Health Resources and Services Administration
Maternal and Child Health Bureau

Discretionary Grant Performance Measures

OMB No. 0915-0298
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Attachment B:
Core Measures, Population Domain Measures, Program-Specific Measures (Detail Sheets)

OMB Clearance Package

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

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

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

BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	Health equity is achieved when every individual has the opportunity to attain his or her full health potential and no one is "disadvantaged from achieving this potential because of social position or socially determined consequences." Achieving health equity is a top priority in the United States.

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

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

- ☐ Developmental Disabilities
- ☐ Medicaid
- ☐ Mental & Behavioral Health
- ☐ Housing
- ☐ Early Intervention/Head Start
- ☐ Education
- ☐ Child Care
- ☐ Juvenile Justice/Judicial System
- ☐ Foster Care/Adoption Agency
- ☐ Transportation
- ☐ Higher Education
- ☐ Law Enforcement
- ☐ Children's Cabinet
- ☐ Other (Specify_____)

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

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

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

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

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

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

CB 4 PERFORMANCE MEASURE **Goal: Sustainability** **Level: Grantee** **Domain: Capacity Building**	The percent of MCHB funded initiatives working to promote sustainability of their programs or initiatives beyond the life of MCHB funding.
	% of grants that have sustainability plans
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	In recognition of the increasing call for recipients of public funds to sustain their programs after initial funding ends, MCHB encourages grantees to work toward sustainability throughout their grant periods. A number of different terms and explanations have been used as operational components of sustainability. These components fall into four major categories, each emphasizing a distinct focal point as being at the heart of the sustainability process: (1) adherence to program principles and objectives, (2) organizational integration, (3) maintenance of health benefits, and (4) State or community capacity building. Specific recommended actions that can help grantees build toward each of these four sustainability components are included as the Tier 2 data elements for this measure.

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

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

CB 8 PERFORMANCE MEASURE **Goal: Quality Improvement** **Level: Grantee** **Domain: Capacity Building**	The percent of programs engaging in quality improvement and through what means, and related outcomes.
GOAL	To measure quality improvement initiatives.
MEASURE	The percent of MCHB funded projects implementing quality improvement initiatives.
DEFINITION	**Tier 1:** Are you implementing quality improvement (QI) initiatives in your program? ☐ Yes ☐ No **Tier 2:** QI initiative: What type of QI structure do you have? (Check all that apply) ☐ Team established within a division, office, department, etc. of an organization to improve a process, policy, program, etc. ☐ Team within and across an organization focused on organizational improvement ☐ Cross sectorial collaborative across multiple organizations What types of aims are included in your QI initiative? (Check all that apply) ☐ Population health ☐ Improve service delivery (process or program) ☐ Improve client satisfaction/ outcomes ☐ Improve work flow ☐ Policy improvement ☐ Reducing variation or errors **Tier 3:** Implementation Are QI goals directly aligned with organization's strategic goals? Y/ N Has the QI team received training in QI? Y/N Do you have metrics to track improvement? Y/N Which methodology are you utilizing for quality improvement? (Check all that apply) ☐ Plan, Do, Study, Act Cycles ☐ Lean ☐ Six Sigma ☐ Other: _____ **Tier 4:** What are the related outcomes? Is there data to support improvement in population health as a result of the QI activities? Y/N Is there data to support organizational improvement as a result of QI activities? Y/N Is there data to support improvement in cross sectorial collaboration as a result of QI activities? Y/N
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported.

Table 1: Activity Data Collection Form for Selected Measures

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

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

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

WMH 1 PERFORMANCE MEASURE **Goal: Prenatal Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/or facilitating timely prenatal care.

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.

WMH 2 PERFORMANCE MEASURE **Goal: Postpartum Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/or facilitating timely postpartum care.
GOAL	To ensure supportive programming for postpartum care.
MEASURE	The percent of MCHB funded projects addressing postpartum care. The percent of pregnant women with a postpartum visit within 4-6 weeks of delivery
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating timely postpartum care in your program? ☐ Yes ☐ No **Tier 2**: Through what processes/ mechanisms are you promoting and/ or facilitating postpartum care? ☐ Technical Assistance ☐ Training ☐ Product Development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Tracking/ Surveillance ☐ Screening/ Assessment ☐ Referral/ care coordination ☐ Direct Service ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of pregnant women with a postpartum visit within 4 to 6 weeks after delivery[1] **Numerator:** Number of women program participants who enrolled prenatally or within 30 days after delivery and received a postpartum visit within 4-6 weeks after delivery[2]. **Denominator:** Number of women program participants who enrolled prenatally or within 30 days after delivery during the reporting period. **Definition:** ACOG recommends that the postpartum visit occur between 4-6 weeks after delivery. ACOG suggests a 7-14 day postpartum visit for high-risk

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

WMH 2 PERFORMANCE MEASURE **Goal: Postpartum Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/or facilitating timely postpartum care.
	women.[3] A participant who has a visit prior to 4-6 weeks must still have a visit between 4-6 weeks to meet the standard and be included in the numerator.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 MICH- D01: Increase the proportion of women giving birth who attend a postpartum care visit with a health worker. Pregnancy Risk Assessment Monitoring System (PRAMS) (91% in 14 states with no timing restriction, 2011); Healthcare Effectiveness Data and Information Set (HEDIS) – (61.8% Medicaid HMO, 2014)
GRANTEE DATA SOURCES	Grantee Data System; Pregnancy Risk Assessment Monitoring System
SIGNIFICANCE	Since the period immediately following birth is a time of many physical and emotional adjustments, the postpartum visit is important for educating new mothers on what to expect during this period and address any concerns which may arise. Additional issues include any health complications the mother may have and the health benefits of breastfeeding for the mother and baby. [4]ACOG Committee on Obstetric Practice. Guidelines for Perinatal Care (7th Edition, p. 207) state that 4 to 6 weeks after delivery, women should have a postpartum visit with her doctor.

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

WMH 3 PERFORMANCE MEASURE **Goal: Well Woman Visit/ Preventive Health Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating well woman visits/ preventive health care.
GOAL	To ensure supportive programming for well woman visits/ preventive health care.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating well woman visits/ preventive health care and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating well woman visits/ preventive health care in your program? ☐ Yes ☐ No **Tier 2**: Through what activities are you promoting and/ or facilitating well woman visits/ preventive health care? ☐ Technical Assistance ☐ Training ☐ Product Development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Tracking/ Surveillance ☐ Screening/ Assessment ☐ Referral/ care coordination ☐ Direct Service ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of women with a well woman/ preventative visit in the past year.[5] **Numerator:** Number of women program participants who received a well-woman or preventive visit (including prenatal or postpartum visit) in the past 12 months prior to last assessment within the reporting period. **Denominator:** Number of women program participants during the reporting period. **Definition:** A participant is considered to have a well-woman or preventive visit and included in the numerator if she has a documented health assessment visit where she obtained recommended preventive

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

WMH 3 PERFORMANCE MEASURE **Goal: Well Woman Visit/ Preventive Health Care** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating well woman visits/ preventive health care.
	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.
BENCHMARK DATA SOURCES	BRFSS (Women 18-44 with a past-year preventive visit: 65.2%, 2013); Vital Statistics (any prenatal care: 98.4%, 2014); PRAMS (postpartum visit: 91%, 2011)
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	An annual well-woman visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. The American College of Obstetrics and Gynecologists (ACOG) recommends an annual well-woman visit beginning in adolescence and continuing across the lifespan with any health care provider offering preventive well-woman care.

WMH 4 PERFORMANCE MEASURE **Goal: Depression Screening** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating depression screening.
GOAL	To ensure supportive programming for depression screening.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating depression screening and through what processes.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating depression screening in your program? ☐ Yes ☐ No **Tier 2**: Through what activities are you promoting and/ or facilitating depression screening? ☐ Technical Assistance ☐ Training ☐ Product Development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Tracking/ Surveillance ☐ Screening/ Assessment ☐ Referral/ care coordination ☐ Direct Service ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of women screened for depression using a validated tool[6] **Numerator:** Number of women program participants who were screened for depression with a validated tool during the reporting period. **Denominator:** Number of women program participants in the reporting period. **Definition:** A participant is considered to have been screened and included in the numerator if a standardized screening tool which is appropriately validated for her circumstances is used. Several screening instruments have been validated for use to assist with systematically identifying patients with depression.[7]

[6] Consistent with Healthy Start Benchmark 12a and 12b: Percent of Healthy Start women participants who receive depression screening and referral.
[7] https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/11/screening-for-perinatal-depression

WMH 4 PERFORMANCE MEASURE **Goal: Depression Screening** **Level: Grantee** **Domain: Women's/ Maternal Health**	The percent of programs promoting and/ or facilitating depression screening.
	% of women who screened positive for depression who receive a referral for services **Numerator:** Number of women participants who screened positive for depression during the reporting period and received a subsequent referral for follow-up services. **Denominator:** Number of HS women participants who screened positive for depression during the reporting period. **Definitions:** A participant is considered to have been referred for follow-up services and included in the numerator if she is referred to a qualified practitioner for further assessment for depression. Referral can be to either an internal or external provider depending on availability and staffing model.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 MICH-D01Objective: (Developmental) Increase the proportion of women who are screened for postpartum depression at their postpartum checkup PRAMS (depression screening).
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	Postpartum depression (PPD) is common, affecting as many as 1 in 7 mothers.[8] Symptoms may include depressed mood, loss of interest or pleasure in activities, sleep disturbance, appetite disturbance, loss of energy, feelings of worthlessness or guilt, diminished concentration, irritability, anxiety, and thoughts of suicide.[8] PPD is associated with negative maternal physical and psychological health, relationship problems, and risky behaviors. [9] PPD is also associated with poor maternal and infant bonding and may negatively influence child development. Infant consequences of PPD include less infant weight gain and stunting, problems with sleep, poor social, emotional, behavioral, cognitive, and language development.[10] Universal screening and treatment for pregnant and postpartum women is recommended by the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the U.S. Preventive Services Task Force.[8]

[8] Pearlstein T, Howard M, Salisbury A, Zlotnick C. Postpartum depression. American Journal of Obstetrics & Gynecology. 2009; 200(4): 357-364. https://pubmed.ncbi.nlm.nih.gov/19318144/
[9] Slomian J, Honvo G, Emonts P, Reginster JY, Bruyere O. Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. Women's Health. 2019; 15:1-55. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6492376/pdf/10.1177_1745506519844044.pdf

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

[1] Consistent with Healthy Start Benchmark 6: Percent of Healthy Start participants who are placed to sleep following safe sleep behaviors.
[2] American Academy of Pediatrics (AAP). Task Force on Sudden Infant Death Syndrome. SIDS and other sleep-related infant deaths: Updated 2016 recommendations for a safe infant sleeping environment. Pediatrics 2016. 138 (5):e20162938.

