physician, APN/NP, PA (specify type):			
	Other (specify type):			
Unknown Provider type				
Total (will auto-populate)				
Total Primary Care (will auto-populate)				

- i. Number and types of providers enrolled for and participating in program consultation (teleconsultation or in-person) and care coordination support services⁰.

⁰ Enrolled provider: a provider who has formally registered with the program to facilitate use of consultation (teleconsultation or in-person) or care coordination support services, at the time of reporting. An enrolled provider is one who is currently enrolled with the program even if initial enrollment occurred prior to current reporting period.

⁰ Participating provider: a provider who has contacted the program for consultation (teleconsultation or in-person) or care coordination support services, and who has not formally registered with the program at the time of reporting.

⁰ This column refers to the number of enrolled providers (registered) who are participating in the program (contacting the program for consultation or care coordination support services).

⁰ Care Coordination Support: In context of MDRBD/PMHCA, care coordination support means, at minimum, that the program provides resources and referrals to a provider when they contact the program, or to the patient/family when the program works with patients/families directly. In these programs, “care coordination support” is synonymous with “providing resources and referrals”.

- ii. Use of program consultation and care coordination support services.
- a. Number of **provider** contacts with the program for consultation (teleconsultation or in-person), care coordination support, or both.

Type of contact	Number of provider contacts with the program for services
Consultation Only	
Care Coordination Support Only	
Both	

- b. Number of **consultations and referrals**⁰ given to providers.

Consultation or referral	Number of consultations or referrals given
Consultations via telehealth	
Consultations in-person	
Referrals	

- c. Please indicate the condition(s) about which providers contacted the program for consultation (teleconsultation or in-person) or care coordination support services. Select all conditions that apply. Specify the number of contacts for each condition. Each contact can involve more than one condition⁰.
- Anxiety disorders
 - Number of contacts for this reason _____
 - Depressive disorders
 - Number of contacts for this reason _____
 - Bipolar and related disorders
 - Number of contacts for this reason _____
 - Attention-Deficit/ Hyperactivity Disorder (ADHD)

⁰ **Referrals** are given to providers (or directly to the patients/families) by the program to introduce specific health providers or services. Referrals are typically provided using the referral database. More than one referral can be provided at a time.

⁰ If the patient has a diagnosed condition, but the provider is calling about another condition, a different presenting concern, or another reason, please count the reason(s) the provider is calling the program. If the patient does not have a diagnosis, the reason for contact can be a suspected diagnosis, diagnostic impression, presenting concerns/symptoms, suspected problem, or another reason. The condition(s) selected should be the reason(s) the provider is calling for consultation (teleconsultation or in-person) or care coordination support services.

- Number of contacts for this reason _____
- Autism Spectrum Disorder
 - Number of contacts for this reason _____
- Disruptive, impulse-control, and conduct disorders
 - Number of contacts for this reason _____
- Feeding and eating disorders
 - Number of contacts for this reason _____
- Obsessive-compulsive and related disorders
 - Number of contacts for this reason _____
- Trauma and stressor-related disorders
 - Number of contacts for this reason _____
- Schizophrenia spectrum and other psychotic disorders
 - Number of contacts for this reason _____
- Substance-related disorders
 - Number of contacts for alcohol _____
 - Number of contacts for marijuana _____
 - Number of contacts for nicotine _____
 - Number of contacts for opioids _____
 - Number of contacts for other substance-related disorders _____
- Suicidality or self-harm
 - Number of contacts for this reason _____
- Other (please specify) _____
 - Number of contacts for this reason _____

- iii. Number of consultations (teleconsultations and in-person) and referrals provided by each member of the mental health team. [Measures applies only to PMHCA awardees]

Member of mental health team	Number of consultations provided	Number of referrals provided
Psychiatrist		
Psychologist		
Social Worker		
Counselor		
Care Coordinator		
Other behavioral clinicians		
Other (specify type):		
Total (will auto-populate)		

2. Training:

- i. Number and types of providers trained.

Provider Type		Number Trained
Primary Care Providers (non-specialty)	Pediatrician	
	Family Medicine	
	OB/GYN	
	Internal Medicine	
	Advanced Practice Nurse/Nurse Practitioner	
	Certified Nurse Midwife	
	Physician Assistant	
Others	Psychiatrist	
	Developmental-Behavioral Pediatrician	
	Nurse	
	Behavioral Health Clinician (e.g. psychologist, therapist, counselor)	
	Care Coordinator/ Patient Navigator	
	Other Specialist Physician, APN/NP, PA (specify type):	
	Other (specify type):	
Unknown Provider type		
Total Primary Care (will auto-populate)		
Total (will auto-populate)		

- ii. Total number of trainings held ____
- a. Topics covered by trainings and number of trainings per topic. Select all that apply:

- Mental or behavioral health conditions-related trainings (e.g., anxiety, depression, substance use disorder, ADHD, OCD, eating disorders, tics, Autism, developmental delay, behavioral dysregulation, etc.) Please include comprehensive trainings that cover medications, screenings, treatments, etc. for specific conditions in this category.

