# Health Resources and Services Administration

# Maternal and Child Health Bureau

# Discretionary Grant Information System

# Attachment C: Program Specific Forms

**OMB No. 0915-0298 - Revision**

**Expires: XX/XX/20XX**

***Public Burden Statement:*** *The purpose of this information collection is to obtain performance data for the following: HRSA program participants, program operations and surveys. In addition, these data will facilitate the ability to demonstrate alignment between MCHB discretionary programs and the Discretionary Grant Information System (DGIS). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0298 and it is valid until XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 1.80 hours per form response across all DGIS programs and form categories; actual burden for an individual grantee may vary depending on the number and types of forms assigned based on the grantee's program activities. This collection-wide estimate reflects variation in the types and number of forms assigned to grantees based on their program activities; actual burden may vary by grantee and form. Send comments regarding this burden estimate or any other aspect of this collection of information, including*

*suggestions for reducing this burden, to HRSA Information Collection Clearance Officer, 5600 Fishers Lane, Room 13N82, Rockville, Maryland, 20857 or paperwork@hrsa.gov. Please see https://www.hrsa.gov/about/508-resources for the HRSA digital accessibility statement.*

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# Training Form 07

## Instructions

### Training 07 Performance Measure

**Goal**: MCH LEAP Program

**Level**: Grantee

**Domain**: MCH Workforce Development

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

#### *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 who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related health professions.

Former LEAP trainees should complete a follow-up survey 2-years and 5-years after graduating to provide information on post-graduation activities.

Trainees should be tracked based on when they graduate from the undergraduate institution. For example, if a LEAP trainee graduated in 2020, 2-year follow-up would be collected and reported to MCHB in 2022 and 5-year follow-up would be collected and reported in 2025.

**MCH Populations**: Includes women, infants and children, adolescents, young adults, and their families including fathers, and children and youth with special health care needs

**Note**: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.

### *Benchmark Data Sources*

Related to the following 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 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*

Attached data collection form to be completed by grantees. A LEAP program follow-up survey should be used to collect the data for the data collection form. A proposed survey template is provided as an option for grantees to use. On the proposed survey, question number 2 provides former trainee data needed to complete the data collection form.

### *Significance*

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

# Data Collection Form for Training 07

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.***

Trainees should be tracked based on when they graduate from the undergraduate institution. For example, if a LEAP trainee graduated in 2020, 2-year follow-up would be collected and reported to MCHB in 2022 and 5-year follow-up would be collected and reported in 2025.

*Note: Each LEAP trainee should be counted once.*

## 2 Years After Graduating From MCH LEAP Program

A. The total number of LEAP Trainees that graduated 2 years ago _____

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 MCH populations since graduating from the MCH LEAP Training Program _____

E. Percent of respondents who report working with MCH populations since graduating from the MCH LEAP Training Program _____

## 5 Years After Graduating From MCH LEAP Program

A. The total number of LEAP Trainees that graduated 5 years ago _____

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 MCH populations since graduating from the MCH LEAP Training Program _____

E. Percent of respondents who report working with MCH populations since graduating from the MCH LEAP Training Program _____

## Comments

_____

_____

## Proposed Survey Questions

Please answer the following questions to help us understand the impact of the LEAP Training Program on your post-graduation activities. Thank you for taking the time to complete this survey. When you have filled out the entire survey, return it to your LEAP Program Director.

What year did you graduate from the MCH LEAP Training Program? _____

1. Are you currently enrolled or have you completed a graduate school program that is preparing you to work with MCH populations?

   ☐ Yes

   ☐ No

   1a. If yes, which graduate programs have you enrolled in or completed?

   ☐ 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): _____

   1b. If yes, did the MCH LEAP Training Program help in your admission to your graduate program?

   ☐ Yes

   ☐ No

   1c. If yes, did the MCH LEAP Training Program help you be successful in your graduate program?

   ☐ Yes

   ☐ No

2. Have you worked with Maternal and Child Health (MCH) populations since graduating from the MCH LEAP Training Program? (i.e., women, infants and children, adolescents, young adults, and their families, including fathers, and children and youth with special health care needs)

   ☐ Yes

☐ No

3. Have you worked with populations that have been medically underserved and/or have limited access to care since graduating from the MCH LEAP Training Program?

   ☐ Yes

   ☐ No

# Training Form 08

## Instructions

### Training 08 Performance Measure

**Goal**: MCH LEAP Program

**Level**: Grantee

**Domain**: MCH Workforce Development

The percent of MCH LEAP Program graduates who have been engaged in work with populations that are medically underserved and/or with limited access to care.

#### *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 medically underserved and/or with limited access to care.

#### *Measure*

The percent of MCH LEAP Program graduates who have been engaged in work with populations that are medically underserved and/or with limited access to care 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 medically underserved and/or have limited access to care 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 who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related fields.

Former LEAP trainees should complete a follow-up survey 2-years and 5-years after graduating to provide information on post-graduation activities.

Trainees should be tracked based on when they graduate from the undergraduate institution. For example, if a LEAP trainee graduates in 2020, 2-year follow-up should be collected and reported to MCHB in 2022 and 5-year follow-up should be collected and reported in 2025.

**Note**: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.

### *Benchmark Data Sources*

Related to the following 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 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*

Attached data collection form to be completed by grantees. A LEAP program follow-up survey should be used to collect the data for the data collection form. A proposed survey template is provided as an option for grantees to use. On the proposed survey, question number 3 provides former trainee data needed to complete the data collection form.

### *Significance*

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

# Data Collection Form for Training 08

MCH Leadership, Education and Advancement in Undergraduate Pathways (LEAP) Program graduates who have worked with populations that are medically underserved and/or have limited access to care ***2 years and 5 years after graduating from their MCH LEAP program***.

Trainees should be tracked based on when they graduate from the undergraduate institution. For example, if a LEAP trainee graduates in 2020, 2-year follow-up should be collected and reported to MCHB in 2022 and 5-year follow-up should be collected and reported in 2025.

*Note: Each LEAP trainee should be counted once.*

## 2 Years After Graduating From MCH LEAP Program

A. The total number of LEAP Trainees that graduated 2 years ago _____

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 have been medically underserved and/or have limited access to care since graduating from the MCH LEAP Training Program _____

E. Percent of respondents who have worked with populations that have been medically underserved and/or have limited access to care since graduating from the MCH LEAP Training Program _____

## 5 Years After Graduating From MCH LEAP Program

A. The total number of LEAP Trainees that graduated 5 years ago _____

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 have been medically underserved and/or have limited access to care since graduating from the MCH LEAP Training Program _____

E. Percent of respondents who have worked with populations that have been medically underserved and/or have limited access to care since graduating from the MCH LEAP Training Program _____

## Comments

_____

_____

## Proposed Survey Questions

Please answer the following questions to help us understand the impact of the LEAP Training Program on your post-graduation activities. Thank you for taking the time to complete this survey. When you have filled out the entire survey, return it to your LEAP Program Director.

What year did you graduate from the MCH LEAP Training Program? _____

1. Are you currently enrolled or have you completed a graduate school program that is preparing you to work with MCH populations?

   ☐ Yes

   ☐ No

   1a. If yes, which graduate programs have you enrolled in or completed?

   ☐ 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): _____

   1b. If yes, did the MCH LEAP Training Program help in your admission to your graduate program?

   ☐ Yes

   ☐ No

   1c. If yes, did the MCH LEAP Training Program help you be successful in your graduate program?

   ☐ Yes

   ☐ No

2. Have you worked with Maternal and Child Health (MCH) populations since graduating from the MCH LEAP Training Program? (i.e., women, infants and children, adolescents, young adults, and their families, including fathers, and children and youth with special health care needs)

   ☐ Yes

☐ No

3. Have you worked with populations that have been medically underserved and/or have limited access to care since graduating from the MCH LEAP Training Program?

   ☐ Yes

   ☐ No

# Training Form 09

## Instructions

### Training 09 Performance Measure

**Goal**: MCH LEAP Program

**Level**: Grantee

**Domain**: MCH Workforce Development

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

#### *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.

Former LEAP trainees should complete a follow-up survey 2-years and 5-years after graduating to provide information on post-graduation activities.

Trainees should be tracked based on when they graduate from the undergraduate institution. For example, if a LEAP trainee graduates in 2020, 2-year follow-up should be collected and reported to MCHB in 2022 and 5-year follow-up should be collected and reported in 2025.