PIH 1 PERFORMANCE MEASURE **Goal: Safe Sleep** **Level: Grantee** **Domain: Perinatal Infant Health**	The percent of MCHB funded projects promoting and/ or facilitating safe sleep practices.
	sharing, and 3) sleeps on a firm sleep surface (crib, bassinet, pack and play, etc.) with no soft objects or loose bedding.[3] The requirement is that the baby is placed on their back to sleep. If they roll over onto their stomach after being placed to sleep, the standard is met. Although safe sleep behaviors are self-reported, programs are encouraged to observe safe sleep practices during home visits, as possible.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 MICH-04: Increase the proportion of infants placed to sleep on their backs (Baseline: 78.7% in 2016; Target: 88.9%); Healthy People 2030 MICH-D3: Increase the proportion of infants who are put to sleep in a safe sleep environment. (Developmental) Pregnancy Risk Assessment Monitoring System (PRAMS) .[4]
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. [5]

[3] https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/aap-expands-guidelines-for-infant-sleep-safety-and-sids-riskreduction.aspx#sthash.1nnEJQwk.dpuf
[4] https://www.cdc.gov/prams/questionnaire.htm#current
[5] American Academy of Pediatrics (AAP). Task Force on Sudden Infant Death Syndrome. SIDS and other sleep-related infant deaths: Updated 2016 recommendations for a safe infant sleeping environment. Pediatrics 2016. 138 (5):e20162938. https://publications.aap.org/pediatrics/article/138/5/e20162938/60309/SIDS-and-Other-Sleep-Related-Infant-Deaths-Updated

PIH 2 PERFORMANCE MEASURE **Goal: Breastfeeding** **Level: Grantee** **Domain: Perinatal Infant Health**	The percent of programs promoting and/ or facilitating breastfeeding.
GOAL	To ensure supportive programming for breastfeeding.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating breastfeeding.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating breastfeeding in your program? ☐ Yes ☐ No **Tier 2**: Through what activities are you promoting and/ or facilitating breastfeeding? ☐ Technical Assistance ☐ Training ☐ Product Development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Tracking/ Surveillance ☐ Screening/ Assessment ☐ Referral/ care coordination ☐ Direct Service ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of child program participants ever breastfed[6] **Numerator:** Total number of child program participants aged <12 months who were ever breastfed or fed pumped breast milk, and whose parent was enrolled prenatally. **Denominator:** Total number of child program participants aged <12 months whose parent was enrolled prenatally. **Definition:** A participant is considered to have ever breastfed and included in the numerator if the child received breast milk direct from the breast or expressed at any time in any amount. % of child program participants breastfed at 6 months[7]

[6] 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.
[7] Consistent with Healthy Start Benchmark 8: Percent of Healthy Start child participants whose parent reports the child was breastfed or fed breastmilk at 6 months.

PIH 2 PERFORMANCE MEASURE **Goal: Breastfeeding** **Level: Grantee** **Domain: Perinatal Infant Health**	The percent of programs promoting and/ or facilitating breastfeeding.
	Numerator: Total number of child program participants age 6 through 11 months that were breastfed or were fed pumped breast milk in any amount at 6 months of age, and whose parent was enrolled prenatally. **Denominator:** Total number of child program participants age 6 through 11 months whose parent was enrolled prenatally. **Definition:** A participant is considered to have ever breastfed at 6 months and included in the numerator if the child received breast milk direct from the breast or expressed at any time in any amount during the sixth month.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 MICH-15: Increase the proportion of infants who are breastfed exclusively through 6 months (Baseline: 24.9% in 2015, Target: 42.4%); Related to Healthy People 2030 MICH-16: Increase the proportion of infants who are breastfed at 1 year (Baseline: 35.9% in 2015, Target: 54.1%).
GRANTEE DATA SOURCES	Grantee data systems.
SIGNIFICANCE	The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months, followed by continued breastfeeding as complementary foods are introduced for 1 year or longer. Exclusive breastfeeding for six months supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer, diabetes, hypertension, and heart disease.

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

PIH 3 PERFORMANCE MEASURE **Goal: Newborn Screening** **Level: Grantee** **Domain: Perinatal Infant Health**	Percent of programs promoting newborn screenings and follow-up.
GRANTEE DATA SOURCES	Title V National Outcome Measure #12 (Developmental)
SIGNIFICANCE	Newborn screening detects thousands of babies each year with potentially devastating, but treatable disorders. The benefits of newborn screening depend upon timely collection of the newborn blood-spots or administration of a point-of-care test (pulse oximeter for critical congenital heart disease), receipt of the newborn blood spot at the laboratory, testing of the newborn blood spot, and reporting out of all results. Timely detection and follow-up with appropriate treatment prevents death or disability and enables children to reach their full potential.[8]

[8] Centers for Disease Control and Prevention. CDC Grand Rounds: Newborn Screening and Improved Outcomes. Morbidity and Mortality Weekly Report. 2012 June 1. 61(21): 390-93. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6121a2.htm

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

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

CH 1 PERFORMANCE MEASURE **Goal: Well Child Visit** **Level: Grantee** **Domain: Child Health**	The percent of programs promoting and/ or facilitating well-child visits.
	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.[2] % of children enrolled in Medicaid/ CHIP with at least one well care visit in the past year **Numerator**: Medicaid/ CHIP-enrolled child program participants who received a well-child visit in the reporting year. **Denominator:** Total number of Medicaid/ CHIP-enrolled child program participants in the reporting year.
BENCHMARK DATA SOURCES	National Survey of Children's Health K4Q20
GRANTEE DATA SOURCES	Title V National Performance Measure #10,
SIGNIFICANCE	Routine pediatrician visits are important to (1) prevent illness and injury through immunizations and anticipatory guidance, (2) track growth and development and refer for interventions as needed, (3) address parent concerns (e.g., behavior, sleep, eating, milestones), and (4) build trusting parent-provider relationships to support optimal physical, mental, and social health of a child.[3]

[2] https://www.aap.org/en-us/Documents/periodicity_schedule.pdf
[3] https://www.aappublications.org/news/aapnewsmag/2015/12/15/WellChild121515.full.pdf

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

[4] https://www.aafp.org/afp/2018/0915/p347.html

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

CH 3 PERFORMANCE MEASURE **Goal: Developmental Screening** **Level: Grantee** **Domain: Child Health**	Percent of programs promoting developmental screenings and follow-up for children.
GOAL	To ensure supportive programming for developmental screenings.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating developmental screening and follow-up for children.
DEFINITION	**Tier 1**: Are you promoting and/or facilitating developmental screening and follow-up in your program? ☐ Yes ☐ No **Tier 2**: Through what processes/ mechanisms are you promoting or facilitating developmental screening and follow-up? ☐ Technical Assistance ☐ Training ☐ Product Development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Tracking/ Surveillance ☐ Screening/ Assessment ☐ Referral/ care coordination ☐ Direct Service ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes in the reporting year? % of children 9 through 35 months receiving a developmental screening using a parental-completed tool? **Numerator:** Children of program participants aged 9 through 35 months who have received a developmental screening using a parent/ caretaker-completed tool. **Denominator:** Children, aged 9 through 35 months, of program participants.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 MICH-17: Increase the proportion of children who receive a developmental screening. (Baseline: 31.1% in 2016-17, Target: 35.8%).
GRANTEE DATA SOURCES	Title V National Performance Measure #6, Title V National Outcome Measure #12.

CH 3 PERFORMANCE MEASURE **Goal: Developmental Screening** **Level: Grantee** **Domain: Child Health**	Percent of programs promoting developmental screenings and follow-up for children.
SIGNIFICANCE	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics (AAP) recommends screening tests at the 9, 18, and 24 or 30 month visit. The developmental screening measure is endorsed by the National Quality Forum and is part of the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.[5]

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

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

CH 4 PERFORMANCE MEASURE **Goal: Injury Prevention** **Level: Grantee** **Domain: Child Health**	The percent of programs promoting and/ or facilitating injury prevention among children.
	Denominator: Total number of children ages 6-11 represented in National Survey of Children's Health results. Dataset reporting from: _____
BENCHMARK DATA SOURCES	Related to HP2030 IVP-02: Reduce emergency department (ED) visits for nonfatal injuries. (Baseline: 9,349.5 ED visits per 100,000 population in 2017 (age adjusted to the year 2000 standard population), Target: 7,738.2 ED visits per 100,000 population).
GRANTEE DATA SOURCES	Title V National Performance Measure #7 Child Injury, AHRQ Healthcare Cost and Utilization Project: National Inpatient Sample or State Inpatient Database; National Survey of Children's Health, Question G1 in the 6-11 year old survey
SIGNIFICANCE	Unintential injury is the leading cause of child and adolescent mortality, from age 1 through 19.[6] Homicide and suicide, violent or intentional injury, are the second and third leading causes of death for adolescents ages 15 through 19.[4] The total death rate for persons aged 10-19 years decreased 33% between 1999 and 2013, then increased 12% between 2013 and 2016 due to an increase in injury deaths.[7] For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.

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

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

Data Collection Form for Detail Sheet # CH 4

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

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

CSHCN 1 PERFORMANCE MEASURE **Goal: Family Engagement** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/ or facilitating family engagement among children and youth with special health care needs.
GOAL	To ensure supportive programming for family engagement among children and youth with special health care needs.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating family engagement among children and youth with special health care needs.
DEFINITION	**Tier 1**: Are you promoting and/ or facilitating family engagement among children and youth with special health care needs in your program? ☐ Yes ☐ No **Tier 2**: Through what processes/ mechanisms are you promoting and/ or facilitating family engagement? ☐ Technical Assistance ☐ Training ☐ Product Development ☐ Research/ Peer-reviewed publications ☐ Outreach/ Information Dissemination/ Education ☐ Tracking/ Surveillance ☐ Screening/ Assessment ☐ Referral/ care coordination ☐ Direct Service ☐ Quality improvement initiatives **Tier 3**: How many are reached through those activities? *(Report in Table 1: Activity Data Collection Form)* # receiving TA # receiving training # products developed # peer-reviewed publications published # receiving information and education through outreach # receiving screening/ assessment # referred/care coordinated # received direct service # participating in quality improvement initiatives **Tier 4**: What are the related outcomes? % of target population with family and CSHCN leaders with meaningful roles on community/ state/ regional/ national level teams focused on CSHCN systems **Numerator:** # of Family and CSHCN leaders with meaningful roles on community/state/regional/national level teams focused on CSHCN systems. **Denominator:** # of CSHCN in catchment area % of racial and ethnic family and CSCHN leaders who are trained and serving on community/ state/ regional/ national level teams focused on CSHCN systems. **Numerator:** #of racial and ethnic family and CSHCN leaders trained and serving on community/state/ regional/ national level teams focused on CSHCN systems. **Denominator:** # of CSHCN in catchment area

CSHCN 1 PERFORMANCE MEASURE **Goal: Family Engagement** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/ or facilitating family engagement among children and youth with special health care needs.
	% of target population with family of CSHCN participating in information exchange forums. **Numerator:** # participating in information exchange forums. **Denominator:** # CSHCN in catchment area % of family and CSCHN leaders trained who report increased knowledge, skill, ability and self-efficacy to serve as leaders on systems-level teams. **Numerator:** # of family and CSHCN leaders trained who report increased knowledge, skill, ability and self-efficacy to serve as leaders on systems-level teams. **Denominator:** # of CSHCN in catchment area. **Definitions:** Family Engagement is defined as "patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system to improve health and health care." This definition is not intended to negate the various levels or degree to which the interaction between families and professionals can take place. Family and Youth Leaders are family members who have experience navigating through service systems and are knowledgeable and skilled in partnering with professionals to carry out necessary system changes. Family members are not limited to the immediate family within the household. Meaningful [Support] Roles for family members/leaders are above and beyond "feedback" surveys. Families are considered to have a meaningful role in decision making when the partnership involves all elements of shared decision-making which are: collaboration, respect, information sharing, encouragement and consideration of preferences and values, and shared responsibility for outcomes.
BENCHMARK DATA SOURCES	None
GRANTEE DATA SOURCES	Title V National Outcome Measure #17.2
SIGNIFICANCE	Children and youth live within the context of families, who are the ultimate decision-makers and health enablers for their children.