Number of trainings covering topic ____

- Medication-focused trainings

Number of trainings covering topic ____

- Screening and assessment/testing-focused trainings

Number of trainings covering topic ____

- Treatment modality-focused trainings

Number of trainings covering topic ____

- Trauma focused trainings

Number of trainings covering topic ____

- Parent and family-focused trainings

Number of trainings covering topic ____

- Practice Improvement/Systems Change/Quality Improvement (e.g., practice workflows, integrating protocols into the EHR, integrating behavioral health into primary care, expanding community referrals, ensuring culturally and linguistically appropriate services)

Number of trainings covering topic ____

- COVID-19-focused trainings

Number of trainings covering topic ____

- Other (please specify) _____

Number of trainings covering topic ____

- b. Training mechanisms used. Select all that apply:

- In-person
Number of trainings using this mechanism _____
- Project ECHO® (distance learning cohort)
Number of trainings using this mechanism _____
- ECHO-like (distance learning cohort)
Number of trainings using this mechanism _____
- Web-based
Number of trainings using this mechanism _____
- Other (please specify)
Number of trainings using this mechanism _____

B. Individuals Served

1. Number of individuals for whom a provider contacted the program for consultation (teleconsultation or in-person) or care coordination support services

	Total	Rural/underserved ⁰
Children 0-11		
Adolescents 12-21		
Women (pregnant or postpartum)		

2. Number of individuals recommended for referral and/or treatment, among those for whom a provider contacted the program for consultation (teleconsultation or in-person) or care coordination support services.

	Referral only	Treatment only	Both referral and treatment
Children 0-11			
Adolescents 12-21			
Women (pregnant or postpartum)			

3. Percent of individuals screened for behavioral or mental health condition [Optional]

	Numerator ⁰	Denominator ⁰	% (auto-
--	------------------------	--------------------------	----------

⁰ For this measure, you may use provider zip codes to identify rural or underserved counties if the patient zip code is unavailable. The use of patient zip codes is not required. HRSA defines rural areas as all counties that are not designated as parts of metropolitan areas (MAs) by the Office of Management and Budget. In addition, HRSA uses Rural Urban Commuting Area Codes to designate rural areas within MAs. This rural definition can be accessed at <https://datawarehouse.hrsa.gov/tools/analyzers/geo/Rural.aspx>. If the county is not entirely rural or urban, follow the link for “Check Rural Health Grants Eligibility by Address” to determine if a specific site qualifies as rural based on its specific census tract within an otherwise urban county. Underserved areas are defined by the following terms: Any Medically Underserved Area/Population (MUA/P); or a Partially MUA/P. MUA/Ps are accessible through <https://data.hrsa.gov/tools/shortage-area/mua-find>

⁰ **For PMHCA:** Number of children and adolescents, 0-21 years of age, for whom a provider contacted the mental health team for consultation or referral, who received at least one screening for a behavioral health condition using a standardized validated tool.

			populated)
Children 0-11 screened for behavioral or mental health condition			
Adolescents 12-21 screened for behavioral or mental health condition			
Women (pregnant or postpartum) screened for behavioral or mental health condition			
Women (pregnant or postpartum) screened for depression			
Women (pregnant or postpartum) screened for anxiety			
Women (pregnant or postpartum) screened for substance use			

**DIVISION OF CHILD ADOLESCENT, AND FAMILY HEALTH
Emergency Medical Services for Children Program
PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE**

For MDRBD: Number of pregnant and postpartum women (PPW) for whom a provider contacted the program for consultation or referral during the reporting period, who received at least one screening for [depression, anxiety, or substance use] using a standardized validated tool.

⁰ **For PMHCA:** Number of children and adolescents, 0-21 years of age, for whom a provider contacted the mental health team for consultation or referral.

For MDRBD: Number of pregnant and postpartum women (PPW) for whom a provider contacted the program for consultation or referral during the reporting period.

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

To increase the percent of EMS agencies in the state/territory that submit NEMSIS version compliant patient care data to the State EMS Office for all 911 initiated EMS activations.

MEASURE

The percent of EMS agencies that 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:

An expanded set of standardized data elements collected by EMS agencies that includes data regarding the care of critically ill or injured children.

NEMSIS Technical Assistance Center (TAC): The NEMSIS TAC is the resource center for the NEMSIS project. The NEMSIS TAC provides assistance states, territories, and local EMS agencies, creates reference documents, maintains the NEMSIS database and XML schemas, and creates compliance policies.
NHTSA – National Highway Traffic Safety Administration

HRSA STRATEGIC OBJECTIVE

Improve Access to Quality Health Care and Services by 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

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.

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 of care and put in place effective, evidenced-based Quality Improvement (QI) efforts in pediatric emergency medical and trauma care.