**Note**: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.

#### *Benchmark Data Sources*

Related to the following 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. A LEAP program follow-up survey should be used to collect the data for the data collection form. A proposed survey template is provided as an option for grantees to use. On the proposed survey, question number 1 provides former trainee data needed to complete the data collection form.

### *Significance*

MCHB training programs assist in developing a public health workforce that addresses key MCH issues and fosters field leadership in the MCH arena.

# Data Collection Form for Training 09

Trainees should be tracked based on when they graduate from the undergraduate institution. For example, if a LEAP trainee graduated in 2020, 2-year follow-up would be collected and reported to MCHB in 2022 and 5-year follow-up would be collected and reported in 2025.

*Note: Each LEAP trainee should be counted once.*

## 2 Years After Graduating From MCH LEAP Program

A. The total number of LEAP Trainees that graduated 2 years ago _____

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 to 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 to work with the MCH population _____

F. Number of LEAP trainees who indicate MCH LEAP Training Program helped in admission to a graduate program _____

G. Percent of LEAP trainees who indicate MCH LEAP Training Program helped in admission to a graduate program _____

H. Number of LEAP trainees who indicate MCH LEAP Training Program helped in being successful in a graduate program _____

I. Percent of LEAP trainees who indicate MCH LEAP Training Program helped in being successful in a graduate program _____

## 5 Years After Graduating From MCH LEAP Program

A. The total number of LEAP Trainees that graduated 5 years ago _____

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 to 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 to work with the MCH population _____

F. Number of LEAP trainees who indicate MCH LEAP Training Program helped in admission to a graduate program _____

G. Percent of LEAP trainees who indicate MCH LEAP Training Program helped in admission to a graduate program _____

H. Number of LEAP trainees who indicate MCH LEAP Training Program helped in being successful in a graduate program _____

I. Percent of LEAP trainees who indicate MCH LEAP Training Program helped in being successful in a graduate program _____

## Comments

_____

# Proposed Survey Questions

Please answer the following questions to help us understand the impact of the LEAP Training Program on your post-graduation activities. Thank you for taking the time to complete this survey. When you have filled out the entire survey, return it to your LEAP Program Director.

What year did you graduate from the MCH LEAP Training Program? _____

1. Are you currently enrolled or have you completed a graduate school program that is preparing you to work with MCH populations?

   ☐ Yes

   ☐ No

   1a. If yes, which graduate programs have you enrolled in or completed?

   ☐ 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): _____

   1b. If yes, did the MCH LEAP Training Program help in your admission to your graduate program?

   ☐ Yes

   ☐ No

   1c. If yes, did the MCH LEAP Training Program help you be successful in your graduate program?

   ☐ Yes

   ☐ No

2. Have you worked with Maternal and Child Health (MCH) populations since graduating from the MCH LEAP Training Program? (i.e., women, infants and children, adolescents, young adults, and their families, including fathers, and children and youth with special health care needs)

   ☐ Yes

☐ No

3. Have you worked with populations that have been medically underserved and/or have limited access to care since graduating from the MCH LEAP Training Program?

   ☐ Yes

   ☐ No

# Training Form 14

## Instructions

### Training 14 Performance Measure

**Goal**: Medium-Term Trainees Skill and Knowledge

**Level**: Grantee

**Domain**: MCH Workforce Development

The percentage of Level I medium-term trainees who report an increase in knowledge and the percentage of Level II medium-term trainees who report an increase in knowledge or skills related to MCH core competencies.

#### *Goal*

To increase the percentage of medium-term trainees (MTT) who report increased knowledge or skills related to MCH core competencies.

#### *Measure*

The percentage of Level I medium-term trainees who report an increase in knowledge and the percentage of Level II medium-term trainees who report an increase in knowledge or skills related to MCH core competencies.

#### *Definition*

**Numerator**: The number of Level I medium-term trainees who report an increase in knowledge and Level II medium-term trainees who report an increase in knowledge or skills related to MCH core competencies.

**Denominator**: The total number of medium-term trainees responding to the survey.

**Medium Term trainees**:

- Level I MTT complete 40-149 hours of training.
- Level II MTT complete 150–299 hours of training.

**Note**: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.

#### *Benchmark Data Sources*

Related to the following 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 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.

# Data Collection Form for Training 14

## 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 Medium-Term Trainees 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 Medium-Term Trainees 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 Medium-Term Trainees 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 _____

## Comments

_____

# Training Form 15

## Instructions

### 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 and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD) program.

#### *Benchmark Data Sources*

None.

#### *Grantee Data Sources*

PMHCA and MMHSUD 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 medically 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 medically underserved areas.

**Tab A. Provider Consultation and Training:** Select your program (PMHCA or MMHSUD). PMHCA will complete data entry for children 0-11 and adolescents 12-21. MMHSUD will complete data entry for pregnant or postpartum women.

**A.1.i:** Select Yes or No to indicate if your program had any enrolled providers during the reporting period.

- If select Yes, enter provider counts for "Number enrolled", as well as "Number participating" and "Number enrolled AND participating" if applicable, by provider type. If there are no providers for a field, enter zero.
    - Provider counts may be duplicated across columns (Number enrolled, Number participating, Number enrolled and participating), but not within cells. For example, if a provider is enrolled AND participating during the reporting period, they should be counted in all three columns; the provider would be counted three times across the cells/row, but only once in each column. The "Number of enrolled AND participating" should be less than or equal to both the "Number enrolled" and the "Number participating" in each row.
- If select No, enter provider counts for "Number participating", by provider type. If there are no providers for a field, enter zero.
- If a provider contacts the program more than once during the reporting period, they should only be counted once in each applicable column.
- If a provider is acting in multiple roles/provider types, categorize them by their primary role as it relates to the encounter. For example, if a family visitor, doula, or social worker is filling the role of a care coordinator/patient navigator, they should be reported as a "Care Coordinator/Patient Navigator". If a social worker is filling the role of behavioral health clinician and acting as a therapist or counselor, they should be reported in the "Behavioral Health Clinician" category.
- Medical Residents should be included in the category for which they are completing their residency. For example, a family medicine resident should be included in "Primary Care Providers (non-specialty), Family Medicine".
- Parents and caregivers are not included in reporting.

**A.1.ii.a**: Enter the number of provider contacts during the reporting period for each type of contact. Enter an unduplicated count of provider contacts across contact types; if a provider is seeking both consultation and care coordination support, count the provider only under "Both". Count each provider contact regardless of whether it is about the same patient or if it is the same provider calling in multiple times. If no providers contacted the program, enter zero (0) in the cell.

- If a provider contacted the consultation line about a patient, and then called a separate time and received either consultation and/or care coordination support for the same patient, they would be counted as two separate provider contacts. If a provider contacts the consultation line and receives consultation and/or care coordination support about multiple patients, this would be counted as one provider contact.
- For PMHCA programs only, consultation can be provided by any member of the PMHCA team and not just the child and adolescent psychiatrist.

**A.1.ii.b**: Enter the number of consultations and/or referrals provided by the team during the reporting period. Report consultations by consultation type (telehealth vs. in-person). Enter an unduplicated count of consultations provided via telehealth or in person; a consultation should only fall into one of those categories. For referrals, count the total number of referrals given during the reporting period. If there were no consultations and/or referrals, enter zero (0) into the cell.

**A.1.ii.c:** Select the condition(s) about which providers received consultation (teleconsultation or in-person) or care coordination support services from the program during the reporting period. Select all conditions that apply.

- For each selected condition, enter the number of consultation (teleconsultation or in-person) or care coordination contacts for each. Each contact can involve more than one condition.
- If the patient has a diagnosed condition, but the provider received consultation about another condition, a different presenting concern, or another reason, count the reason(s) for which the provider received consultation. If the patient does not have a diagnosis, the reason for contact can be a suspected diagnosis, diagnostic impression, presenting concerns/symptoms, suspected concern, or another reason. The condition or conditions selected should be the reason(s) the provider received consultation (teleconsultation or in-person) or care coordination support services. Each contact with the consultation team member can involve more than one condition, however, the conditions should be limited to the primary reasons the provider received consultation and/or care coordination support from the consultation program.
- If the condition is not listed, select “Other” and list the condition(s) or reason(s) in “Other-Description”; multiple conditions can be entered, separated by commas. In the “Other” row, indicate the total number of contacts for all combined “Other” conditions that are listed in the “Other-Description” field.
- Categorize encounters regarding delusions and disorganized thoughts related to postpartum psychosis in “Other” and share more details with HRSA in the non-competing continuation progress report narratives or contacts with the program. Categorize encounters regarding perinatal mood and anxiety disorders in the anxiety category.