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

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

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

CSHCN 3 PERFORMANCE MEASURE **Goal: Transition** **Level: Grantee** **Domain: CSHCN**	The percent of programs promoting and/or facilitating transition to adult health care for youth with special health care needs.
	Numerator: Number of Grantees promoting transition planning early in adolescence. **Denominator:** Total number of grantees reporting transition performance measure. % of grantees linking transition efforts with medical home initiatives. **Numerator:** Number of Grantees promoting transition as part of routine medical home care. **Denominator:** Total number of grantees reporting transition performance measure. % of grantees linking transition efforts with adolescent preventive care efforts. **Numerator:** Number of grantees promoting transition as part of routine adolescent preventive care. **Denominator:** Total number of grantees reporting transition performance measure. **Definitions:** The terms "assessed for readiness" and "deemed ready" used here refer to language utilized by gottransition.org. Health care transition: is the process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care. Transition Readiness: Assessing youth's transition readiness and self-care skills is the third element in these health care transition quality recommendations. Use of a standardized transition assessment tool is helpful in engaging youth and families in setting health priorities; addressing self-care needs to prepare them for an adult approach to care at age 18, and navigating the adult health care system, including health insurance. Providers can use the results to jointly develop a plan of care with youth and families. Transition readiness assessment should begin at age 14 and continue through adolescence and young adulthood, as needed.
BENCHMARK DATA SOURCES	Related to HP2030 AH-02: Increase the proportion of adolescents who speak privately with a physician or other health care provider during a preventive medical visit. (Baseline: 38.4% in 2016-17, Target: 43.3%). Related to HP2030 AH-R01: Increase the proportion of adolescents (aged 12 to 17 years) with and without special health care needs who receive services to support their transition to adult health care. (Research)
GRANTEE DATA SOURCES	Title V National Performance Measure #12.
SIGNIFICANCE	Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college, or be employed. Health and health care are cited as two of the major barriers to making successful transitions. The transition of youth to adulthood,

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

including moving from a child to adult healthcare, is a national priority as evidenced by the 2011 clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families.[1]

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

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

AH 1 PERFORMANCE MEASURE **Goal: Adolescent Well Visit** **Level: Grantee** **Domain: Adolescent Health**	The percent of programs promoting and/ or facilitating adolescent well visits.
BENCHMARK DATA SOURCES	HP2030 AH-01: Increase the proportion of adolescents who received a preventive health care visit in the past year. (Baseline: 78.7% in 2016-17, Target: 82%)
GRANTEE DATA SOURCES	Title V National Performance Measure #10, National Vital Statistics System (NVSS) Birth File.
SIGNIFICANCE	As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors, such as unsafe sexual activity, unsafe driving, and substance use, is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. An annual preventive well visit may help adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease.

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

AH 2 PERFORMANCE MEASURE **Goal: Injury Prevention** **Level: Grantee** **Domain: Adolescent Health**	The percent of programs promoting and/ or facilitating adolescent injury prevention.
	Target Population:_____ Percent of children ages 12-17 missing 11 or more days of school because of illness or injury. **Numerator:** # of children ages 12-17 missing 11 or more days of school. **Denominator:** Total number of children ages 12-17 represented in National Survey of Children's Health result. **Dataset used:** _____
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Injury and Violence Prevention (IVP) objectives 1-7, 9-24 and Injury and Violence Developmental (IV-D) objectives 1-5.
GRANTEE DATA SOURCES	AHRQ Healthcare Cost and Utilization Project: National Inpatient Sample or State Inpatient Database. National Survey of Children's Health, 6-11 year old and 12-17 year old survey, Question G1.
SIGNIFICANCE	Unintentional injury is the leading cause of child and adolescent mortality, from age 1 through 19. Homicide and suicide, violent or intentional injury are the second and third leading causes of death for adolescents ages 15 through 19.[4] The total death rate for persons aged 10-19 years decreased 33% between 1999 and 2013, then increased 12% between 2013 and 2016 due to an increase in injury deaths. For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.

Data Collection Form for Detail Sheet # AH 2

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

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

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

AH 3 PERFORMANCE MEASURE **Goal: Screening for Major Depressive Disorder** **Level: Grantee** **Domain: Adolescent Health**	The percent of programs promoting and/ or facilitating screening for major depressive disorder.
	% of adolescents identified with a MDD that receive treatment **Numerator:** Adolescents involved with your program identified as having an MDD that received treatment during the reporting year. **Denominator:** Adolescents involved with your program during the reporting year identified as having an MDD. % of adolescents with a MDD **Numerator:** Adolescents involved with your program during the reporting year identified as having an MDD. **Denominator:** Adolescents involved with your program in the reporting year. Age range of adolescents served: _____
BENCHMARK DATA SOURCES	Healthy People 2030 MHMD-08: Increase the proportion of primary care office visits where adolescents and adults are screened for depression (Baseline 8.5% of primary care office visits included screening for depression in persons aged 12 years and over in 2016, Target: 13.5%). Healthy People 2030 MHMD-06: Increase the proportion of adolescents with major depressive episodes (MDEs) who receive treatment (Baseline: 41.4% of adolescents aged 12 to 17 years with MDEs received treatment in the past 12 months, in 2018; Target: 46.4%).
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	Depression is under recognized and undertreated in adolescents, with an estimated 75% of depressed adolescents not receiving treatment. Untreated depression in adolescence is associated with debilitating immediate and long-term psychological and physical outcomes, as well as increased risk of suicide. Validated screening instruments and effective treatment are available. Routine depression screening for all adolescents helps reduce the challenges of case-finding due to stigma, parental/patient denial and common assumptions about "typical teenage" behavior.[1]

[1] Maslow GR, Dunlap K, Chung RJ. Depression and Suicide in Children and Adolescents. Pediatrics. 2015, 36(7): 299-310. https://pubmed.ncbi.nlm.nih.gov/26133305/

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

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

LC 1 PERFORMANCE MEASURE **Goal: Adequate Health Insurance Coverage** **Level: Grantee** **Domain: Life Course/ Cross Cutting**	The percent of programs promoting and/ or facilitating adequate health insurance coverage.
BENCHMARK DATA SOURCES	Related to HP2030 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%)
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Inadequately insured children are more likely to have delayed or forgone care, lack a medical home, be less likely to receive needed referrals and care coordination, and receive family-centered care.[2] Approximately 27% of American children were not adequately insured in 2018-2019.[3]

[2] Kogan MD, Newacheck PW, Blumberg SJ, Ghandour RM, Singh GK, Strickland BB, van Dyck PC. Underinsurance among children in the United States. N Engl J Med. 2010 Aug 26;363(9):841-51. http://www.nejm.org/doi/full/10.1056/NEJMsa0909994
[3] Child and Adolescent Health Measurement Initiative. 2018-2019 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 11/09/2021 from https://www.childhealthdata.org/browse/survey/results?q=7888&r=1

Data Collection form for #LC 1

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

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

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

LC 2 PERFORMANCE MEASURE **Goal: Tobacco and eCigarette Use** **Level: Grantee** **Domain: Life Course/ Cross Cutting**	The percent of programs promoting and/ or facilitating tobacco and eCigarette cessation.
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Adverse effects of parental smoking on children have been a clinical and public health concern for decades.[1] Children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections; and SIDS.

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

Data Collection form for #LC 2

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

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

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

LC 3 PERFORMANCE MEASURE **Goal: Oral Health** **Level: Grantee** **Domain: Life Course/ Cross Cutting**	The percent of programs promoting and/ or facilitating oral health.
	through 17 years who reside in households with income less than 200 percent of the federal poverty level received a preventive dental service in 2016-17; Target: 82.7%).
GRANTEE DATA SOURCES	Title V National Performance Measure #13
SIGNIFICANCE	Oral health is a vital component of overall health and oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. To prevent tooth decay and oral infection, the American Academy of Pediatric Dentistry (AAPD) recommends preventive dental care for all children after the eruption of the first tooth or by 12 months of age, usually at intervals of every 6 months.[1] Preventive dental care in pregnancy is also recommended by the American College of Obstetricians and Gynecologists (ACOG) to improve lifelong oral hygiene habits and dietary behavior for women and their families.[2]

[1] American Academy of Pediatric Dentistry. Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Health Treatment for Infants, Children, and Adolescents. 2018. Reference Manual of Pediatric Dentistry. https://www.aapd.org/globalassets/media/policies_guidelines/bp_periodicity.pdf
[2] National Maternal and Child Oral Health Resource Center. Oral Health During Pregnancy: A National Consensus Statement. (n.d.) https://www.mchoralhealth.org/materials/consensus_statement.php

Data Collection Form for #LC 3

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

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

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

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

Training 01 PERFORMANCE MEASURE **Goal: Family/ Youth/ Community Engagement in MCH Training and Healthy Tomorrows Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB training and Healthy Tomorrows programs that ensure family, youth, and community member participation in program and policy activities.
GOAL	To increase family, youth, and/or community member participation in MCH Training and Healthy Tomorrows programs.
MEASURE	The percent of MCHB training and Healthy Tomorrows programs that ensure family/ youth/ community member participation in program and policy activities.
DEFINITION	Attached is a table of five elements that demonstrate family member/youth/community member participation, including an emphasis on partnerships and building leadership opportunities for family members/youth/community members in MCH Training or Healthy Tomorrows programs. Please check yes or no to indicate if your MCH Training Program or Healthy Tomorrows program has met each element.
BENCHMARK DATA SOURCES	PHI-3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs, and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula
GRANTEE DATA SOURCES	Attached data collection form to be completed by grantee.
SIGNIFICANCE	Over the last decade, policy makers and program administrators have emphasized the central role of families and other community members as advisors and participants in program and policy-making activities. In accordance with this philosophy, MCH Training Programs and Healthy Tomorrows Programs are facilitating such partnerships at the local, State and national levels. MCH Training programs support interdisciplinary/interprofessional graduate education and training programs that emphasize leadership, and family-centered, community-based, and culturally responsive systems of care. Training programs are required to incorporate family members/youth/community members as faculty, trainees, and partners. The Healthy Tomorrows program supports community initiated and community-based projects that apply principles of health promotion, disease prevention, and the benefits of coordinated health care to the provision of services that improve access to comprehensive, community-based, family-centered,

Training 01 PERFORMANCE MEASURE **Goal: Family/ Youth/ Community Engagement in MCH Training and Healthy Tomorrows Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB training and Healthy Tomorrows programs that ensure family, youth, and community member participation in program and policy activities.
	culturally/linguistically responsive, and coordinated care. Healthy Tomorrows projects are required to incorporate family members/youth/community members as project staff, advisors, volunteers, and partners. This performance measure directly relates to MCHB Strategic Plan Objective 1.3: Ensure family and consumer leadership and partnership in efforts to improve health and strengthen MCH systems of care.