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.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 01

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

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

Which statement best describes your current status?	Current Progress
Our State EMS Office has not yet transitioned to NEMSIS compliant version 3.x or higher.	0
Our State EMS Office intends to transition to NEMSIS version 3.X or higher compliant patient care data to submit to NEMSIS TAC by or before 2021.	1
Our State EMS Office submits NEMSIS version 3.X or higher compliant patient care data to NEMSIS TAC with less than 10% of EMS agencies reporting.	2
Our State EMS Office submits NEMSIS version 3.X or higher compliant patient care data to NEMSIS TAC with at least 10% and less than 50% of the EMS agencies reporting.	3
Our State EMS Office submits NEMSIS version 3.X or higher compliant patient care data to NEMSIS TAC with at least 50% and less than 80% of the EMS agencies reporting.	4
Our State EMS Office submits NEMSIS version 3.X or higher compliant patient care data to NEMSIS TAC with at least 80% of the EMS agencies reporting.	5
Numerator: The number of EMS agencies in the state/territory that submit National Emergency Medical Services Information System (NEMSIS) version 3.X or higher compliant patient care data to the State Emergency Medical Services Office for all 911 initiated EMS activations	
Denominator: Total number of EMS agencies in the state/territory actively responding to 911 requests for assistance.	
Percent:	

Proposed Survey Questions:

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

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).
- ☐ 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.

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

To increase the percent of EMS agencies in the state/territory that 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 report having a designated individual who coordinates pediatric emergency care for the agency or a 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 an 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.

HRSA STRATEGIC OBJECTIVE

Strengthen the Health Workforce

GRANTEE DATA SOURCES

Survey of EMS agencies

SIGNIFICANCE

The Institute of Medicine (IOM) report⁰ "Emergency Care for Children: Growing Pains" (2007) recommends

⁰ Institute of Medicine. 2007. Emergency Care for Children: Growing Pains. Washington, DC: The National Academies Press.
<https://doi.org/10.17226/11655>

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.

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 study⁰ 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.

⁰ Gausche-Hill M, Ely M, Schmuhl P, Telford R, Remick KE, Edgerton EA, Olson LM. A national assessment of pediatric readiness of emergency departments. *JAMA Pediatr.* 2015 Jun;169(6):527-34. doi: 10.1001/jamapediatrics.2015.138. Erratum in: *JAMA Pediatr.* 2015 Aug;169(8):791. PMID: 25867088.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 02

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

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

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

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

Proposed Survey Questions:

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

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

- Ensure that the pediatric perspective is included in the development of EMS protocols
- Ensure that fellow providers follow pediatric clinical practice guidelines
- 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	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: Use of pediatric-specific equipment Level: Grantee Domain: Emergency Medical Services for Children	
GOAL	To increase the percent of EMS agencies that have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.
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. 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
HRSA STRATEGIC OBJECTIVE	Goal I: Improve Access to Quality Health Care and Services (by improving quality) or; Goal II: Strengthen the Health Workforce
GRANTEE DATA SOURCES	Survey of EMS agencies
SIGNIFICANCE	The Institute of Medicine (IOM) report “Emergency Care for Children: Growing Pains” reports that because EMS providers rarely treat seriously ill or injured pediatric patients, providers may be unable to maintain the necessary skill level to care for these patients. Continuing education such as the Pediatric Advance Life

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.

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.

In the EMS environment this can be translated to task training at skill stations, integrated skills training during case scenarios, and integrated team performance while treating patients in the field.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 03

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

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

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

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

Proposed Survey Questions:

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

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

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

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

We realize that there are multiple processes that might be used to assess correct use of pediatric equipment. Initial focus of this performance measure metrics is on 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	To increase the percent of hospitals that 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 regional system of care for children that includes a

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.

recognition program for hospitals capable of stabilizing and/or managing pediatric medical emergencies. A standardized recognition and/or designation program, based on compliance with the current published pediatric emergency/trauma care guidelines, contributes to the development of an organized system of care that assists hospitals in determining their capacity and readiness to effectively deliver pediatric emergency/trauma and specialty care.

This measure helps to ensure essential resources and protocols are available in facilities where children receive care for medical and trauma emergencies. A recognition program can also facilitate EMS transfer of children to appropriate levels of resources. Additionally, a pediatric recognition program, that includes a verification process to identify facilities meeting specific criteria, has been shown to increase the degree to which EDs are compliant with published guidelines and improve hospital pediatric readiness statewide.

In addition, Performance Measure EMSC 04 does not require that the recognition program be mandated. Voluntary facility recognition is accepted.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 04

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

Numerator:	
Denominator:	
Percent	

Numerator: Number of hospitals with an ED that are recognized through a statewide, territorial or regional program that are able to stabilize and/or manage pediatric medical emergencies.

Denominator: Total number of hospitals with an ED in the State/Territory.

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

Element	0	1	2	3	4	5
1. Indicate the degree to which a facility recognition program for pediatric medical emergencies exists.						