**A.1.iii:** [Measure applies only to PMHCA awardees] Enter the number of consultations and referrals provided during the reporting period, by PMHCA team member type. If no consultations and/or referrals were provided by the PMHCA team member type, enter zero (0).

- If a single provider contact results in multiple referral recommendations, each referral should be counted separately. For example, if a team member refers the provider to a mental health counselor for psychotherapy AND provides a referral for an addiction counselor, this would count as two referrals.
- If a provider is acting in multiple roles/provider types, categorize them by their primary role as it relates to the encounter. Social workers, counselors etc. working in the role of care coordinator should be counted as care coordinators.
- If a team member type is not listed, select "Other" and list the member type(s) in "Other-Description"; multiple team member types can be entered, separated by commas. In the "Other" row, indicate the total number of consultations or referrals provided for all combined "Other" team member types that are listed.
- For consultations or referrals provided by an interdisciplinary team, each member of the interdisciplinary team should be counted for consultations or referrals provided.

**A.2.i:** Enter the number of providers trained during the reporting period, by provider type.

- Report unduplicated counts of providers. If a provider attended more than one training conducted by the program during the reporting period, the provider should only be counted once.
- If a provider type is not listed, select "Other" and list the member type(s) in "Other-Description"; multiple provider types can be entered, separated by commas. In the "Other" row, indicate the total number of "Other" providers attending training for all combined "Other" provider types.

**A.2.ii.:** Enter the total number of trainings provided by the program during the reporting period. Report an unduplicated count of trainings.

**A.2.ii.a**: Enter the number of trainings provided during the reporting period, by topic. Each individual training reported in A.2.ii. should be associated with ONLY ONE topic; the sum of trainings by topic should equal the total number of trainings reported in A.2.ii. Trainings often cover multiple topics; choose the most appropriate training topic to categorize each training provided by the program. If a topic was not covered, enter a zero (0) in that cell.

- Continuing Education (CE) is not required to count as a training.
- If the primary training topic is not listed, select "Other" and list the topic(s) in "Other-Description"; multiple topics can be entered, separated by commas. In the "Other" row, indicate the total number of trainings held during the reporting period for all combined "Other" topics.

**A.2.ii.b:** Report the total number of trainings covered by each training mechanism. Each individual training reported in A.2.ii. should be associated with ONLY ONE mechanism; the sum of trainings by mechanism should equal the total number of trainings reported in A.2.ii.

- If the training mechanism is not listed, select "Other" and list the mechanism(s) in "Other-Description"; multiple mechanisms can be entered, separated by commas. In the "Other" row, indicate the total number of trainings held during the reporting period for all combined "Other" mechanisms.

**Tab B. Individuals Served**

**B.1:** Enter the number of individuals for whom a provider contacted the program for consultation (teleconsultation or in-person) or care coordination support services during the reporting period. Enter an unduplicated count of individuals for whom a provider contacted the program; if a provider contacted the program about an individual multiple times, they should only be counted once. Enter both the total number, as well as the number from rural/medically underserved areas.

- Only include children and adolescents (PMHCA) and pregnant and postpartum women (MMHSUD) about whom a provider contacted the consultation team/program for consultation or referral. Do not include the entire patient panel of enrolled or participating providers.
- Do not count parents or caregivers who contact the program.
- Provider zip codes may be used to identify rural or medically underserved counties. The use of patient zip codes is not required.

**B.2:** Enter the number of individuals recommended for referral only, treatment only, or both referral and treatment, among those for whom a provider contacted the program for consultation (teleconsultation or in-person) or care coordination support services during the reporting period. If there were no recommendations for referral and/or treatment, enter zero (0) into the cell.

- Only include individuals about whom a provider contacted the program for consultation or referral. Do not include the entire patient panel of enrolled or participating providers.
- If the provider called in multiple times about the same patient, the outcome of the call (referral, treatment, or both) would be counted separately for each contact.

**B.3: [Optional]** Enter the numerator and denominator for the percent screened for each applicable measure. If there were no screenings for behavioral or mental health condition, enter zero (0) into the cell.

- HRSA strongly encourages programs to report these data if programs are collecting screening data from electronic medical records (EMRs) or electronic health records (EHRs). If programs can't get EMR or EHR data, programs would add these data by provider report or not report since this measure is optional.
- PMHCA
    - **Numerator**: 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.
    - **Denominator**: Number of children and adolescents, 0-21 years of age, for whom a provider contacted the mental health team for consultation or referral.

- MMHSUD
  - **Numerator**: Number of pregnant or postpartum women, for whom a provider contacted the program for consultation or care coordination support, who received at least one screening for a behavioral health condition (depression, anxiety, or substance use, separately) using a standardized validated tool.
  - **Denominator**: Number of pregnant or postpartum women, for whom a provider contacted the program for consultation or care coordination support.
- Do not report data when there is only an assumption about whether the patient was screened. If programs cannot ask the provider whether a screening has occurred, then do not report.
- Include screens conducted by the provider or practice that is calling for the consultation or referral. A paraprofessional may not be conducting screens but can validate that a screening occurred and report that to the consult line.
- Report on screens conducted within the previous 12 months at the time of the consultation/referral call.
- HRSA Project Officers will provide examples of validated screening tools.

## Definitions

**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 currently enrolled with the program even if initial enrollment occurred prior to current reporting period. An enrolled provider may or may not be a participating provider.

**Participating Provider**: A provider who has contacted the program for consultation (teleconsultation or in-person) or care coordination support services, and who may or may not be an enrolled provider.

**Enrolled AND Participating Provider**: Refers to the number of enrolled providers (registered) who are participating in the program (contacting the program for consultation or care coordination support services).

**Care Coordination Support**: In context of MMHSUD/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”.

**Telehealth** is the use of electronic information and telecommunication technologies to support and promote long-distance clinical consultation, patient and professional health-related education, public health and health administration. Permitted telehealth modalities between providers include (but are not limited to): real-time video, telephonic communications, electronic mail (email) with encryption, store-and-forward imaging, and mobile health (mHealth) applications.

**Referrals** are given to providers (or directly to the patients/families) by the program to introduce specific health providers or services. Recommending "family therapy" without providing a specific provider name or practice would not be considered a referral, but a recommendation for treatment. Referrals are typically provided using resources included in the referral database. Referrals fall under the category of care coordination support in the context of MMHSUD/PMHCA.

- ***Example 1****: The PMHCA/MMHSUD program recommends Jonathan Smith, PhD, clinical psychologist specializing in childhood anxiety disorders, address xxxx Main Street, Springfield, TX, phone number xxx-xxx-xxxx, email address xx@xx.com. This counts as one referral.*
- ***Example 2****: The PMHCA/MMHSUD program refers the provider or family to a specific mental health counselor or therapist for psychotherapy AND provides a referral for a specific addiction counselor or specific practice. The consultation team member provided 2 referrals.*
- ***Example 3****: A provider calls into the consultation line regarding a patient experiencing depression. The patient's family is experiencing housing insecurity, and the provider shares that information for assistance. The consultation team member provides a referral to a behavioral health therapist and to a social worker who specializes in subsidized housing. This counts as 2 referrals.*

**Training** refers to education programs or sessions that serve to enhance the knowledge and/or maintain the credentials and licensure of professional providers. Training may also serve to enhance the knowledge base of community outreach workers, families, and other members who directly serve the community. Examples of trainings include mental or behavioral health conditions, medication, screening and assessment, treatment modalities, trauma, etc. Conference presentations would be considered training if training was the intent of the presentation. A conference presentation that describes an intervention or program would not be considered training.

- **In-person training**: Any form of training that occurs "in person" and in real time between trainers and participants.
- **Project ECHO® (Extension for Community Healthcare Outcomes) distance learning cohort**: Refers to a group of individuals who advance through an educational program together as part of their participation in Project ECHO®. Project ECHO® is a collaborative model of medical education and care management that uses tele-mentoring to share knowledge between specialists and outlying Primary Care Providers (PCPs) with the goals of supporting PCPs in their administration of high-quality, leading-edge care to their patients and improving health outcomes for medically underserved patients.
- **ECHO-like distance learning cohort**: A technology-enabled educational model, in which a mentor with specialized knowledge provides interactive and case-based guidance to a group of mentees for the purpose of strengthening their skills and knowledge to provide high-quality healthcare. These programs are similar in structure and goals to Project ECHO® but not officially Project ECHO®.