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

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

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

NOTES/COMMENTS:

Training 02 PERFORMANCE MEASURE **Goal: Cultural Responsiveness in MCH Training and Healthy Tomorrows Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB training and Healthy Tomorrows programs that have incorporated cultural and linguistic responsiveness elements into their policies, guidelines, and training.
GOAL	To increase the percentage of MCH Training and Healthy Tomorrows programs that have integrated cultural and linguistic responsiveness into their policies, guidelines, and training.
MEASURE	The percent of MCHB training and Healthy Tomorrows programs that have integrated cultural and linguistic responsiveness into their policies, guidelines, and training.
DEFINITIONS	Attached is a checklist of 6 elements that demonstrate cultural and linguistic responsiveness. Please check yes or no to indicate if your MCH Training or Healthy Tomorrows program has met each element. Please keep the completed checklist attached. Cultural and linguistic responsiveness is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals th-at enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Responsiveness' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989; cited from National Center for Cultural Competence (http://nccc.georgeto wn.edu/foundations/frameworks.html) Linguistic responsiveness is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic responsiveness requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. (Goode, T. and W. Jones, 2004. National Center for Cultural Competence; http://www.nccccurricula.info/linguisticcompetence.html) Cultural and linguistic responsiveness is a process that occurs along a developmental continuum. A culturally and linguistically responsive program is characterized by elements including the following: written strategies for advancing cultural responsiveness; cultural and linguistic responsiveness policies and practices; cultural and

Training 02 PERFORMANCE MEASURE **Goal: Cultural Responsiveness in MCH Training and Healthy Tomorrows Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB training and Healthy Tomorrows programs that have incorporated cultural and linguistic responsiveness elements into their policies, guidelines, and training.
	linguistic responsiveness knowledge and skills building efforts; research data on populations served according to racial, ethnic, and linguistic groupings; faculty and other instructors are racially and ethnically diverse; faculty and staff participate in professional development activities related to cultural and linguistic responsiveness; and periodic assessment of trainees' progress in developing cultural and linguistic responsiveness.
BENCHMARK DATA SOURCES	Related to the following HP2030 Objectives: PHI-RO3: Increase the use of core and discipline-specific competencies to drive workforce development PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education. PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education
GRANTEE DATA SOURCES	Attached data collection form is to be completed by grantees. There is no existing national data source to measure the extent to which MCHB supported programs have incorporated cultural responsiveness elements into their policies, guidelines, and training.
SIGNIFICANCE	Over the last decade, researchers and policymakers have emphasized the central influence of cultural values and cultural/linguistic barriers: health seeking behavior, access to care, and racial and ethnic disparities. In accordance with these concerns, cultural responsiveness objectives have been: (1) incorporated into the Division of MCH Workforce Development priorities; and (2) in guidance materials related to the MCH Training and Healthy Tomorrows Programs. The Division of MCH Workforce Development provides support to programs that address cultural and linguistic responsiveness through development of curricula, research, learning and practice environments. This performance measure directly relates to MCHB Strategic Plan Objective 3.2: Support training and educational opportunities to create a diverse an culturally responsive MCH workforce, including professionals, community-based workers, and families.

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

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

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

NOTES/COMMENTS*:*

Training 03 PERFORMANCE MEASURE **Goal: Healthy Tomorrow's Partnership** **Level: Grantee** **Domain: MCH Workforce Development**	The degree to which the Healthy Tomorrows Partnership for Children program collaborates with State Title V agencies, other MCH or MCH-related programs.
GOAL	To assure that the Healthy Tomorrows program has collaborative interactions related to professional development, policy development and product development and dissemination with relevant national, state and local MCH programs, agencies and organizations.
MEASURE	The degree to which a Healthy Tomorrows program collaborates with State Title V agencies, and other MCH or MCH-related programs.
DEFINITION	Attached is a list of the 7 elements that describe activities carried out by Healthy Tomorrows programs for or in collaboration with State Title V and other agencies on a scale of 0 to 1 (0=no; 1=yes). If a value of '1' (yes) is selected, provide the number of activities for the element. The total score for this measure will be determined by the sum of those elements noted as '1.'
BENCHMARK DATA SOURCES	ECBP-DO9: Increase core clinical prevention and population health education in medical schools. ECBP-D10: Increase core clinical prevention and population health education in nursing schools. ECBP-D11: Increase core clinical prevention and population health education in physician assistant training programs. ECBP-D12: Increase core clinical prevention and population health education in pharmacy schools. ECBP-D13: Increase core clinical prevention and population health education in dental schools. PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education. PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education. PHI-DO1: Increase the proportion of tribal public health agencies that use core competencies in continuing education.
GRANTEE DATA SOURCES	The Healthy Tomorrows program completes the attached table which describes the categories of collaborative activity.
SIGNIFICANCE	As a SPRANS grantee, a Healthy Tomorrows program enhances the Title V State block grants that support MCHB Strategic Plan Goal 1: to assure access to high-quality and equitable health services to optimize health and well-being for all MCH populations. Interactive collaboration between a Healthy Tomorrows program and Federal, Tribal, State and local agencies dedicated to

Training 03 PERFORMANCE MEASURE **Goal: Healthy Tomorrow's Partnership** **Level: Grantee** **Domain: MCH Workforce Development**	The degree to which the Healthy Tomorrows Partnership for Children program collaborates with State Title V agencies, other MCH or MCH-related programs.

improving the health of MCH populations will increase active involvement of many disciplines across public and private sectors and increase the likelihood of success in meeting the goals of relevant stakeholders.

This measure will document a Healthy Tomorrows program's abilities to:

1) collaborate with State Title V and other agencies (at a systems level) to support achievement of the MCHB Strategic Goals and Healthy People 2030 objectives;
2) make the needs of MCH populations more visible to decision-makers and help states achieve best practice standards for their systems of care;
3) internally use these data to assure a full scope of these program elements in all regions.

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

Indicate the degree to which the Healthy Tomorrows program collaborates with State Title V (MCH Block Grant) agencies and other MCH or MCH-related programs[1,2] by entering the following values:
0= Does not collaborate on this element 1= Does collaborate on this element.

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

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

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

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

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

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

the likelihood of success in meeting the goals of relevant stakeholders.

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

1) collaborate with State Title V and other agencies (at a systems level) to support achievement of MCHB Strategic Goals and Healthy People 2030 objectives;
2) make the needs of MCH populations more visible to decision-makers and can help states achieve best practice standards for their systems of care; and
3) internally use these data to assure a full scope of these program elements in all regions.

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

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

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

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

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

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

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

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

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

CATEGORY #1: Training on Policy and Advocacy

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

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

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

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

Training 06 PERFORMANCE MEASURE **Goal: Long Term Training Programs** **Level: Grantee** **Domain: MCH Workforce Development**	The percentage of participants in MCHB long-term training programs who are from racial and ethnic groups who are underrepresented in the MCH workforce.
GRANTEE DATA SOURCES	Data will be collected annually from grantees about their trainees. MCHB does not maintain a master list of all trainees who are supported by MCHB long-term training programs. References supporting Workforce Diversity: ● In the Nation's Compelling Interest: Ensuring Diversity in the Healthcare Workforce (2004). Institute of Medicine. ● Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2002). Institute of Medicine.
SIGNIFICANCE	HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. Training an ethnically and racially diverse group of professionals is necessary in order to provide a diverse public health workforce to meet the needs of the changing demographics of the U.S. and to ensure access to culturally responsive and effective services. This performance measure provides the necessary data to report on HRSA's initiatives to reduce health disparities. This national performance measure relates directly to MCHB Strategic Plan Objective 3.2: Support training and educational opportunities to create a diverse and culturally responsive MCH workforce, including professionals, community-based workers, and families.

DATA COLLECTION FORM FOR DETAIL SHEET: Training 06 – Long Term Training Programs

Report on the percentage of long-term trainees (≥300 contact hours) who are from a racial/ethnic group that is underrepresented in the MCH workforce. Please use the space provided for notes to detail the data source and year of data used.

- Report on all long-term trainees (≥ 300 contact hours) including MCHB-funded and non MCHB-funded trainees
- Report race and ethnicity separately
- Trainees who select multiple ethnicities should be counted once
- Grantee reported numerators and denominator will be used to calculate percentages

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

Ethnic Categories
Number of long-term trainees who are Hispanic or Latino (Ethnicity) _____

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

Number of long-term trainees who are Asian _____

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

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

Number of long-term trainees who are more than one race _____

Notes/Comments:

Training 07 PERFORMANCE MEASURE **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 from underserved or underrepresented backgrounds, including trainees from racially and ethnically underrepresented groups who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related health professions. **MCH Populations**: Includes women, infants and children, adolescents, young adults, and their families including fathers, and children and youth with special health care needs
BENCHMARK DATA SOURCES	Related to Healthy People 2030: AHS-R01: Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it. AHS-R02: Increase the use to telehealth to improve access to health services. PHI-R02: Expand public health pipeline programs that include service or experiential learning. PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development
GRANTEE DATA SOURCES	A LEAP program follow-up survey will be used to collect these data. Data Sources Related to Training and Work Settings/Populations: Rittenhouse Diane R, George E. Fryer, Robert L. Pillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps Participation. *Ann Fam Med* 2008;6:397-405. DOI: 10.1370/afm.885. Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career

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.
	Choices Regarding Internal Medicine *JAMA*. 2008;300(10):1154-1164 (doi:10.1001/jama.300.10.1154)
SIGNIFICANCE	HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce for MCH.

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

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

NOTE: Each LEAP trainee should be counted once.

2 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

A. The total number of graduates, 2 years following completion of program _____

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

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

D. Number of respondents who report working with an MCH population since graduating from the MCH LEAP Training Program _____

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

5 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

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

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

D. Number of respondents who report working with an MCH population since graduating from the MCH LEAP Training Program _____

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

Training 08 PERFORMANCE MEASURE **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 underserved or have been marginalized.
GOAL	To increase the percent of graduates of MCH Leadership, Education and Advancement in Undergraduate Pathways (LEAP) Programs who have been engaged in work with populations that are underserved or have been marginalized.
MEASURE	The percent of MCH LEAP Program graduates who have been engaged in work with populations that are underserved or have been marginalized since graduating from the MCH LEAP Training Program.
DEFINITION	**Numerator:** Number of LEAP graduates reporting they have been engaged in work with populations that are underserved or have been marginalized since graduating from the MCH LEAP Training Program. **Denominator**: The total number of trainees responding to the survey **Units**: 100 **Text**: Percent MCH LEAP trainees are defined as undergraduate students from underserved or underrepresented backgrounds, including trainees from racially and ethnically underrepresented groups who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related fields. Populations that are underserved or have been marginalized refers to groups of individuals at higher risk for health disparities by virtue of their race or ethnicity, socioeconomic status, geography, gender,age, disability status, or other risk factors including those associated with sex and gender.
BENCHMARK DATA SOURCES	Related to Healthy People 2030: AHS-R01: Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it. AHS-R02: Increase the use of telehealth to improve access to health services. PHI-R02: Expand public health pipeline programs that include service or experiential learning. PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development.
GRANTEE DATA SOURCES	A LEAP program follow-up survey will be used to collect these data. Data Sources Related to Training and Work Settings/Populations: Rittenhouse Diane R, George E. Fryer, Robert L. Pillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health

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 underserved or have been marginalized.
	Service Corps Participation. *Ann Fam Med* 2008;6:397-405. DOI: 10.1370/afm.885. Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career Choices Regarding Internal Medicine *JAMA*. 2008;300(10):1154-1164 (doi:10.1001/jama.300.10.1154)
SIGNIFICANCE	HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce for MCH.