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

1= Research has been conducted on the effectiveness of a pediatric medical facility recognition program (i.e., improved pediatric outcomes)

And/or

Developing a pediatric medical facility recognition program has been discussed by the EMSC Advisory Committee and members are working on the issue.

2= Criteria that facilities must meet in order to receive recognition as being able to stabilize and/or manage pediatric medical emergencies have been developed.

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

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

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

EMSC 05 PERFORMANCE MEASURE	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric trauma.
Goal: Standardized System for Pediatric Trauma Level: Grantee Domain: Emergency Medical Services for Children	
GOAL	To increase the percent of hospitals that are recognized as part of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric trauma.
MEASURE	The percent of hospitals recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric traumatic emergencies.
DEFINITION	Numerator: Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric trauma. Denominator: Total number of hospitals with an ED in the State/Territory. Units: 100 Text: Percent Standardized system: A system of care provides a framework for collaboration across agencies, health care organizations/services, families, and youths for the purposes of improving access and expanding coordinated culturally and linguistically competent care for children and youth. The system is coordinated, accountable and includes a facility recognition program for pediatric traumatic injuries. Recognizing the pediatric emergency care capabilities of hospitals supports the development of a system of care that is responsive to the needs of children and extends access to specialty resources when needed. Hospital: Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department. Excludes Military and Indian Health Service hospitals.
EMSC STRATEGIC OBJECTIVE	Ensure the operational capacity and infrastructure to provide pediatric emergency care. Develop a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies and trauma.
GRANTEE DATA SOURCES	This performance measure will require grantees to determine how many hospitals participate in their facility recognition program (if the state has a facility recognition program) for pediatric trauma.

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.

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 emergency medical services to deliver quality 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	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: Inter-facility transfer guidelines	
Level: Grantee	
Domain: Emergency Medical Services for Children	
GOAL	To increase the percent of hospitals in the State/Territory have written inter-facility transfer guidelines for children that include specific components of pediatric transfer.
MEASURE	The percentage of hospitals in the State/Territory that have written inter-facility transfer guidelines for children that include specific components of pediatric 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	Inter-facility transfer guidelines: Hospital-to-hospital, ... Grantees should consult the EMSC Program representative if they have questions regarding guideline inclusion of pediatric patients. 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. 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

EMSC 06 PERFORMANCE MEASURE	The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and that contain all the components as per the implementation manual.
Goal: Inter-facility transfer guidelines Level: Grantee Domain: Emergency Medical Services for Children	with EMTALA does not constitute having inter-facility transfer guidelines. Hospital: Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department (ED). Excludes Military and Indian Health Service hospitals.
EMSC STRATEGIC OBJECTIVE	Ensure the operational capacity and infrastructure to provide pediatric emergency care. Develop written pediatric inter-facility transfer guidelines for hospitals.
GRANTEE DATA SOURCE(S)	• Surveys of hospitals with an emergency department. • Hospital licensure rules and regulations.
SIGNIFICANCE	In order to assure that children receive optimal care, timely transfer to a specialty care center is essential. Such transfers are better coordinated through the presence of inter-facility transfer agreements and guidelines.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 06

Performance Measure EMSC 06: The percentage of hospitals in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and that include the following components of transfer:

- Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication).
- Process for selecting the appropriate care facility.
- Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.).
- Process for patient transfer (including obtaining informed consent).
- Plan for transfer of patient medical record.
- Plan for transfer of copy of signed transport consent.
- Plan for transfer of personal belongings of the patient.
- Plan for provision of directions and referral institution information to family.

Hospitals with Inter-facility Transfer Guidelines that Cover Pediatric Patients:

You will be asked to enter a numerator and a denominator, not a percentage. **NOTE:** This measure only applies to hospitals with an Emergency Department (ED).

NUMERATOR: _____

Number of hospitals with an ED that have written inter-facility transfer guidelines that cover pediatric patients and that include specific components of transfer according to the data collected.

DENOMINATOR: _____

Total number of hospitals with an ED that provided data.

EMSC 07 PERFORMANCE MEASURE	The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
Goal: Inter-facility Transfer Agreements Level: Grantee Domain: Emergency Medical Services for Children	
GOAL	To increase the percent of hospitals in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
MEASURE	The percentage of hospitals in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
DEFINITION	Numerator: Number of hospitals with an ED that have written inter-facility transfer agreements that cover pediatric patients according to the data collected. Denominator: Total number of hospitals with an ED that provided data. Units: 100 Text: Percent Pediatric: Any person 0 to 18 years of age. Inter-facility transfer agreements: Written contracts between a referring facility (e.g., community hospital) and a specialized pediatric center or facility with a higher level of care and the appropriate resources to provide needed care required by the child. The agreements must formalize arrangements for consultation and transport of a pediatric patient to the higher-level care facility. Inter-facility agreements do not have to specify transfers of pediatric patients only. An agreement that applies to all patients or patients of all ages would suffice, as long as it is not written ONLY for adults. Grantees should consult the NRC if they have questions regarding inclusion of pediatric patients in established agreements.
EMSC STRATEGIC OBJECTIVE	Ensure the operational capacity and infrastructure to provide pediatric emergency care. Develop written pediatric inter-facility transfer agreements to facilitate timely movement of children to appropriate facilities.
DATA SOURCE(S) AND ISSUES	• Surveys of hospitals with an emergency department. • Hospital licensure rules and regulations
SIGNIFICANCE	In order to assure that children receive optimal care, timely transfer to a specialty care center is essential. Such transfers are better coordinated through the presence of inter-facility transfer agreements and guidelines.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 07

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

Hospitals with Inter-facility Transfer Agreements that Cover Pediatric Patients:

You will be asked to enter a numerator and a denominator, not a percentage.