- **Web-based training**: Refers to computer-based training that takes place online via the internet. This can include synchronous web-based training that is trainer-led and involves real-time interactions between trainers and trainees; asynchronous web-based training that takes place without real-time instruction, where content is available online, pre-recorded, and trainees can access it at their convenience; or blended web-based training, which involves both real-time interactions between a trainer and trainees and pre-recorded content that can be self-paced according to one's schedule.
- **Hybrid training**: Refers to a training model that involves both in-person and online instruction and activities.

**Treatment** is the provision, coordination, or management of health care and related services among health care providers. Providers contacting the programs for consultation may or may not be the ones providing the treatment that is recommended by the consulting provider.

**Rural/Medically Underserved**: 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://www.hrsa.gov/rural-health/about-us/what-is-rural. If the county is not entirely rural or urban, follow the link for "Rural Health Grants Eligibility Analyzer" to determine if a specific site qualifies as rural based on its specific census tract within an otherwise urban county. Medically 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.

# Data Collection Form for Training 15

## A. Provider Consultation and Training

Select Program:

☐ PMHCA

☐ MMHSUD

1. Consultation:

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

   Did you have any enrolled providers during the reporting period? ☐ Yes ☐ No

| Category | Provider Type | Number enrolled | Number participating | Number enrolled AND participating |
|---|---|---|---|---|
| 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 | | | |
| | Doula | | | |
| | Other Specialist Physician, APN/NP, PA (specify type): _____ | | | |

| Category | Provider Type | Number enrolled | Number participating | Number enrolled AND participating |
|---|---|---|---|---|
| | Other (specify type): _____ | | | |
| Unknown Provider type | | | | |
| Total (will auto-populate) | | | | |
| Total Primary Care (will auto-populate) | | | | |

ii. Use of program consultation and care coordination support services.

- 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 | |

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

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

- Please indicate the condition(s) about which providers received consultation (teleconsultation or in-person) or care coordination support services from the program. Select all conditions that apply. Specify the number of contacts for each condition. Each contact can involve more than one condition.

☐ Anxiety disorders

Number of contacts for this reason _____

☐ Depressive disorders (excluding postpartum depression)

Number of contacts for this reason _____

☐ Postpartum depression

Number of contacts for this reason _____

☐ Bipolar and related disorders

Number of contacts for this reason _____

☐ Attention-Deficit/ Hyperactivity Disorder (ADHD)

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 _____

☐ Neurodevelopmental disorders (including developmental delay and intellectual disabilities)

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 _____

☐ Social and contextual factors

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. [Measure 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)** | | |

- Training:

i. Number and types of providers trained.

| Category | 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 | |
| | Doula | |
| | Other Specialist Physician, APN/NP, PA (specify | |

| Category | Provider Type | Number Trained |
|---|---|---|
| | type): _____ | |
| | Other (specify type): _____ | |
| Unknown Provider type | | |
| Total Primary Care (will auto-populate) | | |
| Total (will auto-populate) | | |

ii. Total number of trainings held _____

1. Topic focus of trainings and number of trainings per topic focus. Select all that apply [Note: Each individual training should be associated with only one topic focus; the sum of trainings for each individual training topic focus should equal the total number of trainings held]:

   ☐ 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, etc.)
   Number of trainings covering topic _____

   ☐ Other (please specify) _____
   Number of trainings covering topic _____

2. 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 _____
☐ Hybrid (combination of in-person and virtual)
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

| Population | Total | Rural/Medically underserved |
|---|---|---|
| Children 0-11 | | |
| Adolescents 12-21 | | |
| Children and Adolescents – age Unknown | | |
| Pregnant or postpartum women | | |

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.

| Population | Referral only | Treatment only | Both referral and treatment |
|---|---|---|---|
| Children 0-11 | | | |
| Adolescents 12-21 | | | |
| Children and Adolescents – age unknown | | | |
| Pregnant or postpartum women | | | |

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

| Population | Numerator | Denominator | % (auto-populated) |
|---|---|---|---|
| Children 0-11 screened for behavioral or mental health condition | | | |
| Adolescents 12-21 screened for behavioral or mental health condition | | | |
| Children and Adolescents – age unknown, screened for behavioral or mental health condition | | | |
| Pregnant or postpartum women screened for behavioral or mental health condition | | | |
| Pregnant or postpartum women screened for depression | | | |
| Pregnant or postpartum women screened for anxiety | | | |
| Pregnant or postpartum women screened for substance use | | | |

## Comments

# EMSC 04

## Instructions

### 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 emergencies.

#### *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 emergencies.

#### *Measure*

The percent of hospitals recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies.

#### *Definition*

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

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

**Units**: 100

**Text**: Percent

**Hospital**: Facilities that can admit patients for medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department. For the purposes of this measure, data reported should exclude Military and Indian Health Service hospitals.

**Standardized program**: A program or system of care, also referred to as a pediatric readiness recognition program, that provides a framework for collaboration across agencies, health care organizations/services, families, and youths for the purposes of improving access and expanding coordinated care for children and youth. The program/system is coordinated, accountable and recognizes the pediatric emergency care capabilities of hospitals in a state, territory or region. The program supports the development of a standardized system of care that is responsive to the emergency needs of children and extends access to specialty resources when needed.

**Note**: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.

### *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 emergencies.

### *Grantee Data Sources*

This performance measure will require grantees to determine how many hospitals participate in their statewide, territorial or regional standardized program (if the state has a standardized program) for emergencies.

### *Significance*

The performance measure emphasizes the importance of the existence of a standardized statewide, territorial, or regional standardized program of care for children that includes a recognition program for hospitals capable of stabilizing and/or managing pediatric 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 emergencies. A standardized program can also facilitate EMS transfer of children to appropriate levels of resources.

Additionally, a standardized 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.

This Performance Measure (EMSC 04) does not require that the standardized program be mandated. Voluntary recognition is accepted.

# Data Collection Form for EMSC 04

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

| | |
|---|---|
| **Numerator**: Number of hospitals with an ED that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies. | |
| **Denominator**: Total number of hospitals with an ED in the State/Territory. For the purposes of data collection, exclude Military and Indian Health Service hospitals. | |
| **Percent**: | |

## Further Disaggregation of Data for Geographic Distribution[1]

| | |
|---|---|
| **Numerator**: Number of hospitals with an ED located in a rural area that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies. | |
| **Denominator**: Number of hospitals with an ED that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies | |
| **Percent**: | |

| | |
|---|---|
| **Numerator**: Number of hospitals with an ED located in an urban area that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies. | |
| **Denominator**: Number of hospitals with an ED that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies. | |
| **Percent**: | |

[1] Rural and urban area classifications use the Office of Management and Budget definition. Rural: counties classified as a micro area (urban core of 10,000-49,999 people) or counties outside of metro and micro areas. Urban: counties with a core population of 50,000 or more.

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

| Element | 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1. Indicate the degree to which a standardized program for pediatric emergencies exists. | | | | | | |

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

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

And/or

Developing a standardized 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 emergencies have been developed.

**3** = An implementation process/plan for the standardized program has been developed.

**4** = The implementation process/plan for the standardized program has been piloted.

**5** = At least one facility has been formally recognized through the standardized program. Supporting documentation will be requested to confirm this selection.

## Comments

_____

_____

# EMSC 08

## Instructions

### EMSC 08 Performance Measure

**Goal**: EMSC Permanence

**Level**: Grantee

**Domain**: Emergency Medical Service for Children

The degree to which the state/territory has established permanence of EMSC in the state/territory EMS system.

#### *Goal*

To increase the number of states/territories that have established permanence of EMSC in the state/territory EMS system.

#### *Measure*

The degree to which states/territories have established permanence of EMSC in the state/territory EMS system.

#### *Definition*

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 has met at least four times during the grant 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.

**Note**: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.

### *EMSC Strategic Objective*

Establish permanence of EMSC in each state/territory EMS system.

Establish an EMSC Advisory Committee within each state/territory

Incorporate pediatric representation on the state/territory EMS Board

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

### *Grantee Data Sources*

Attached data collection form to be completed by grantee.

### *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 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) _____

## Comments

_____

_____

# EMSC 09

## Instructions

### EMSC 09 Performance Measure

**Goal**: Integration of EMSC priorities

**Level**: Grantee

**Domain**: Emergency Medical Services for Children

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

#### *Goal*

To increase integration of EMSC priorities into existing EMS or hospital statutes/regulations/rules.

#### *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/rules.

#### *Definition*

The number of elements that are associated with integrating EMSC priorities in a state/territory EMS system on a scoring system ranging from a possible score of no elements (0) to eleven elements (11).