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

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

NOTE: Each LEAP trainee should be counted once.

2 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

A. The total number of graduates, 2 years following completion of program

_____

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

_____

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

_____

D. Number of respondents who have worked with populations that are underserved or have been marginalized since graduating from the MCH LEAP Training Program

_____

E. Percent of respondents who have worked with populations that are underserved or have been marginalized since graduating from the MCH LEAP Training Program

_____

5 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

_____

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

_____

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

_____

D. Number of respondents who have worked with populations that are underserved or have been marginalized since graduating from the MCH LEAP Training Program

_____

E. Percent of respondents who have worked with populations that are underserved or have been marginalized since graduating from the MCH LEAP Training Program

_____

Training 09 PERFORMANCE MEASURE **Goal: Graduate Program Enrollment** **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.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objectives: ECBP-DO9: Increase core clinical prevention and population health education in medical schools. ECBP-D10: Increase core clinical prevention and population health education in nursing schools. ECBP-D11: Increase core clinical prevention and population health education in physician assistant training programs. ECBP-D12: Increase core clinical prevention and population health education in pharmacy schools. ECBP-D13: Increase core clinical prevention and population health education in dental schools. PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development. PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education. PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education. PHI-DO1: Increase the proportion of tribal public health agencies that use core competencies in continuing education
GRANTEE DATA SOURCES	Attached data collection form to be completed by grantees.
SIGNIFICANCE	MCHB training programs assist in developing a public health workforce that addresses key MCH issues and fosters field leadership in the MCH arena. This national performance measure relates directly to MCHB Strategic

Training 09 PERFORMANCE MEASURE **Goal: Graduate Program Enrollment** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of LEAP graduates that enter graduate programs preparing them to work with the MCH population.
	Plan Goal 3: Strengthen public health capacity and workforce for MCH.

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

2 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

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

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

D. Total number of respondents that are enrolled in or have completed graduate programs preparing them work with the MCH population _____

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

Medicine (e.g. Pediatric, Ob/Gyn, Primary Care): _____
Public health: _____
Nutrition: _____
Social work: _____
Nursing: _____
Pediatric dentistry: _____
Psychology: _____
Pediatric occupational/physical therapy: _____
Speech language pathology: _____
Other MCH-related health profession (specify):_____

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

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

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

5 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

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

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

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

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

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

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

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

DATA COLLECTION FORM FOR DETAIL SHEET: Training 10 – Field Leadership

SECTION A: 2 YEAR FOLLOW-UP

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

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

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

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

B. The total number of long-term trainees, **2 years** post program completion, to follow-up _____

C. Number of respondents (A-B) _____

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

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

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

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

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

3. Number of trainees that have participated in **public health practice** leadership activities since completing their MCH Training Program _____

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

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

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

SECTION B: 5 YEAR FOLLOW-UP

Numerator: The number of long-term trainees who have demonstrated field leadership 5 years after completing their MCH Training Program.

Denominator: The total number of long-term trainees, 5 years following completion of an MCHB-funded training program, included in this report.

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

F. The total number of long-term trainees, **5 years** post program completion, included in this report _____

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

H. Number of respondents (A-B) _____

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

J. Percent of long-term trainees, **5 years** post program completion, who have demonstrated field leadership in **at least one** of the following areas: _____

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

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

- Disseminated information on MCH Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)

- Conducted research or quality improvement on MCH issues
- Provided consultation or technical assistance in MCH areas
- Taught/mentored in their discipline or other MCH related field
- Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
- Procured grant and other funding in MCH areas
- Conducted strategic planning or program evaluation

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

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

3. **Number of trainees that have participated in** public health practice **leadership activities** since completing their MCH Training Program _____

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

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

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

NOTES/COMMENTS:

Training 11 PERFORMANCE MEASURE **Goal: Long-term trainees working with MCH populations** **Level: Grantee** **Domain: MCH Workforce Development**	The percentage of long-term trainees who are engaged in work focused on MCH populations after completing their MCH Training Program.
GOAL	To increase the percent of long-term trainees engaged in work focused on MCH populations two and five years after completing their MCH Training Program.
MEASURE	The percentage of long-term trainees who are engaged in work focused on MCH populations after completing their MCH Training Program.
DEFINITION	**Numerator:** Number of long-term trainees reporting they are engaged in work focused on MCH populations after completing their MCH Training Program. **Denominator:** The total number of trainees responding to the survey **Units:** 100 **Text:** Percent Long-term trainees are defined as those who have completed a long-term (greater than or equal to 300 contact hours) MCH Training Program, including those who received MCH funds and those who did not. MCH Populations: Includes all of the Nation's women, infants, children, adolescents, young adults and their families, including and children with special health care needs.
BENCHMARK DATA SOURCES	Related to Healthy People 2030 objectives: PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development. PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education. PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education. PHI-DO1: Increase the proportion of tribal public health agencies that use core competencies in continuing education
GRANTEE DATA SOURCES	A trainee follow-up survey that incorporates the new form for collecting data on the involvement of those completing an MCH training program in work related to MCH populations will be used to collect these data. Data Sources Related to Training and Work Settings/Populations: Rittenhouse Diane R, George E. Fryer, Robert L. Pillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps

Training 11 PERFORMANCE MEASURE **Goal: Long-term trainees working with MCH populations** **Level: Grantee** **Domain: MCH Workforce Development**	The percentage of long-term trainees who are engaged in work focused on MCH populations after completing their MCH Training Program.
	Participation. *Ann Fam Med*2008;6:397-405. DOI: 10.1370/afm.885. Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career Choices Regarding Internal Medicine *JAMA.*2008;300(10):1154-1164 (doi:10.1001/jama.300.10.1154).
SIGNIFICANCE	HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce for MCH.

DATA COLLECTION FORM FOR DETAIL SHEET: Training 11 - Long-term trainees working with MCH populations

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

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

2 YEAR FOLLOW-UP	
A. The total number of long-term trainees, **2 years** following program completion	
B. The total number of long-term trainees lost to follow-up (**2 years** following program completion)	
C. The total number of respondents (A-B) = denominator	
D. Number of respondents **2 years** following completion of program who report working with an MCH population	
E. Percent of respondents **2 years** following completion of program who report working with an MCH population	
5 YEAR FOLLOW-UP	
F. The total number of long-term trainees, **5 years** following program completion	
G. The total number of long-term trainees lost to follow-up (**5 years** following program completion),	
H. The total number of respondents (F-G) = denominator	
I. Number of respondents **5 years** following completion of program who report working with an MCH population	
J. Percent of respondents **5 years** following completion of program who report working with an MCH population	

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

Training 12 PERFORMANCE MEASURE **Goal: Long-term Trainees** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of long-term trainees who, at 2, 5 and 10 years post training, have worked in an interdisciplinary manner to serve the MCH population (e.g., individuals with disabilities and their families, adolescents and their families, etc.).
	MICH-20: Increase the proportion of children and adolescents with special health care needs who have a system of care.
GRANTEE DATA SOURCES	The trainee follow-up survey is used to collect these data.
SIGNIFICANCE	Leadership education is a complex interdisciplinary field that must meet the needs of MCH populations. This measure addresses one of a training program's core values and its unique role to prepare professionals for comprehensive systems of care/practice. By providing interdisciplinary coordinated care, training programs help to ensure that all MCH populations receive the most comprehensive care that takes into account the complete and unique needs of the individuals and their families. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce for MCH.

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

A. 2 YEAR FOLLOW-UP

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

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

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

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

Number of respondents (Denominator) _____

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

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

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

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

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

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

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

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

Collaborated with various disciplines across agencies/entities? _____%

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

B. 5 YEAR FOLLOW-UP

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

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

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

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

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

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

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

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

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

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

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

Collaborated with various disciplines across agencies/entities? _____%

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

C. 10 YEAR FOLLOW-UP

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

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

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

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

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

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

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

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

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

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

Collaborated with various disciplines across agencies/entities? _____%

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

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

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

Level I Medium-Term Trainees - Knowledge

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

Level II Medium-Term Trainees – Knowledge:

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

Level II Medium-Term Trainees - Skills :

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

Training 15 PERFORMANCE MEASURE **Goal: Consultation and Training for Mental and Behavioral Health** **Level: Grantee** **Domain: MCH Workforce Development**	
GOAL	Increase the availability and accessibility of consultation services to providers caring for individuals with behavioral or mental health conditions.
MEASURE	Number of providers participating in consultation and care coordination support services.
DEFINITION	Total number of providers participating in consultation (teleconsultation and in-person) and care coordination support services provided by the Pediatric Mental Health Care Access (PMHCA) program and the Screening for Maternal Depression and Related Behavioral Disorders (MDRBD) program.
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	PMHCA and MDRBD awardees report using the data collection form.
SIGNIFICANCE	Mental and behavioral health issues are prevalent among children and adolescents, and pregnant and postpartum women in the United States. However, due to shortages in the number of psychiatrists, developmental-behavioral providers, and other behavioral health clinicians, access to mental and behavioral health services is lacking. Research indicates that telehealth can improve access to care, reduce health care costs, improve health outcomes, and address workforce shortages in underserved areas. Telehealth strategies that connect primary care providers with specialty mental and behavioral health care providers can be an effective means of increasing access to mental and behavioral health services for children and pregnant and postpartum women, especially those living in rural and other underserved areas.

Training 15 Data Collection Form

A. Provider Consultation and Training

1. Consultation:

i. Number and types of providers enrolled for and participating in program consultation (teleconsultation or in-person) and care coordination support services[4].

Provider Type		**Number enrolled (if applicable)[1]**	**Number participating[2]**	**Number enrolled AND participating (if applicable)[3]**
Primary Care Providers (non-specialty)	Pediatrician			
	Family Medicine			
	OB/GYN			
	Internal Medicine			
	Advanced Practice Nurse/Nurse Practitioner			
	Certified Nurse Midwife			
	Physician Assistant			
Others	Psychiatrist			
	Developmental-Behavioral Pediatrician			
	Nurse			
	Behavioral Health Clinician (e.g. psychologist, therapist, counselor)			
	Care Coordinator/ Patient Navigator			
	Other Specialist Physician, APN/NP, PA (specify type):			
	Other (specify type):			
Unknown Provider type				
Total (will auto-populate)				
Total Primary Care (will auto-populate)				

[1] 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.

[2] 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.

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

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

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

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

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

b. Number of **consultations and referrals**[5] given to providers.

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

c. Please indicate the condition(s) about which providers contacted the program for consultation (teleconsultation or in-person) or care coordination support services. Select all conditions that apply. Specify the number of contacts for each condition. Each contact can involve more than one condition[6].

- ☐ 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

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

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

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

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

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

2. Training:

i. Number and types of providers trained.