NOTE: *This measure only applies to hospitals with an Emergency Department (ED).*

NUMERATOR: _____

Number of hospitals with an ED that have written inter-facility transfer agreements that cover pediatric patients according to the data collected.

DENOMINATOR: _____

Total number of hospitals with an ED that provided data.

EMSC 08 PERFORMANCE MEASURE	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	
GOAL	To increase the number of States/Territories that have established permanence of EMSC in the State/Territory EMS system.
MEASURE	The degree to which States/Territories have established permanence of EMSC in the State/Territory EMS system.
DEFINITION	The number of elements that are associated with permanence of EMSC in a State/Territory EMS system on a scoring system ranging from a possible score of no elements (0) to five elements (5). Permanence of EMSC in a State/Territory EMS system is defined as: • The EMSC Advisory Committee has the required members as per the implementation manual. • The EMSC Advisory Committee meets at least four times a year. • Pediatric representation incorporated on the State/Territory EMS Board. • The State/Territory require pediatric representation on the EMS Board. • One full time EMSC Manager is dedicated solely to the EMSC Program. EMSC: The component of emergency medical care that addresses the infant, child, and adolescent needs, and the Program that strives to ensure the establishment and permanence of that component. EMSC includes emergent at the scene care as well as care received in the emergency department, surgical care, intensive care, long-term care, and rehabilitative care. EMSC extends far beyond these areas yet for the purposes of this manual this will be the extent currently being sought and reviewed. EMS system: The continuum of patient care from prevention to rehabilitation, including pre-hospital, dispatch communications, out-of-hospital, hospital, primary care, emergency care, inpatient, and medical home. It encompasses every injury and illness.
EMSC STRATEGIC OBJECTIVE	• Establish permanence of EMSC in each State/Territory EMS system. • Establish an EMSC Advisory Committee within each State/Territory • Incorporate pediatric representation on the State/Territory EMS Board • Establish one full-time equivalent EMSC manager that is dedicated solely to the EMSC Program.

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

GRANTEE DATA SOURCES

- Attached data collection form to be completed by grantee.

SIGNIFICANCE

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

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 08

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

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

Yes = 1

No = 0

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

EMSC 09 PERFORMANCE MEASURE	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	To increase the integration of EMSC priorities into existing EMS or hospital/healthcare facility statutes/regulations.
MEASURE	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.
DEFINITION	Priorities: The priorities of the EMSC Program include the following: • EMS agencies are required to submit NEMSIS compliant data to the State EMS Office. • EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care. • EMS agencies in the state/territory have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment. • 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 • 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 • Hospitals in the State/Territory have written inter-facility transfer agreements that cover pediatric patients. • BLS and ALS pre-hospital provider agencies in the State/Territory are required to have on-line and off-line pediatric medical direction available. • 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. • Requirements adopted by the State/Territory that

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**

requires pediatric continuing education prior to the renewal of BLS/ALS licensing/certification.

EMSC STRATEGIC OBJECTIVE

Establish permanence of EMSC in each State/Territory EMS system.

GRANTEE DATA SOURCES

Attached data collection form to be completed by grantee.

SIGNIFICANCE

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

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 09

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

Element	Yes	No
1. There is a statute/regulation that requires the submission of NEMSIS compliant data to the state EMS office		
2. There is a statute/regulation that assures an individual is designated to coordinate pediatric emergency care.		
3. There is a statute/regulation that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.		
4. There is a statute/regulation for a hospital recognition program for identifying hospitals capable of dealing with pediatric medical emergencies.		
5. There is a statute/regulation for a hospital recognition system for identifying hospitals capable of dealing with pediatric traumatic emergencies.		
6. There is a statute/regulation for written inter-facility transfer guidelines that cover pediatric patients and include specific components of transfer.		
7. There is a statute/regulation for written inter-facility transfer agreements that cover pediatric patients.		
8. There is a statute/regulation for pediatric on-line medical direction for ALS and BLS pre-hospital provider agencies.		
9. There is a statute/regulation for pediatric off-line medical direction for ALS and BLS pre-hospital provider agencies.		
10. There is a statute/regulation for pediatric equipment for BLS and ALS patient care units.		
11. There is a statute/regulation for the adoption of requirements for continuing pediatric education 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