**Priorities**: The priorities of the EMSC Program include the following:

- Prehospital EMS agencies are required to submit NEMSIS compliant data to the State EMS Office.
- Prehospital EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care.
- Prehospital 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 program that recognizes hospitals that are able to stabilize and/or manage pediatric emergencies
- 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 requires pediatric continuing education prior to the renewal of BLS/ALS licensing/certification.

**Note**: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.

### *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 State Partnership 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 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 program 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) _____

## Comments

_____

_____

# EMSC 10

## Instructions

### EMSC 10 Performance Measure

**Goal**: Prehospital Emergency Medical Services Readiness

**Level**: Grantee

**Domain**: Emergency Medical Services for Children

The percent of prehospital Emergency Medical Services (EMS) agencies recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies.

#### *Goal*

To increase the percent of prehospital EMS agencies that are recognized as part of a statewide, territorial, or regional standardized program that are able to stabilize and/or manage pediatric emergencies.

#### *Measure*

The percent of prehospital EMS agencies recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies.

#### *Definition*

**Numerator**: Number of prehospital EMS agencies that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies.

**Denominator**: Total number of prehospital EMS agencies in the State/Territory.

**Units**: 100

**Text**: Percent

**EMS**: Emergency Medical Services

**Prehospital EMS Agency**: A prehospital 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.

**Standardized program**: A program or system of care, also referred to as a pediatric readiness recognition program, that provides a framework for collaboration across agencies, health care organizations/services, families, and youth for the purposes of improving access and expanding coordinated care for children and youth. The program/system is coordinated, accountable, and recognizes the pediatric emergency care capabilities of prehospital EMS agencies in a state, territory,

or region. The program supports the development of a standardized system of care that is responsive to the needs of children, and extends access to specialty resources when needed.

**Note**: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.

### *EMSC Strategic Objective*

Ensure the operational capacity and infrastructure to provide pediatric emergency care.

Develop a statewide, territorial, or regional program that recognizes prehospital EMS agencies that are able to stabilize and/or manage pediatric emergencies.

### *Grantee Data Sources*

This performance measure will require grantees to determine how many prehospital EMS agencies participate in their standardized recognition program (if the state has a standardized recognition program) for emergencies.

### *Significance*

The performance measure emphasizes the importance of the existence of a standardized statewide, territorial, or regional program of care for children that includes a recognition program for prehospital EMS agencies capable of stabilizing and/or managing pediatric emergency care. A standardized recognition program contributes to the development of an organized system of care in determining their capacity and readiness to effectively deliver pediatric emergency.

This measure helps to ensure essential pediatric resources, pediatric-trained personnel and pediatric protocols are available in prehospital EMS agencies. A standardized program can also facilitate EMS transfer of children to appropriate levels of resources and includes a verification process to identify prehospital EMS agencies meeting specific criteria.

This performance measure (EMSC 10) does not require that the standardized program be mandated. Voluntary recognition is accepted.

# Data Collection Form for EMSC 10

The percent of prehospital EMS agencies that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies.

| | |
|---|---|
| **Numerator**: Number of prehospital EMS agencies that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies. | |
| **Denominator**: Total number of prehospital EMS agencies in the State/Territory | |
| **Percent:** | |

## Further Disaggregation of Data for Geographic Distribution[0]

| | |
|---|---|
| **Numerator**: Number of prehospital EMS agencies located in ruralareas that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies. | |
| **Denominator**: Total number of prehospital EMS agencies that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies. | |
| **Percent**: | |

| | |
|---|---|
| **Numerator**: Number of prehospital EMS agencies located in urban areas that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies. | |
| **Denominator**: Total number of prehospital EMS agencies that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies. | |
| **Percent**: | |

Number of children served during the reporting period by prehospital EMS agencies formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies. (If an exact number cannot be obtained, your best estimate is fine.)

_____

☐ Check this box if the number reported above is an estimate

Using a scale of 0-5, please rate the degree to which your state/territory has made towards

[0] Rural and urban area classifications use the Office of Management and Budget definition. Rural: counties classified as a micro area (urban core of 10,000-49,999 people) or counties outside of metro and micro areas. Urban: counties with a core population of 50,000 or more.

establishing a prehospital EMS standardized program for pediatric emergencies.

| Element | 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| 1. Indicate the degree to which a prehospital standardized program for pediatric emergencies exists. | | | | | | |

**0** = No progress has been made towards developing a statewide, territorial, or regional standardized program that recognizes prehospital EMS agencies that are able to stabilize and/or manage pediatric emergencies

**1** = Research has been conducted on the importance of a prehospital EMS standardized program

And/or

Developing a prehospital EMS standardized program has been discussed by the EMSC Advisory Committee and members are working on the issue.

**2** = Criteria that prehospital EMS agencies must meet in order to receive recognition for the stabilization and/or management of pediatric emergencies has been developed.

**3** = An implementation process/plan for the prehospital EMS standardized program has been developed.

**4** = The implementation process/plan for the prehospital EMS standardized program has been piloted.

**5** = At least one prehospital EMS agency has been formally recognized through the prehospital standardized program. Supporting documentation will be requested to confirm this selection.

## Comments

# HS 04

## Instructions

### HS 04 Performance Measure

**Goal:** Interpersonal Violence Screening

**Level:** Grantee

**Domain:** Healthy Start

The percent of HS women participants who receive interpersonal violence screening and referral.

#### *Goal*

To increase the proportion of Healthy Start women participants who receive interpersonal violence (IPV) screening to 90%; of those who screen positive for IPV, increase proportion who receive referrals to 95%.

#### *Measure*

The percent of Healthy Start women participants who receive interpersonal violence screening and referral.

#### *Definition*

**% of Healthy Start (HS) women participants screened for IPV using a standardized screening tool**

**Numerator**: Number of HS women participants who received interpersonal violence screening using a standardized screening tool during the reporting period.

**Denominator**: Total number of HS women participants in the reporting period.

**Definition**: 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.

**% of HS women participants who screened positive for IPV who received a referral for services**

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

**Denominator**: Number of HS women participants who screened positive for IPV during the reporting period.

**Definition**: 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 IPV. Referral can be to either an internal or external provider depending on availability and staffing model.[0]

[0] Niolon, P. H., Kearns, M., Dills, J., Rambo, K., Irving, S., Armstead, T., & Gilbert, L. (2017). Intimate Partner Violence Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Available at: https://www.cdc.gov/violence-prevention/media/pdf/resources-for-action/IPV-Prevention-Resource_508.pdf

**Interpersonal 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]

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

### *Benchmark Data Sources*

PRAMS

### *Grantee Data Sources*

Grantee data systems

### *Significance*

Interpersonal Violence is a substantial yet preventable public health problem that affects women across the world. Research shows that interpersonal violence screening differs among health care specialties and is overall relatively low. The U.S. Department of Health and Human Services recommends IPV screening and counseling be a core part of a women's well visit.[0]

## Data Collection Form for HS 04

| HS Measure | Numerator | Denominator | Percent |
|---|---|---|---|
| HS 04 – IPV – Screening (%) | | | |
| HS 04 – IPV – Referral (%) | | | |

## Comments

[0] Health Resources and Services Administration, Office of Women's Health, 2023-2025 HRSA Strategy to Address Intimate Partner Violence. Rockville, Maryland: 2023. Available at: https://www.hrsa.gov/sites/default/files/hrsa/owh/2023-2025-hrsa-ipv-strategy.pdf

[0] Health Resources and Services Administration. Women's Preventive Services Guidelines. Available at: https://www.hrsa.gov/womens-guidelines

# HS 10

## Instructions

### HS 10 Performance Measure

**Goal**: Prenatal Care

**Level**: Grantee

**Domain**: Healthy Start

The percent of pregnant HS participants who receive prenatal care beginning in the first trimester.

#### *Goal*

To increase the proportion of pregnant HS participants who receive prenatal care in the first trimester to 80 percent.

#### *Measure*

The percent of pregnant HS participants who receive prenatal care beginning in the first trimester.

#### *Definition*

**During the reporting period:**

**Numerator:** Number* of pregnant HS participants who began prenatal care in the first trimester of pregnancy.

* The number of pregnant participants is unduplicated. Pregnant HS participants should be counted only once during a calendar year unless they have experienced more than one pregnancy in that calendar year. (If pregnant participant is counted more than once in the numerator, they should be counted more than once in the denominator.)

**During the reporting period:**

**Denominator**: Number of pregnant HS participants who had enrolled prenatally, prior to their second trimester of pregnancy.