Provider Type		**Number Trained**
Primary Care Providers (non-specialty)	Pediatrician	
	Family Medicine	
	OB/GYN	
	Internal Medicine	
	Advanced Practice Nurse/Nurse Practitioner	
	Certified Nurse Midwife	
	Physician Assistant	

Others	Psychiatrist	
	Developmental-Behavioral Pediatrician	
	Nurse	
	Behavioral Health Clinician (e.g. psychologist, therapist, counselor)	
	Care Coordinator/ Patient Navigator	
	Other Specialist Physician, APN/NP, PA (specify type):	
	Other (specify type):	
Unknown Provider type		
Total Primary Care (will auto-populate)		
Total (will auto-populate)		

ii. Total number of trainings held ____

a. Topics covered by trainings and number of trainings per topic. Select all that apply:

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

 Medication-focused trainings
Number of trainings covering topic _____

 Screening and assessment/testing-focused trainings
Number of trainings covering topic _____

 Treatment modality-focused trainings
Number of trainings covering topic _____

 Trauma focused trainings
Number of trainings covering topic _____

 Parent and family-focused trainings
Number of trainings covering topic _____

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

 COVID-19-focused trainings
Number of trainings covering topic _____

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

b. Training mechanisms used. Select all that apply:

 In-person
Number of trainings using this mechanism _____

 Project ECHO® (distance learning cohort)
Number of trainings using this mechanism _____

 ECHO-like (distance learning cohort)
Number of trainings using this mechanism _____

 Web-based
Number of trainings using this mechanism _____

 Other (please specify)
Number of trainings using this mechanism _____

B. Individuals Served

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

	Total	Rural/underserved[7]
Children 0-11		
Adolescents 12-21		
Women (pregnant or postpartum)		

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

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

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

	Numerator[8]	Denominator[9]	% (auto-populated)
Children 0-11 screened for behavioral or mental health condition			
Adolescents 12-21 screened for behavioral or mental health condition			
Women (pregnant or postpartum) screened for behavioral or mental health condition			
Women (pregnant or postpartum) screened for depression			

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

[8] **For PMHCA:** Number of children and adolescents, 0-21 years of age, for whom a provider contacted the mental health team for consultation or referral, who received at least one screening for a behavioral health condition using a standardized validated tool.
For MDRBD: Number of pregnant and postpartum women (PPW) for whom a provider contacted the program for consultation or referral during the reporting period, who received at least one screening for [depression, anxiety, or substance use] using a standardized validated tool.

[9] **For PMHCA**: Number of children and adolescents, 0-21 years of age, for whom a provider contacted the mental health team for consultation or referral.
For MDRBD: Number of pregnant and postpartum women (PPW) for whom a provider contacted the program for consultation or referral during the reporting period.

Women (pregnant or postpartum) screened for anxiety			
Women (pregnant or postpartum) screened for substance use			

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

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

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

EMSC 01 PERFORMANCE MEASURE **Goal: Submission of NEMSIS compliant version 3.x or higher data** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The degree to which Emergency Medical Services (EMS) agencies submit National Emergency Medical Services Information System (NEMSIS) compliant version 3.x or higher data to the State EMS Office.
	advancing evidence-based and promising practices to achieve health equity.
GRANTEE DATA SOURCES	State EMS Offices
SIGNIFICANCE	Access to quality data and effective data management play an important role in improving the performance of an organization's health care systems. Collecting, analyzing, interpreting, and acting on data for specific performance measures allows health care professionals to identify where systems are falling short, to make corrective adjustments, and to track outcomes. However, uniform data collection is needed to consistently evaluate systems and develop Quality Improvement programs. The NEMSIS operated by the National Highway Traffic Safety Administration, provides a basic platform for states and territories to collect and report patient care data in a uniform manner. NEMSIS enables both state and national EMS systems to evaluate their current prehospital delivery of care and put in place effective, evidenced-based Quality Improvement (QI) efforts in pediatric emergency medical and trauma care. NEMSIS version 3.X or higher is available today and in use in several states.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 01

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

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

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

Proposed Survey Questions:

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

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

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

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

EMSC 02 PERFORMANCE MEASURE **Goal: Pediatric Emergency Care Coordination Level: Grantee** **Domain: Emergency Medical Services for Children**	The percentage of EMS agencies in the state/territory that have a designated individual who coordinates pediatric emergency care.

SIGNIFICANCE

The Institute of Medicine (IOM) report[10] "Emergency Care for Children: Growing Pains" (2007) recommends that EMS agencies and emergency departments (EDs) appoint a pediatric emergency care coordinator to provide pediatric leadership for the organization. This individual need not be dedicated solely to this role and could be personnel already in place with a special interest in children who assumes this role as part of their existing duties.

Gausche-Hill et al in a national study[11] of EDs found that the presence of a physician or nurse pediatric emergency care coordinator was associated with an ED being more prepared to care for children. EDs with a coordinator were more likely to report having important policies in place and a quality improvement plan that addressed the needs of children than EDs that reported not having a coordinator.

The IOM report further states that pediatric coordinators are necessary to advocate for improved competencies and the availability of resources for pediatric patients. The presence of an individual who coordinates pediatric emergency care at EMS agencies may result in ensuring that the agency and its providers are more prepared to care for ill and injured children.

The individual designated as the Pediatric Emergency Care Coordinator (PECC) may be a member of the EMS agency or that individual could serve as the PECC for one of more individual EMS agencies within the county or region.

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

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

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 02

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

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

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

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

Proposed Survey Questions:

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

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

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

A DESIGNATED INDIVIDUAL who coordinates pediatric emergency care need not be dedicated solely to this role; it can be an individual already in place who assumes this role as part of their existing duties. The individual may be located at your agency, county or region.

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

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

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

Is this individual:

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

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

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

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

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

Promote pediatric continuing education opportunities

- ☐ Yes
- ☐ No

Oversee pediatric process improvement

- ☐ Yes
- ☐ No

Ensure the availability of pediatric medications, equipment, and supplies

- ☐ Yes
- ☐ No

Promote agency participation in pediatric prevention programs

- ☐ Yes
- ☐ No

Liaise with the emergency department pediatric emergency care coordinator

- ☐ Yes
- ☐ No

Promote family-centered care at the agency

- ☐ Yes
- ☐ No

Promote agency participation in pediatric research efforts

- ☐ Yes
- ☐ No

Other

- ☐ Yes
- ☐ No

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

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

EMSC 03 PERFORMANCE MEASURE **Goal: Use of pediatric-specific equipment** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The percentage of EMS agencies in the state/territory that have a process or plan that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.
GOAL	To increase the percent of EMS agencies that have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.
MEASURE	The percentage of EMS agencies in the state/territory that have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.
DEFINITION	**Numerator:** The number of EMS agencies in the state/territory that score a '6' or more on a 0-12 scale. **Denominator:** Total number of EMS agencies in the state/territory that provided data. **Units:** 100 **Text:** Percent **EMS:** Emergency Medical Services **EMS Agency:** An EMS agency is defined as an organization staffed with personnel who render medical care in response to a 911 or similar emergency call. Data will be gathered from both transporting and non-transporting agencies. **EMS Providers:** EMS providers are defined as people/persons who are certified or licensed to provide emergency medical services during a 911 or similar emergency call. There are four EMS personnel licensure levels: Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), and Paramedic. Reference the National Highway Traffic Safety Administration (NHTSA) National EMS Scope of Practice Model http://www.ems.gov/education/EMSScope.pdf
HRSA STRATEGIC OBJECTIVE	**Goal I**: Improve Access to Quality Health Care and Services (by improving quality) or; **Goal II**: Strengthen the Health Workforce
GRANTEE DATA SOURCES	Survey of EMS agencies
SIGNIFICANCE	The Institute of Medicine (IOM) report "Emergency Care for Children: Growing Pains" reports that because EMS providers rarely treat seriously ill or injured pediatric patients, providers may be unable to maintain the necessary skill level to care for these patients. Continuing education such as the Pediatric Advance Life Support (PALS) and Pediatric Education for Prehospital

EMSC 03 PERFORMANCE MEASURE **Goal: Use of pediatric-specific equipment** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The percentage of EMS agencies in the state/territory that have a process or plan that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.

Professionals (PEPP) courses are vitally important for maintaining skills and are considered an effective remedy for skill atrophy. These courses are typically only required every two years. More frequent practice of skills using different methods of skill ascertainment are necessary for EMS providers to ensure their readiness to care for pediatric patients when faced with these infrequent encounters.

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

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 03

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

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

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

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

Proposed Survey Questions:

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

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

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

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

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

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

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

- ☐ Yes
- ☐ No

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

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

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

- ☐ Yes
- ☐ No

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

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

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

- ☐ Yes
- ☐ No

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

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

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

EMSC 04 PERFORMANCE MEASURE **Goal: Emergency Department Preparedness** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric medical emergencies.
GOAL	To increase the percent of hospitals that are recognized as part of a statewide, territorial, or regional standardized program that are able to stabilize and/or manage pediatric medical emergencies.
MEASURE	The percent of hospitals recognized through a statewide, territorial or regional program that are able to stabilize and/or manage pediatric medical emergencies.
DEFINITION	**Numerator:** Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric medical emergencies. **Denominator:** Total number of hospitals with an ED in the State/Territory. **Units**: 100 **Text**: Percent **Standardized system:** A system of care provides a framework for collaboration across agencies, health care organizations/services, families, and youths for the purposes of improving access and expanding coordinated culturally and linguistically competent care for children and youth. The system is coordinated, accountable and includes a facility recognition program for pediatric medical emergencies. Recognizing the pediatric emergency care capabilities of hospitals supports the development of a system of care that is responsive to the needs of children and extends access to specialty resources when needed. **Hospital:** Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department. Excludes Military and Indian Health Service hospitals.
EMSC STRATEGIC OBJECTIVE	Ensure the operational capacity and infrastructure to provide pediatric emergency care. Develop a statewide, territorial, or regional program that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies.
GRANTEE DATA SOURCES	This performance measure will require grantees to determine how many hospitals participate in their facility recognition program (if the state has a facility recognition program) for medical emergencies.

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

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 04

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

Numerator:	
Denominator:	
Percent	

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

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

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

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

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

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

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

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

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

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

EMSC 05 PERFORMANCE MEASURE **Goal: Standardized System for Pediatric Trauma** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The percent of hospitals with an Emergency Department (ED) recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric trauma.
SIGNIFICANCE	A standardized recognition and/or designation program, based on compliance with the current published pediatric emergency/trauma care guidelines, contributes to the development of an organized system of emergency medical services to deliver quality pediatric emergency/trauma and specialty care. This measure addresses the development of a pediatric trauma recognition program. Recognition programs are based upon State-defined criteria and/or adoption of national current published pediatric emergency and trauma care consensus guidelines that address administration and coordination of pediatric care; the qualifications of physicians, nurses and other ED staff; a formal pediatric quality improvement or monitoring program; patient safety; policies, procedures, and protocols; and the availability of pediatric equipment, supplies and medications. Additionally, EMSC 05 does not require that the recognition trauma program be mandated. Voluntary facility recognition is accepted. However, the preferred status is to have a program that is monitored by the State/Territory.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 05

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

Numerator:	
Denominator:	
Percent	

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

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

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

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

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

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

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

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

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

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

EMSC 06 PERFORMANCE MEASURE **Goal: Inter-facility transfer guidelines** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and that contain all the components as per the implementation manual.
GOAL	To increase the percent of hospitals in the State/Territory have written inter-facility transfer guidelines for children that include specific components of pediatric transfer.
MEASURE	The percentage of hospitals in the State/Territory that have written inter-facility transfer guidelines for children that include specific components of pediatric transfer. • Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication). • Process for selecting the appropriate care facility. • Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.). • Process for patient transfer (including obtaining informed consent). • Plan for transfer of patient medical record • Plan for transfer of copy of signed transport consent • Plan for transfer of personal belongings of the patient • Plan for provision of directions and referral institution information to family
DEFINITION	**Numerator**: Number of hospitals with an ED that have written inter-facility transfer guidelines for children that include specific components of pediatric transfer. **Denominator**: Total number of hospitals with an ED that provided data. **Units**: 100 **Text**: Percent **Pediatric**: Any person 0 to 18 years of age. **Inter-facility transfer guidelines**: Hospital-to-hospital, including out of State/Territory, guidelines that outline procedural and administrative policies for transferring critically ill patients to facilities that provide specialized pediatric care, or pediatric services not available at the referring facility. Grantees should consult the EMSC Program representative if they have questions regarding guideline inclusion of pediatric patients. Inter-facility guidelines do not have to specify transfers of pediatric