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

HS 01 PERFORMANCE MEASURE	The percent of Healthy Start participants that have a documented reproductive life plan. ⁰
Goal: Reproductive Life Plan	
Level: Grantee	
Domain: Healthy Start	
GOAL	To increase the proportion of Healthy Start women participants who have a documented reproductive life plan to 90%.
MEASURE	The percent of Healthy Start women participants that have a documented reproductive life plan.
DEFINITION	Numerator: Number of Healthy Start (HS) women participants with a documented reproductive life plan in the reporting period. Denominator: Number of HS women participants in the reporting period. There is no formal written format for a reproductive life plan. A participant is considered to have a reproductive life plan and included in the numerator if there is documentation in the participant's record of an <u>annually updated</u> statement to include: 1) goals for having or not having children; and 2) plans for how to achieve those goals. Participants with permanent birth control are included in both the denominator and numerator. If a participant completes the Reproductive Life Plan questions within the Healthy Start Screening tools during the reporting period, then they are considered to have a documented Reproductive Life Plan.
BENCHMARK DATA SOURCES	Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 8, Question 14
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	A reproductive life plan reduces the risk of unintended pregnancy, identifies unmet reproductive health care needs, and increases the number of women who plan their pregnancies and engage in healthy behaviors <i>before</i> becoming pregnant. ⁰

⁰ Consistent with Healthy Start Benchmark 2.

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

HS 02 PERFORMANCE MEASURE Goal: Usual Source of Care Level: Grantee Domain: Healthy Start	The percent of Healthy Start women and child participants that have a usual source of care. ⁰
GOAL	To increase the percent of Healthy Start women and child participants who have a usual source of care to 80%.
MEASURE	The percent of Healthy Start women and child participants that have a usual source of care.
DEFINITION	a. Numerator: Total number of Healthy Start (HS) women participants that report having a usual source of care as of the last assessment in the reporting period. Denominator: Total number of women HS participants in the reporting period. b. Numerator: Total number of Healthy Start (HS) child participants whose parent/ caregiver reports that they have a usual source of care as of the last assessment in the reporting period. Denominator: Total number of child HS participants in the reporting period. A participant is considered to have a usual source of care and included in the numerator if the participant identifies a regular place where they can go for routine and sick care other than an emergency room. A participant receiving regular prenatal care from a prenatal provider is considered to have a usual source of care.
BENCHMARK DATA SOURCES	National Survey of Children’s Health (Children 0-5 with a Usual Source of Care 75.2%, 2019); National Health Interview Survey (Children 0-4 with a Usual Source of Care: 97.6%, 2019; National Health Interview Survey (Women aged 18 and over with a Usual Place of Care, 89.3%, 2018)
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. ⁰⁰ 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. ⁰

⁰ Consistent with Healthy Start Benchmark 4.

⁰ 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.

⁰ DeVoe JE, Tillotson CJ, Wallace LS, Lesko SE, Pandhi. Is health insurance enough? A usual source of care may be more important to ensure a child receives preventive health counseling. Matern Child Health J. Feb 2012; 16(2):306-15.

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

HS 03 PERFORMANCE MEASURE	The percent of Healthy Start women participants who conceive within 18 months of a previous birth. ⁰
Goal: Interconception Planning	
Level: Grantee	
Domain: Healthy Start	
GOAL	To reduce the proportion of Healthy Start women participants who conceive within 18 months of a previous birth to 30%.
MEASURE	The percent of Healthy Start women participants who conceive within 18 months of a previous birth.
DEFINITION	Numerator: Number of Healthy Start (HS) women participants whose current pregnancy during the reporting period was conceived within 18 months of the previous birth. Denominator: Total number of HS women participants enrolled before the current pregnancy in the reporting period who had a prior pregnancy that ended in a live birth. The interval between the most recent pregnancy and previous birth is derived from the delivery date of the birth and the date of conception for the most recent pregnancy.
BENCHMARK DATA SOURCES	CDC National Survey of Family Growth, Healthy People 2030 Family Planning Goal 2; Vital Statistics ⁰
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Family planning is important to ensure spacing pregnancies at least 18 months apart to reduce health risks for both mother and baby. Pregnancy within 18 months of giving birth is associated with increased risk for the baby including low birth weight, small size for gestational age, and preterm birth. Additionally, the mother needs time to fully recover from the previous birth. ⁰

⁰ Consistent with Healthy Start Benchmark 10.