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

#### *Benchmark Data Sources*

Related to Healthy People 2030 Objective MICH-08: Increase the proportion of pregnant women who receive early and adequate prenatal care. (Baseline: 76.4% in 2018, Target: 80.5%)[0]

#### *Grantee Data Sources*

Grantee Data System

[0] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2030. Available at: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08

***Significance***

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.

## Data Collection Form for HS 10

| HS Measure | Numerator | Denominator | Percent |
|---|---|---|---|
| HS 10 – Prenatal Care (%) | | | |

## Comments

# HS 11

## Instructions

### HS 11 Performance Measure

**Goal**: Perinatal/Postpartum Care

**Level**: Grantee

**Domain**: Healthy Start

The percent of pregnant/newly postpartum HS participants who received a postpartum visit within 12 weeks of delivery.

#### *Goal*

To increase the proportion of HS women participants who receive a postpartum visit to 80 percent.

#### *Measure*

The percent of pregnant/newly postpartum HS participants with a postpartum visit within 12 weeks of delivery.[0]

#### *Definition*

**During the reporting period:**

**Numerator:** The number* of pregnant/newly postpartum HS participants, who had enrolled prenatally or within 30 days after delivery, and received a comprehensive postpartum visit within 12 weeks after delivery.

*The number of pregnant/newly postpartum participants with a postpartum visit within 12 weeks of delivery is unduplicated. Pregnant/newly postpartum HS participants should be counted only once during a calendar year unless they have experienced more than one pregnancy in that calendar year.

**During the reporting period:**

**Denominator:** The number of HS participants who enrolled prenatally or within 30 days after delivery.

**Definition:** Professional obstetrics and gynecology groups recommend that postpartum care would ideally include an initial assessment, either in person or by phone, within the first 3 weeks postpartum to address acute postpartum issues. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive well-woman visit no later than 12 weeks after birth.[0]

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

[0] Consistent with Healthy Start Benchmark 3: The percent of Healthy Start women participants who receive a postpartum visit.
[0] Stuebe A, Auguste T, Gulati M, Presidential Task Force on Redefining the Postpartum Visit, & Committee on Obstetric Practice. (2018). Optimizing postpartum care. Committee Opinion No. 736. *Obstetrics & Gynecology*, 131(5), e140-e150.

### *Benchmark Data Sources*

PRAMS (postpartum visit: 88%, 2020)

### *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]

## Data Collection Form for HS 11

| HS Measure | Numerator | Denominator | Percent |
|---|---|---|---|
| HS 11 – Perinatal/Postpartum Care (%) | | | |

## Comments

[0] Blenning CE, Paladine H. (2005). An approach to the postpartum office visit. *Am Fam Physician*, 72(12): 2491-2496.

# HS 12

## Instructions

### HS 12 Performance Measure

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

**Level**: Grantee

**Domain**: Healthy Start

The percent of HS women participants with a well-woman/preventive visit in the past year.[0]

#### *Goal*

To increase the proportion of HS women participants that receive a well-woman/preventive visit in the past year to 80 percent.

#### *Measure*

The percent of HS women participants with a well-woman/preventive visit in the past year.

#### *Definition*

**Numerator:** Number of HS women participants within the reporting period who received a well-woman or preventive visit (including prenatal or postpartum visit) in the past 12 months prior to last assessment.

**Denominator:** Total number of HS women participants during the reporting period.

**Definition:** A participant is considered to have a well-woman or preventive visit and included in the numerator if she has a documented health assessment visit where she obtained recommended preventive services that are age and developmentally appropriate within twelve months of her last contact with the Program in the reporting year. For purposes of reporting, a prenatal visit or postpartum visit during the twelve month period would meet the standard.

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

#### *Benchmark Data Sources*

BRFSS (Women 18-44 with a past-year preventive visit: 72%, 2019-2020); PRAMS (early prenatal care: 87%, 2020); PRAMS (postpartum visit: 88%, 2020)

#### *Grantee Data Sources*

Grantee Data Systems

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

***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. Professional obstetrics and gynecology groups recommend an annual well-woman visit beginning in adolescence and continuing across the lifespan with any health care provider offering preventive well-woman care.

## Data Collection Form for HS 12

| HS Measure | Numerator | Denominator | Percent |
|---|---|---|---|
| HS 12 – Well Woman Visit/Preventive Visit (%) | | | |

### Comments

# HS 13

## Instructions

### HS 13 Performance Measure

**Goal**: Depression Screening

**Level**: Grantee

**Domain**: Healthy Start

The percent of HS women participants who receive depression screening and referral.

#### *Goal*

To increase the proportion of HS women participants who receive depression screening to 90%; of those who screen positive for depression, increase the proportion who receive a referral to 95%.

#### *Measure*

The percent of HS women participants who receive depression screening and referral.

#### *Definition*

**Percent of women screened for depression using a validated tool**[0]

**Numerator**: Number of HS women participants who were screened for depression with a validated tool during the reporting period.

**Denominator**: Number of HS women 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]

**Percent of women who screened positive for depression who receive a referral for services**

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

**Denominator**: Number of HS women participants who screened positive for depression during the reporting period.

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

[0] Consistent with Healthy Start Benchmark 12a and 12b: Percent of Healthy Start women participants who receive depression screening and referral.
[0] Committee on Obstetric Practice. (2018). Screening for perinatal depression. Committee Opinion No. 757. *Obstetrics & Gynecology*, 132(5), e208-e212.

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

### *Benchmark Data Sources*

Related to Healthy People 2030 Objective MICH-D01: (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 8 mothers.[0] 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.[0] PPD is associated with negative maternal physical and psychological health, relationship problems, and risky behaviors.[0] PPD is also associated with poor maternal and infant bonding and may negatively influence child development. Infant consequences of postpartum stress (including PPD) include less infant weight gain and stunting, problems with sleep, poor social, emotional, behavioral, cognitive, and language development.[0] Universal screening and treatment for pregnant and postpartum women is recommended by professional medical groups.[0]

## Data Collection Form for HS 13

| HS Measure | Numerator | Denominator | Percent |
|---|---|---|---|
| HS 13 – Depression – Screening (%) | | | |
| HS 13 – Depression – Referral (%) | | | |

## Comments

[0] Bauman BL, Ko JY, Cox S, et al. Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression — United States, 2018. *MMWR Morb Mortal Wkly Rep*. 2020; 69: 575-581.
[0] Pearlstein T, Howard M, Salisbury A, Zlotnick C. Postpartum depression. *American Journal of Obstetrics & Gynecology*. 2009; 200(4): 357-364.
[0] 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.
[0] Oyetunji A, Chandra P. Postpartum stress and infant outcome: A review of current literature. *Psychiatry Research*, 284, 112769.
[0] Committee on Obstetric Practice. (2018). Screening for perinatal depression. Committee Opinion No. 757. *Obstetrics & Gynecology*, 132(5), e208-e212.

# HS 14

## Instructions

### HS 14 Performance Measure

**Goal**: Safe Sleep

**Level**: Grantee

**Domain**: Healthy Start

Percent of HS infants placed to sleep following safe sleep practices.[0]

#### *Goal*

To increase the proportion of HS infants placed to sleep following safe sleep practices to 80%.

#### *Measure*

The percent of HS infants placed to sleep following safe sleep practices.

#### *Definition*

**Numerator**: Number of HS infant participants aged <12 months whose parent/caregiver reports that they are always or most often placed to sleep on their backs, on a separate sleep surface, and without soft objects or loose bedding.[0]

**Denominator**: Total number of HS infant participants aged <12 months.

A participant is considered to engage in safe sleep practices and included in the numerator if it is reported that the baby is 'always' or 'most often' 1) placed to sleep on their back, 2) always or often sleeps alone in his or her own crib or bed with no bed sharing, and 3) sleeps on a firm sleep surface (crib, bassinet, pack and play, etc.) with no soft objects or loose bedding.[17]

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.

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

#### *Benchmark Data Sources*

**Related to Healthy People 2030 Objective MICH-14**: Increase the proportion of infants placed to sleep on their backs (Baseline: 78.7% in 2016; Target: 88.9%); Healthy People 2030 Objective MICH-D03: Increase the proportion of infants who are put to sleep in a safe sleep environment. (Developmental) Pregnancy Risk Assessment Monitoring System

[0] Consistent with Healthy Start Benchmark 6: Percent of Healthy Start participants who are placed to sleep following safe sleep behaviors.
[0] Centers for Disease Control and Prevention. Sudden Unexpected Infant Death and Sudden Infant Death Syndrome: Providing Care for Babies to Sleep Safely. Available at: https://www.cdc.gov/sudden-infant-death/sleep-safely/index.html

(PRAMS).