EMSC 06 PERFORMANCE MEASURE **Goal: Inter-facility transfer guidelines** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and that contain all the components as per the implementation manual.
	patients only. A guideline that applies to all patients or patients of all ages would suffice, as long as it is not written only for adults. In addition, hospitals may have one document that comprises both the inter-facility transfer guideline and agreement. This is acceptable as long as the document meets the definitions for pediatric inter-facility transfer guidelines and agreements (i.e., the document contains all components of transfer). All hospitals in the State/Territory should have guidelines to transfer to a facility capable of providing pediatric services not available at the referring facility. If a facility cannot provide a particular type of care (e.g., burn care), then it also should have transfer guidelines in place. Consult the NRC to ensure that the facility (facilities) providing the highest level of care in the state/territory is capable of definitive care for all pediatric needs. Also, note that being in compliance with EMTALA does not constitute having inter-facility transfer guidelines. **Hospital**: Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department (ED). Excludes Military and Indian Health Service hospitals.
EMSC STRATEGIC OBJECTIVE	Ensure the operational capacity and infrastructure to provide pediatric emergency care. Develop written pediatric inter-facility transfer guidelines for hospitals.
GRANTEE DATA SOURCE(S)	• Surveys of hospitals with an emergency department. • Hospital licensure rules and regulations.
SIGNIFICANCE	In order to assure that children receive optimal care, timely transfer to a specialty care center is essential. Such transfers are better coordinated through the presence of inter-facility transfer agreements and guidelines.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 06

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

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

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

NUMERATOR:_____

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

DENOMINATOR:_____

Total number of hospitals with an ED that provided data.

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

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 07

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

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

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

DENOMINATOR:_____
Total number of hospitals with an ED that provided data.

EMSC 08 PERFORMANCE MEASURE **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 meets at least four times a year. • Pediatric representation incorporated on the State/Territory EMS Board. • The State/Territory require pediatric representation on the EMS Board. • One full time EMSC Manager is dedicated solely to the EMSC Program. **EMSC:** The component of emergency medical care that addresses the infant, child, and adolescent needs, and the Program that strives to ensure the establishment and permanence of that component. EMSC includes emergent at the scene care as well as care received in the emergency department, surgical care, intensive care, long-term care, and rehabilitative care. EMSC extends far beyond these areas yet for the purposes of this manual this will be the extent currently being sought and reviewed. **EMS system:** The continuum of patient care from prevention to rehabilitation, including pre-hospital, dispatch communications, out-of-hospital, hospital, primary care, emergency care, inpatient, and medical home. It encompasses every injury and illness.
EMSC STRATEGIC OBJECTIVE	• Establish permanence of EMSC in each State/Territory EMS system. • Establish an EMSC Advisory Committee within each State/Territory • Incorporate pediatric representation on the State/Territory EMS Board

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.
	• 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 DETAIL SHEET: EMSC 08

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

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

Yes = 1
No = 0

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

EMSC 09 PERFORMANCE MEASURE **Goal: Integration of EMSC priorities** **Level: Grantee** **Domain: Emergency Medical Services for Children**	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.
GOAL	To increase the integration of EMSC priorities into existing EMS or hospital/healthcare facility statutes/regulations.
MEASURE	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system by integrating EMSC priorities into statutes/regulations.

DEFINITION	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:
	
	• EMS agencies are required to submit NEMSIS compliant data to the State EMS Office.
	• EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care.
	• EMS agencies in the state/territory have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.
	• The existence of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage
	  • pediatric medical emergencies
	  • trauma
	• Hospitals in the State/Territory have written inter-facility transfer guidelines that cover pediatric patients and that include the following components of transfer:
	  • Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication).
	  • Process for selecting the appropriate care facility.
	  • Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.).
	  • Process for patient transfer (including obtaining informed consent).
	  • Plan for transfer of patient medical record
	  • Plan for transfer of copy of signed transport consent
	  • Plan for transfer of personal belongings of the patient
	  • Plan for provision of directions and referral institution information to family
	• Hospitals in the State/Territory have written inter-facility transfer agreements that cover pediatric patients.

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.
	• 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.
EMSC STRATEGIC OBJECTIVE	Establish permanence of EMSC in each State/Territory EMS system.
GRANTEE DATA SOURCES	Attached data collection form to be completed by grantee.
SIGNIFICANCE	For the EMSC Program to be sustained in the long-term and reach permanence, it is important for the Program's priorities to be integrated into existing State/Territory mandates. Integration of the EMSC priorities into mandates will help ensure pediatric emergency care issues and/or deficiencies are being addressed State/Territory-wide for the long-term.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 09

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

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

Yes = 1
No = 0

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

DIVISION OF HEALTHY START AND PERINATAL SERVICES
PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

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

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

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

HS 02 PERFORMANCE MEASURE **Goal: Usual Source of Care** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start women and child participants that have a usual source of care.[3]
GOAL	To increase the percent of Healthy Start women and child participants who have a usual source of care to 80%.
MEASURE	The percent of Healthy Start women and child participants that have a usual source of care.
DEFINITION	**a.** **Numerator**: Total number of Healthy Start (HS) women participants that report having a usual source of care as of the last assessment in the reporting period. **Denominator**: Total number of women HS participants in the reporting period. **b.** **Numerator:** Total number of Healthy Start (HS) child participants whose parent/ caregiver reports that they have a usual source of care as of the last assessment in the reporting period. **Denominator:** Total number of child HS participants in the reporting period. A participant is considered to have a usual source of care and included in the numerator if the participant identifies a regular place where they can go for routine and sick care other than an emergency room. A participant receiving regular prenatal care from a prenatal provider is considered to have a usual source of care.
BENCHMARK DATA SOURCES	National Survey of Children's Health (Children 0-5 with a Usual Source of Care 75.2%, 2019); National Health Interview Survey (Children 0-4 with a Usual Source of Care: 97.6%, 2019; National Health Interview Survey (Women aged 18 and over with a Usual Place of Care, 89.3%, 2018)
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Having a usual source of medical care has been shown to improve care quality as well as access to and receipt of preventative services.[4] [5] Further, patients having a usual source of care reduce overall costs to patients, employers, and health plans by reducing emergency department visits, hospital readmissions, and inpatient visits.[6]

[3] Consistent with Healthy Start Benchmark 4.
[4] Blewett LA, Johnson PJ, Lee B, Scal PB. When a usual source of care and usual provider matter: adult prevention and screening services. J Gen Intern Med. September 2008 [Epub Ahead of Print May 28, 2008];23(9):1354-60.
[5] DeVoe JE, Tillotson CJ, Wallace LS, Lesko SE, Pandhi. Is health insurance enough? A usual source of care may be more important to ensure a child receives preventive health counseling. Matern Child Health J. Feb 2012; 16(2):306-15.
[6] https://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home

HS 03 PERFORMANCE MEASURE **Goal: Interconception Planning** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start women participants who conceive within 18 months of a previous birth.[7]
GOAL	To reduce the proportion of Healthy Start women participants who conceive within 18 months of a previous birth to 30%.
MEASURE	The percent of Healthy Start women participants who conceive within 18 months of a previous birth.
DEFINITION	**Numerator**: Number of Healthy Start (HS) women participants whose current pregnancy during the reporting period was conceived within 18 months of the previous birth. **Denominator:** Total number of HS women participants enrolled before the current pregnancy in the reporting period who had a prior pregnancy that ended in a live birth. The interval between the most recent pregnancy and previous birth is derived from the delivery date of the birth and the date of conception for the most recent pregnancy.
BENCHMARK DATA SOURCES	CDC National Survey of Family Growth, Healthy People 2030 Family Planning Goal 2; Vital Statistics[8]
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Family planning is important to ensure spacing pregnancies at least 18 months apart to reduce health risks for both mother and baby. Pregnancy within 18 months of giving birth is associated with increased risk for the baby including low birth weight, small size for gestational age, and preterm birth. Additionally, the mother needs time to fully recover from the previous birth.[9]

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

HS 04 PERFORMANCE MEASURE **Goal: Intimate Partner Violence Screening** **Level: Grantee** **Domain: Healthy Start**	The percent of HS women participants who receive intimate partner violence screening.[10]
GOAL	To increase proportion of Healthy Start women participants who receive intimate partner violence (IPV) screening to 100%.
MEASURE	The percent of Healthy Start women participants who receive intimate partner violence screening.
DEFINITION	**Numerator:** Number of Healthy Start (HS) women participants who received intimate partner violence screening using a standardized screening tool during the reporting period. **Denominator:** Total number of HS women participants in the reporting period. A participant is considered to have been screened and included in the denominator if a standardized screening tool which is appropriately validated for her circumstances is used. A number of screening tools have been validated for IPV screening. Intimate Partner Violence is a pattern of assaultive behavior and coercive behavior that may include physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and reproductive coercion. These behaviors are committed by someone who is, was, or wishes to be involved in an intimate relationship with the participant.[11]
BENCHMARK DATA SOURCES	PRAMS
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Intimate Partner Violence is a substantial yet preventable public health problem that affects women across the world. Research shows that intimate partner violence screening differs among health care specialties and is overall relatively low. The U.S. Department of Health and Human Services recommends that IPV screening and counseling to be a core part of a women's well visit.[12]

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

HS 05 PERFORMANCE MEASURE **Goal: Father/ Partner Involvement during pregnancy** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy.[13]
GOAL	To increase proportion of Healthy Start women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes) to 90%.
MEASURE	The percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy.
DEFINITION	**Numerator:** Number of Healthy Start (HS) prenatal participants who report supportive father and/or partner involvement (e.g., attend appointments, classes) in the reporting period. **Denominator:** Total number HS prenatal participants in the reporting period. A participant is considered to have support and included in the numerator if she self- reports a partner who has a significant and positive role in the participant's pregnancy. Involvement during pregnancy may include, but is not limited to: • Partnership; social/ emotional support • Attending prenatal appointments • Attending prenatal classes • Assisting in preparing the home for the baby (e.g., putting together a crib) • Providing economic support
BENCHMARK DATA SOURCES	Child Trend Research Brief, CDC National Health Statistics Report
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Research suggests that paternal involvement has been recognized to have an impact on both pregnancy and infant outcomes. Father involvement during pregnancy has shown to reduce negative maternal health behaviors, risk of preterm birth, low birth weight, fetal growth restrictions, and neonatal death rate[14,15].

[13] Consistent with Healthy Start Benchmark 14.
[14] Kortsmit K, Garfield C, Smith RA, Boulet S, Simon C, Pazol K, Kapaya M, Harrison L, Barfield W, Werner L. Public Health Reports. Paternal Involvement and Maternal Perinatal Behaviors: Pregnancy Risk Assessment Monitoring System, 2012-2015. 2020;135(2):253-261.
[15] Alio AA, Mbah AK, Kornosky JL, Wathington D, Marty PH, Salihu HM. Assessing the impact of paternal involvement on racial/ethnic disparities in infant mortality rates. J Community Health. 2011 Feb;36(1):63-8.