⁰ http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_03.pdf

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

HS 04 PERFORMANCE MEASURE Goal: Intimate Partner Violence Screening Level: Grantee Domain: Healthy Start	The percent of HS women participants who receive intimate partner violence screening. ⁰
GOAL	To increase proportion of Healthy Start women participants who receive intimate partner violence (IPV) screening to 100%.
MEASURE	The percent of Healthy Start women participants who receive intimate partner violence screening.
DEFINITION	Numerator: Number of Healthy Start (HS) women participants who received intimate partner violence screening using a standardized screening tool during the reporting period. Denominator: Total number of HS women participants in the reporting period. A participant is considered to have been screened and included in the denominator if a standardized screening tool which is appropriately validated for her circumstances is used. A number of screening tools have been validated for IPV screening. Intimate Partner Violence is a pattern of assaultive behavior and coercive behavior that may include physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion. These behaviors are committed by someone who is, was, or wishes to be involved in an intimate relationship with the participant.⁰
BENCHMARK DATA SOURCES	PRAMS
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Intimate Partner Violence is a substantial yet preventable public health problem that affects women across the world. Research shows that intimate partner violence screening differs among health care specialties and is overall relatively low. The U.S. Department of Health and Human Services recommends that IPV screening and counseling to be a core part of a women's well visit. ⁰

⁰ Consistent with Healthy Start Benchmark 13.

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

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

HS 05 PERFORMANCE MEASURE	The percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy. ⁰
Goal: Father/ Partner Involvement during pregnancy	
Level: Grantee	
Domain: Healthy Start	
GOAL	To increase proportion of Healthy Start women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes) to 90%.
MEASURE	The percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy.
DEFINITION	Numerator: Number of Healthy Start (HS) prenatal participants who report supportive father and/or partner involvement (e.g., attend appointments, classes) in the reporting period. Denominator: Total number HS prenatal participants in the reporting period. A participant is considered to have support and included in the numerator if she self- reports a partner who has a significant and positive role in the participant’s pregnancy. Involvement during pregnancy may include, but is not limited to: • Partnership; social/ emotional support • Attending prenatal appointments • Attending prenatal classes • Assisting in preparing the home for the baby (e.g., putting together a crib) • Providing economic support
BENCHMARK DATA SOURCES	Child Trend Research Brief, CDC National Health Statistics Report
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Research suggests that paternal involvement has been recognized to have an impact on both pregnancy and infant outcomes. Father involvement during pregnancy has shown to reduce negative maternal health behaviors, risk of preterm birth, low birth weight, fetal growth restrictions, and neonatal death rate ^{0,0} .

⁰ Consistent with Healthy Start Benchmark 14.

⁰ Kortsmits K, Garfield C, Smith RA, Boulet S, Simon C, Pazol K, Kapaya M, Harrison L, Barfield W, Werner L. Public Health Reports. Paternal Involvement and Maternal Perinatal Behaviors: Pregnancy Risk Assessment Monitoring System, 2012-2015. 2020;135(2):253-261.

⁰ Alio AA, Mbah AK, Kornosky JL, Wathington D, Marty PH, Salihu HM. Assessing the impact of paternal involvement on racial/ethnic disparities in infant mortality rates. J Community Health. 2011 Feb;36(1):63-8.

HS 06 PERFORMANCE MEASURE	The percent of Healthy Start women participants that demonstrate father and/or partner involvement with child <24 months. ⁰
Goal: Father and/or Partner Involvement with child <24 Months	
Level: Grantee	
Domain: Healthy Start	
GOAL	To increase proportion of HS women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) with child <24 months to 80%.
MEASURE	The percent of Healthy Start women participants that demonstrate father and/or partner involvement with child <24 months.
DEFINITION	Numerator: Number of Healthy Start (HS) child participants whose mother reports supportive father and/or partner involvement (e.g., attend appointments, classes, child care, etc.) during the reporting period. Denominator: Total number of Healthy Start women participants with a child participant <24 months. A participant is considered to have support and included in the numerator if she self- reports a partner who has a significant and positive role for the child. Involvement includes, but is not limited to:⁰ • Engagement or direct interaction with the child, including taking care of, playing with, or teaching the child • Accessibility or availability, which includes monitoring behavior from the next room or nearby and allowing direct interaction if necessary • Responsibility for the care of the child, which includes making plans and arrangements for care • Economic support or breadwinning • Attending postpartum and well child visits • Other meaningful support
BENCHMARK DATA SOURCES	None
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Research suggests that paternal involvement has been recognized to have an impact on both pregnancy and infant outcomes

⁰ Consistent with Healthy Start Benchmark 15.

⁰ <http://www.cdc.gov/nchs/data/nhsr/nhsr071.pdf>

HS 07 PERFORMANCE MEASURE	The percent of Healthy Start child participants age 6 through 23 months who are read to by a family member 3 or more times per week, on average. ⁰
Goal: Daily Reading Level: Grantee Domain: Healthy Start	
GOAL	To increase the proportion of Healthy Start child participants age 6 through 23 months who are read to 3 or more times per week to 50%.
MEASURE	The percent of Healthy Start child participants age 6 through 23 months who are read to by a family member 3 or more times per week, on average.
DEFINITION	Numerator: Number of Healthy Start children participants whose parent/ caregiver reports that they were read to by a family member on 3 or more days during the past week during the reporting period. Denominator: Total number of Healthy Start child participants 6 through 23 months of age during the reporting period. Reading by a family member may include reading books, picture books, or telling stories.
BENCHMARK DATA SOURCES	National Survey of Children's Health
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Reading to a child teaches them about communication, introduces concepts such as numbers, letters, colors, and shapes, builds listening, memory, and vocabulary skills, and gives them information about the world around them. ⁰ 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. ⁰

⁰ Consistent with Healthy Start Benchmark 16.