### *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, professional pediatric medical groups recommended the back (supine) sleep position. In 2011, the recommendations were expanded 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]

## Data Collection Form for HS 14

| HS Measure | Numerator | Denominator | Percent |
|---|---|---|---|
| HS 14 – Safe Sleep (%) | | | |

## Comments

[0] Centers for Disease Control and Prevention. Sudden Unexpected Infant Death and Sudden Infant Death Syndrome: Providing Care for Babies to Sleep Safely. Available at: https://www.cdc.gov/sudden-infant-death/sleep-safely/index.html

# HS 15

## Instructions

### HS 15 Performance Measure

**Goal**: Breastfeeding

**Level**: Grantee

**Domain**: Healthy Start

The percent of HS infant participants who were ever breastfed or fed pumped breast milk, and/or were fed breast milk at 6 months of age.

#### *Goal*

To increase the proportion of HS infant participants who were:

- ever breastfed or fed pumped breast milk to 82 percent
- breastfed or fed pumped breast milk at 6 months to 50 percent.

#### *Measure*

The percent of HS infant participants who were ever breastfed or fed pumped breast milk, and/or were fed breast milk at 6 months of age.

#### *Definition*

**Percent of HS infant participants ever breastfed or fed pumped breast milk[0]**

**Numerator:** Total number of HS infant participants aged <12 months who were ever breastfed or fed pumped breast milk, and whose parent was enrolled prenatally.

**Denominator:** Total number of HS infant 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 infant received breast milk directly from the breast or that was pumped/expressed; this includes breast milk received at any time in any amount.

**Percent of HS infant participants breastfed or fed pumped breast milk at 6 months[0]**

**Numerator:** Total number of HS infant participants age 6 through 11 months who were breastfed or were fed pumped breast milk in any amount at 6 months of age, and whose parent was enrolled prenatally.

[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.

**Denominator:** Total number of HS infant 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 infant received breast milk directly from the breast or that was pumped/expressed; this includes breast milk received in any amount during the sixth month.

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

### *Benchmark Data Sources*

Related to Healthy People 2030 Objective 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*

Professional pediatric medical groups recommend 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.

## Data Collection Form for HS 15

| HS Measure | Numerator | Denominator | Percent |
|---|---|---|---|
| HS 15 – Breastfeeding – Ever (%) | | | |
| HS 15 – Breastfeeding – at 6 months (%) | | | |

## Comments

# HS 16

## Instructions

### HS 16 Performance Measure

**Goal**: Well Child Visit

**Level**: Grantee

**Domain**: Healthy Start

The percent of HS child participants who received well-child visits.[0]

#### *Goal*

To increase the proportion of HS child participants who received the last age-appropriate recommended well-child visit based on the Bright Futures schedule to 90 percent.

#### *Measure*

The percent of HS child participants who received recommended well-child visits.

#### *Definition*

**Numerator:** Number of HS child participants whose parent/caregiver reports that they received the last recommended well-child visit based on the Bright Futures schedule well-child visit as of the last assessment within the reporting period.

**Denominator:** Total number of HS child participants in the reporting period.

**Definition:** A participant is considered to have received the last recommended a well-child visit based on the Bright Futures 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 Bright Futures. The Bright Futures schedule recommends children be seen by a healthcare provider for preventive care at each of the following ages: by 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 24 months/2 years, 30 months, 3 years, and then annually thereafter.[0]

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

#### *Benchmark Data Sources*

National Survey of Children's Health

#### *Grantee Data Sources*

Grantee data systems

[0] Consistent with Healthy Start Benchmark 11: The percent of Healthy Start child participants who receive well-child visits.
[0] Health Resources and Services Administration. Bright Futures. Available at: https://mchb.hrsa.gov/programs-impact/bright-futures

***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.[22]

## Data Collection Form for HS 16

| HS Measure | Numerator | Denominator | Percent |
|---|---|---|---|
| HS 16 – Well Child Visit (%) | | | |

## Comments

# HS 17

## Instructions

### HS 17 Performance Measure

**Goal**: Adequate Health Insurance Coverage

**Level**: Grantee

**Domain**: Healthy Start

The percent of HS women and child participants with health insurance coverage.

#### *Goal*

To increase the proportion of HS women and child participants with health insurance to 90 percent (reduce uninsured to less than 10 percent).

#### *Measure*

The percent of HS women and child participants who had health insurance as of the last assessment during the reporting period.[0]

#### *Definition*

**% of HS women participants with health insurance**

**Numerator:** Number of HS women participants with health insurance as of the last assessment during the reporting period

**Denominator:** Total number of HS women participants during the reporting period.

**% of HS child participants with health insurance**

**Numerator:** Number of HS child participants with health insurance as of the last assessment during the reporting period

**Denominator:** Total number of HS child 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

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

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

### *Benchmark Data Sources*

Related to Healthy People 2030 Objective AHS-01: Increase the proportion of people with health insurance (Baseline: 89.0% of persons under 65 years had medical insurance in 2018; Target: 92.1%); National Survey of Children's Health (Children's Average 92.5%, 2023/2024).[0]

### *Grantee Data Sources*

Grantee data systems

### *Significance*

Individuals who acquire health insurance are more likely to have access to a usual source of care, receive well child care and immunizations, to have developmental milestones monitored, and receive prescription drugs, appropriate care for asthma and basic dental services. Insured children not only receive more timely diagnosis of serious health care conditions but experience fewer avoidable hospitalizations, improved asthma outcomes and fewer missed school days.

## Data Collection Form for HS 17

| HS Measure | Numerator | Denominator | Percent |
|---|---|---|---|
| HS 17 – Health Insurance Coverage – Women (%) | | | |
| HS 17 – Health Insurance Coverage – Children (%) | | | |

## Comments

[0] Child and Adolescent Health Measurement Initiative. 2023-2024 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). Available at: https://www.childhealthdata.org/browse/survey/results?q=11969&r=1

# HS 18

## Instructions

### HS 18 Performance Measure

**Goal**: Prenatal Tobacco and eCigarette Use

**Level**: Grantee

**Domain**: Healthy Start

The percent of prenatal HS participants who abstain from smoking cigarettes, or using any tobacco products, in their third trimester.

#### *Goal*

To increase the proportion of pregnant HS participants that abstain from cigarette smoking, or using any tobacco products, to 90 percent.

#### *Measure*

The percent of prenatal HS participants who abstain from smoking cigarettes, or using any tobacco products, in their third trimester.

#### *Definition*

**Numerator:** Number of prenatal Healthy Start participants who abstained from using any tobacco products during their third trimester (i.e., last 3 months of pregnancy).

**Denominator:** Total number of prenatal Healthy Start participants who were enrolled at least 90 days before delivery.

Smoking includes all tobacco products and e-cigarettes.

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

#### *Benchmark Data Sources*

Related to Healthy People 2030 Objective 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%)

#### *Grantee Data Sources*

Grantee data systems

#### *Significance*

Research shows that smoking in pregnancy is directly linked to problems including premature birth, certain birth defects, sudden infant death syndrome (SIDS), and separation of the placenta from the

womb prematurely. Women who smoke may have a harder time getting pregnant and have increased risk of miscarriage.

## Data Collection Form for HS 18

| HS Measure | Numerator | Denominator | Percent |
|---|---|---|---|
| HS 18 – Prenatal Tobacco and eCigarette Use (%) | | | |

## Comments

# HS 19

## Instructions

### HS 19 Performance Measure

**Goal**: Low Birthweight

**Level**: Grantee

**Domain**: Healthy Start

Percent of low birthweight infants among all singleton live births to Healthy Start participants.

#### *Goal*

To reduce the proportion of low birthweight infants among all singleton live births to HS participants.[0]

#### *Measure*

The percent of low birthweight infants among all live births to Healthy Start participants.

#### *Definition*

**Numerator:** Number of singleton live births with birth weight less than 2,500 grams in the calendar year among HS participants.

**Denominator:** Total number of singleton live births in the calendar year among HS participants.

Count only participants who gave birth while enrolled in Healthy Start.