⁰ http://kidshealth.org/parent/positive/all_reading/reading_babies.html

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

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

⁰ 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. ⁰
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. Community Member: an individual who has lived experience that is representative of the project's Healthy Start target population. 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.

BENCHMARK DATA SOURCES

⁰ Consistent with Healthy Start Benchmark 18.

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.

DIVISION OF CHILDREN WITH SPECIAL HEALTH NEEDS
Family to Family Health Information Center Program
PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

Performance Measure	Topic
F2F 1	Provide National Leadership for families with children with special health needs

F2F 1 Performance Measure Goal: Provide National Leadership for families with children with special health needs Level: Grantee Category: Family Participation	The percent of families with Children and Youth with Special Health Care Needs (CYSHCN) that have been provided information, education, and/or training by Family-to-Family Health Information Centers.
GOAL	To increase the number of families with CYSHCN receiving needed health and related information, training, and/or education opportunities in order to partner in decision making and be satisfied with services that they receive.
MEASURE	The percent of families with CYSHCN that have been provided information, education and/or training by Family-to-Family Health Information Centers.
DEFINITION	Numerator: The total number of families of CYSHCN receiving one-to-one services and training from Family-To-Family Health Information Centers. Denominator: The estimated number of families with CYSHCN in the state. Units: 100 Text: Percent
BENCHMARK DATA SOURCES	Related to Objective MICH-20: Increase the proportion of children and adolescents with special health care needs who have a system of care.
GRANTEE DATA SOURCES	Progress reports from Family-To-Family Health Care Information and Education Centers, National Survey for Children's Health (NSCH), Title V Information System
SIGNIFICANCE	The last decade has emphasized the central role of families as informed consumers of services and participants in policy-making activities. Research has indicated that families need information they can understand and information from other parents who have experiences similar to theirs and who have navigated services systems.

DATA COLLECTION FORM FOR DETAIL SHEET #F2F 1

A. PROVIDING INFORMATION, EDUCATION, AND/OR TRAINING

The estimated number of families with CYSHCN in your state: _____
(populated with data from the National Survey of Children's Health)

1. The total number of families served is based solely on "one-to-one" service conducted by the F2F. This includes one-to-one family navigation, consultation, counseling, information, education, referrals, case management, mentoring, and small group individualized assistance etc.

a. Total number of families receiving one-to-one services (including small group individualized assistance) and training from Family-To-Family Health Information Centers. (unduplicated count): _____

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

2. The types of services provided to families.

a. Total number of service/trainings provided to families (this will be a duplicated count): _____

b. Of the total numbers of service/trainings, 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) _____

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

a. Total number of professionals/providers served/trained (unduplicated count): _____

4. The total number of services provided to professionals/providers. This includes the duplicated count of one-to-one services and trainings, group trainings, meetings/conferences, and outreach events. This does not include social media impressions or web hits (to be reported in Q5).

- a. Total number of services provided to professionals/providers (duplicated count):: _____

5. 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/print
 - ☐ Public television/radio
 - ☐ Social media (Specify platform): _____
 - ☐ Text messaging

B. MODELS OF FAMILY ENGAGEMENT COLLABORATION

1. 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. Total number of State-wide agencies/programs: _____

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

	Check the box if you worked with this type of organization
Title V MCH/CSHCN Program	
Newborn Screening Program	
Early Hearing Detection and Intervention/Newborn Hearing Screening	
Emergency Medical Services for Children	
Home Visiting	
State Medicaid	
State CHIP	
State Mental and/or Behavioral Health	
Government Housing Program	
Early Intervention/Part C	
Head Start Collaboration Office	
Other (Specify):	
None	

2. 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. Total number of community-based organizations: _____

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

	Check the box if you worked with this type of organization
Medical homes, providers, clinics, hospitals	
Provider organizations (for example, American Academy of Pediatric chapter)	

Provider training programs (for example, residency programs; schools of medicine, nursing, public health, LEND programs, social work, etc.)	
Schools (K-12, pre-school)	
Faith-based organizations, places of worship	
Condition-specific organizations (for example, United Cerebral Palsy, March of Dimes, etc.)	
Child care programs	
Local Head start	
Other community organization (Specify): _____	
None	

c. Of those community-based organizations, indicate if any were dedicated to specific populations

	Check the box if you worked with this type of organization
American Indian or Alaska Native	
Black or African-American	
Hispanic or Latino	
Asian-American, Native Hawaiian or Pacific Islander	
Other (please specify)	

3. Number of staff who work on Family-to-Family HIC activities _____

4. Number of near/full-time (30+ hours/week) F2F staff who are family/have a disability _____

5. Number of part-time F2F staff who are family/have a disability _____