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

#### *Benchmark Data Sources*

CDC, NCHS (2020 data: 8.24%)[0]

HS Budget Justification (Targets: 2024=9.6%; 2025=9.6%)[0]

#### *Grantee Data Sources*

Grantee data systems

#### *Significance*

Low birthweight (LBW) is among the leading causes of infant death in the United States. LBW infants are also more likely to have health problems. After reaching its highest level in four decades, the LBW rate

[0] Womack LS, Rossen LM, Martin JA. Singleton Low Birthweight Rates, by Race and Hispanic Origin: United States, 2006-2016. NCHS Data Brief No. 306, March 2018. Available at: https://www.cdc.gov/nchs/products/databriefs/db306.htm

[0] National Center for Health Statistics. Birthweight and Gestation. Available at: https://www.cdc.gov/nchs/fastats/birthweight.htm

[0] Health Resources and Services Administration. (2024). *Fiscal Year 2025 Congressional Budget Justification*. U.S. Department of Health and Human Services. Available at: https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2025.pdf

among all births declined from 2006 to 2014, but the trend reversed in 2015 and 2016 when the LBW rate increased, moving further away from the Healthy People 2020 goal of reducing LBW rates to 7.8% of live births.

## Data Collection Form for HS 19

| HS Measure | Numerator | Denominator | Percent |
|---|---|---|---|
| HS 19 – Low Birthweight (%) | | | |

## Comments

# HS 20

## Instructions

### HS 20 Performance Measure

**Goal**: Preterm Birth

**Level**: Grantee

**Domain**: Healthy Start

Percent of infants born preterm (delivery prior to 37 completed weeks of gestation) among all singleton live births to Healthy Start participants.

#### *Goal*

To reduce the proportion of infants born preterm among all singleton live births to HS participants.

#### *Measure*

Percent of infants born preterm (delivery prior to 37 completed weeks of gestation) among all singleton live births to Healthy Start participants.

#### *Definition*

**Numerator:** Number of singleton infants born preterm (delivery prior to 37 completed weeks of gestation) in the calendar year among HS participants.

**Denominator:** Total number of singleton live births in the calendar year among HS participants.

Count only participants who gave birth while enrolled in Healthy Start.

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

#### *Benchmark Data Sources*

Related to Healthy People 2030 Objective MICH-07: Reduce preterm births (Baseline 10.0%, 2018; Target 9.4%)[0]

CDC, NCHS (2019 data: 10.2%)[0]

[HS Data for 2020 (singleton): 9.4%]

#### *Grantee Data Sources*

Grantee data systems

[0] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2030. Available at: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-preterm-births-mich-07

[0] National Center for Health Statistics. Birthweight and Gestation. Available at: https://www.cdc.gov/nchs/fastats/birthweight.htm

***Significance***

Infants born before 37 weeks of gestation have a higher risk of infections, developmental problems, breathing problems, and even death. Preterm births are more common in some racial/ethnic groups. Strategies to reduce preterm births include promoting adequate birth spacing, helping women quit smoking, and providing high-quality medical care for women during pregnancy.[28]

The overall preterm birth rate has remained static at 10.4% between 2023 and 2024.[0]

## Data Collection Form for HS 20

| HS Measure | Numerator | Denominator | Percent |
|---|---|---|---|
| HS 20 – Preterm Birth (%) | | | |

### Comments

[0] Hamilton BE, Martin JA, Osterman MJK. Births: Provisional data for 2024. Vital Statistics Rapid Release. 2025. Apr;(38):1–10. Available at: https://www.cdc.gov/nchs/data/vsrr/vsrr038.pdf

# HS 21

## Instructions

### HS 21 Performance Measure

**Goal**: Infant Mortality

**Level**: Grantee

**Domain**: Healthy Start

The infant mortality rate (per 1,000 live births) of enrolled Healthy Start (HS) infants.

#### *Goal*

To reduce infant death among enrolled Healthy Start participants.

#### *Measure*

The infant mortality rate (per 1,000 live births) of enrolled Healthy Start (HS) infants.

#### *Definition*

**Numerator:** Number of deaths of enrolled HS infants (from birth through 364 days of age to HS participants in the calendar year).

**Definition:** Count deaths that occurred in both infants "born into the program" to enrolled participants (regardless of infant enrollment status) AND infants enrolled at some point after their birth and before their first birthday (less than one year in age/through 364 days of age).

"Born into the program" refers to infants born to participants who were enrolled prenatally.[0]

**Denominator:** Total number of live births in the calendar year among HS participants.

**Note**: This form utilizes the Data Collection Table for Healthy Start Forms and DGIS Form 10.A for annual performance objective and data reporting.

#### *Benchmark Data Sources*

Note: All IMR data below reported in the format of "number of infant deaths per 1,000 live births."

Related to Healthy People 2030 Objective MICH-02: Reduce the rate of infant deaths (Baseline 5.8, 2017; Target 5.0)[0]

CDC, NCHS (2023 data: 5.61)[0]

[0] Healthy Start Benchmarks Data Dictionary (2024). Available at: https://healthystart-tasc.org/wp-content/uploads/2024/09/HS-Benchmarks-Data-Dictionary_Aug2024.pdf

[0] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2030. Available at: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/infants/reduce-rate-infant-deaths-mich-02

[0] Ely DM, Driscoll AK. Infant mortality in the United States, 2023: Data from the period linked birth/infant death file. Natl Vital Stat Rep. 2025 Jun;74(7):1–20.

[HS IMR Data: 2020: 7.04, 2019: 8.05, 2018: 6.26]

### *Grantee Data Sources*

Grantee data systems

### *Significance*

Every year in the United States, thousands of infants die from causes like preterm birth, low birth weight, and sudden infant death syndrome. Although the rate of infant deaths has fallen over the past decade, there are differences by subgroups. High-quality care for moms and babies and community-based interventions can help reduce the rate of infant deaths.

## Data Collection Form for HS 21

| HS Measure | Numerator | Denominator | Rate |
|---|---|---|---|
| HS 21 – Infant Mortality (Rate per 1,000) | | | |

## Comments

# F2F 1

## Instructions

### 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

**Note**: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.

#### *Benchmark Data Sources*

Related to Healthy People 2030 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 Information 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.

## Complete the data collection table below.

For the purpose of this form:

- "Families" may include biological, foster, or adoptive parents and/or siblings, spouses or partners, or members of an extended family. Families have experience through their first-hand knowledge of navigating systems and services either on behalf of a family member or for the family as a whole (for example, parents of infants and toddlers, family members of children and youth with special health care needs, etc.).
- "One-to-one services" include all services that an F2F can collect recipient demographic/identifier information to be able to collect an unduplicated number. Examples include but are not limited to family navigation, consultation, counseling, education, referrals, case management, mentoring and individualized assistance.
- "State agency" is defined as any public agency.

**A**: The estimate of families with CYSHCN in your state comes from the National Survey of Children's Health. This number will be provided to and entered by grantees in the New Competing Performance Report (NCPR). The value entered in the NCPR will stay the same throughout an entire grant cycle and will prepopulate into subsequent DGIS reports.

**A.1.b:** Report race and/or ethnicity at the level that the F2F collects this information from families (for example, child, caregiver, or at the family level). The "Unknown/Unrecorded" option for race and/or ethnicity is to be used when a family either refuses, is not asked, or their race and/or ethnicity is not known.

**A.2.a:** This question captures the number of instances families receive services (duplicated count of families) and shows the number of times families are connected with services.

**A.2.b:** The numbers reported here do not have to sum to the number in A.2.a.

**A.4.a:** Number of service/trainings is the total number of trainings/services provided.

# Data Collection Form for F2F 1

## A. Providing Information, Education, and/or Training

The estimated number of families with CYSHCN in your state: _____

(*Denominator: data from the National Survey of Children's Health*)

1. **Families served via "one-to-one" services conducted by the F2F.**

   - Total number of families receiving one-to-one services from Family-To-Family Health Information Centers. (Numerator; unduplicated count): _____

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

   **Ethnicity**

   1. Hispanic _____
   2. Non-Hispanic _____
   3. Unknown _____

   **Race**

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

2. Unknown **The number and types of services provided to families.**

   a. Total number of service/trainings provided to families _____

   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
   ☐ Listservs
   ☐ Hardcopy/print
   ☐ Public television/radio
   ☐ Text messaging
   ☐ Social media platform description (specify): _____
   ☐ Other (specify): _____

## 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 agencies/programs with which your organization has worked: _____

   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/CSYHCN 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

      ☐ 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

      ☐ Child care programs

      ☐ Local Head Start

      ☐ Other community organization (Specify): _____

      ☐ None

   c. Of those community-based organizations, indicate if any were dedicated to specific racial and/or ethnic 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 F2F staff who are family/have a disability _____

## Comments

_____