HS 06 PERFORMANCE MEASURE **Goal: Father and/or Partner Involvement with child <24 Months** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start women participants that demonstrate father and/or partner involvement with child<24 months.[16]
GOAL	To increase proportion of HS women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) with child <24 months to 80%.
MEASURE	The percent of Healthy Start women participants that demonstrate father and/or partner involvement with child <24 months.
DEFINITION	**Numerator:** Number of Healthy Start (HS) child participants whose mother reports supportive father and/or partner involvement (e.g., attend appointments, classes, child care, etc.) during the reporting period. **Denominator:** Total number of Healthy Start women participants with a child participant <24 months. A participant is considered to have support and included in the numerator if she self- reports a partner who has a significant and positive role for the child. Involvement includes, but is not limited to:[17] • Engagement or direct interaction with the child, including taking care of, playing with, or teaching the child • Accessibility or availability, which includes monitoring behavior from the next room or nearby and allowing direct interaction if necessary • Responsibility for the care of the child, which includes making plans and arrangements for care • Economic support or breadwinning • Attending postpartum and well child visits • Other meaningful support
BENCHMARK DATA SOURCES	None
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Research suggests that paternal involvement has been recognized to have an impact on both pregnancy and infant outcomes

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

HS 07 PERFORMANCE MEASURE **Goal: Daily Reading** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start child participants age 6 through 23 months who are read to by a family member 3 or more times per week, on average.[18]
GOAL	To increase the proportion of Healthy Start child participants age 6 through 23 months who are read to 3 or more times per week to 50%.
MEASURE	The percent of Healthy Start child participants age 6 through 23 months who are read to by a family member 3 or more times per week, on average.
DEFINITION	**Numerator:** Number of Healthy Start children participants whose parent/ caregiver reports that they were read to by a family member on 3 or more days during the past week during the reporting period. **Denominator:** Total number of Healthy Start child participants 6 through 23 months of age during the reporting period. Reading by a family member may include reading books, picture books, or telling stories.
BENCHMARK DATA SOURCES	National Survey of Children's Health
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Reading to a child teaches them about communication, introduces concepts such as numbers, letters, colors, and shapes, builds listening, memory, and vocabulary skills, and gives them information about the world around them.[19] The American Academy of Pediatrics (AAP) promotes reading aloud as a daily fun family activity to promote early literacy development as an important evidence-based intervention beginning in infancy and continuing at least until the age of school entry.[20]

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

HS 08 PERFORMANCE MEASURE **Goal: CAN implementation** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN).[21]
GOAL	To increase the proportion of HS grantees with a fully implemented Community Action Network (CAN) to 100%.
MEASURE	The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN).
DEFINITION	**Two benchmarks are calculated to capture Community Action Network (CAN) implementation and progress towards achieving collective impact:** **Numerator**: Number of related CAN measure components implemented by the CAN in which the Healthy Start grantee participates. **Denominator**: 3 (representing total of CAN components) This is a scaled measure which reports progress towards full implementation of a CAN. A "yes" answer is scored 1 point; a "no" answer receives no point. To meet the standard of "fully implemented" for this measure, the HS grantee must answer "yes" to all three core elements listed below: 1. Does your CAN have regularly scheduled meetings? (Regular scheduled is minimally defined as every quarter during the reporting period). This can be documented by using sign in sheets. Yes = 1 No = 0 2. Does your CAN have members from three or more community sectors? (e.g., individuals with lived experience, Healthy Start consumer, faith based, hospital, school setting, community based organizations, government, business, medical provider(s), child care provider(s)). Yes = 1 No = 0 3. Does your CAN have a twelve month work plan? This work plan should outline the CAN's goals, objectives, activities, entities responsible for completing, and timelines. Yes = 1 No = 0 --- **Numerator**: Number of related Collective Impact (CI) measure components implemented by the CAN in which the Healthy Start grantee participates. **Denominator**: 10 (representing total points for 5 CI measure components) 1. Does your CAN have a common agenda developed? All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions. This can be documented by using a theory of change, logic model, work plan template that captures this information, and/or a charter. Yes = 2 In Process = 1 Not started = 0

[21] Consistent with Healthy Start Benchmark 17.

HS 08 PERFORMANCE MEASURE **Goal: CAN implementation** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN).[21]

2. Does your CAN have Shared Measurement Systems? The CAN has identified a common set of indicators that tracks progress/action related to the common agenda, collects data across partners, presents data on a consistent basis, and uses data to make informed decisions and to hold each other accountable.

Yes = 2 In Process = 1 Not started = 0

3. Does your CAN engage in Mutually Reinforcing Activities? Participant activities are differentiated while still being coordinated through a mutually reinforcing plan of action. This plan of action can be included on the work plan noted above and should include at least two to three activities, a description of how it is believed that the activities will impact the common agenda, how the activities will be measured, who/what organization will take the lead, and the timeline for implementation.

Yes = 2 In Process = 1 Not started = 0

4. Does your CAN have Continuous Communication? Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and appreciate common motivation. A communication plan agreed upon by stakeholders should be included as a part of the work plan noted above.

Yes = 2 In Process = 1 Not started = 0

5. Does your CAN have a backbone infrastructure in place? Creating and managing collective impact requires a dedicated staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies. Documentation is shared with CAN members describing roles and responsibilities, and skills required for staff of the entity(ies) supporting the backbone infrastructure.

Yes = 2 In Process = 1 Not started = 0

BENCHMARK DATA SOURCES	None
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	A Community Action Network, or CAN, is an existing, formally organized partnership of organizations and individuals. The CAN represents consumers and appropriate agencies which unite in an effort to collectively apply their resources to the implementation of one or more commons strategies to achieve a common goal within that project area.

HS 9 PERFORMANCE MEASURE **Goal: CAN participation** **Level: Grantee** **Domain: Healthy Start**	The percent of Healthy Start grantees with at least 25% community members and Healthy Start program participants serving as members of their CAN.[22]
GOAL	To increase the proportion of Healthy Start grantees with at least 25% community members and Healthy Start program participants serving as members of their CAN to 100%.
MEASURE	The percent of Healthy Start grantees with at least 25% community members and Healthy Start program participants serving as members of their CAN.
DEFINITION	**Numerator:** Number of community members and Healthy Start (HS) program participants serving as members of the CAN. **Denominator:** Total number of individual members serving on the CAN. **Community Member:** an individual who has lived experience that is representative of the project's Healthy Start target population. Community members may include former Healthy Start participants, fathers and/or partners of Healthy Start participants, males and family members. **Program Participant:** an individual having direct contact with Healthy Start staff or subcontractors and receiving Healthy Start services on an ongoing systematic basis to improve perinatal and infant health. Specifically, program participants are pregnant women and women of reproductive age and children up to age 2. A Community Action Network, or CAN, is an existing, formally organized partnership of organizations and individuals. The CAN represents consumers and appropriate agencies which unite in an effort to collectively apply their resources to the implementation of one or more commons strategies to achieve a common goal within that project area.
BENCHMARK DATA SOURCES	
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Consumer involvement in setting the community agenda and informing efforts to effectively meet the community's needs is critical to the effectiveness of the CAN.

[22] Consistent with Healthy Start Benchmark 18.

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DIVISION OF SERVICES FOR CHILDREN WITH SPECIAL HEALTH NEEDS

Family to Family Health Information Center Program

PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

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

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

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DATA COLLECTION FORM FOR DETAIL SHEET #F2F 1

A. PROVIDING INFORMATION, EDUCATION, AND/OR TRAINING

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

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

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

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

Ethnicity
1. Hispanic
2. Non-Hispanic

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

2. The types of services provided to families.

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

b. Of the total numbers of service/trainings, how many provided:
1. Individualized assistance (Includes one-on-one instruction, consultation, counseling, case management, and mentoring) _____
2. Basic contact information and referrals _____
3. Group training opportunities _____
4. Meetings/Conferences and Public Events (includes outreach events and presentations) _____

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

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

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

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

5. Our organization conducted communication and outreach to families and other appropriate entities through a variety of methods.

a. Select the modes of how print/media information and resources are disseminated. (Select all that apply).

- ☐ Electronic newsletters and listservs
- ☐ Hardcopy/print
- ☐ Public television/radio
- ☐ Social media platform description: _____
- ☐ Text messaging

B. MODELS OF FAMILY ENGAGEMENT COLLABORATION

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

a. Total number of State-wide agencies/programs 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 (for example, American Academy of Pediatric chapter)	

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

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

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

3. Number of staff who work on Family-to-Family HIC activities_____
4. Number of near/full-time (30+ hours/week) F2F staff who are family/have a disability _____
5. Number of part-time F2F staff who are family/have a disability _____

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Health Resources and Services Administration
Maternal and Child Health Bureau

Discretionary Grant Performance Measures

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Attachment D:
Additional Data Elements

OMB Clearance Package

Table of Contents

Attachment D:
Additional Data Elements

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TECHNICAL ASSISTANCE/COLLABORATION FORM

DEFINITION: Technical Assistance/Collaboration refers to mutual problem solving and collaboration on a range of issues, which may include program development, clinical services, collaboration, program evaluation, needs assessment, and policy & guidelines formulation. It may include administrative services, site visitation and review/advisory functions. Collaborative partners might include State or local health agencies, and education or social service agencies. Faculty may serve on advisory boards to develop &/or review policies at the local, State, regional, national or international levels. The technical assistance (TA) effort may be a one-time or on-going activity of brief or extended frequency. The intent of the measure is to illustrate the reach of the training program beyond trainees.

TA recipients are counted as the number of individual recipients engaged in each TA or collaborative activity. For example, if your organization provides TA to five (5) individuals within a Title V agency, the number of TA recipients is 5.

Provide the following summary information on **ALL** TA provided.

Total Number of Technical Assistance/ Collaboration Activities	**Total Number of TA Recipients**	**TA Activities by Type of Recipient**	**Number of TA Activities by Target Audience**
_____	_____	☐ Other Divisions/ Departments in a University ☐ Title V (MCH Programs) ☐ State Health Dept. ☐ Health Insurance/ Organization ☐ Education ☐ Medicaid agency ☐ Social Service Agency ☐ Mental Health Agency ☐ Juvenile Justice or other Legal Entity ☐ State Adolescent Health ☐ Developmental Disability Agency ☐ Early Intervention ☐ Other Govt. Agencies ☐ Mixed Agencies ☐ Professional Organizations/Associations ☐ Family and/or Consumer Group ☐ Foundations ☐ Clinical Programs/ Hospitals ☐ Other: Please Specify_____	_____ Local _____ Title V _____ Within State _____ Another State _____ Regional _____ National _____ International _____

B. Provide information below on the **5-10 most significant** technical assistance/ collaborative activities in the past year. In the notes, briefly state why these were the most significant TA events.

Title		**Topic of Technical Assistance/Collaboration** *Select one from list A and all that apply from List B.*		**Recipient of TA/ Collaborator**	**Intensity of TA**	**Primary Target Audience**
		List A (select one) A. Clinical care related (including medical home) B. Cultural Responsiveness Related C. Data, Research, Evaluation Methods (Knowledge Translation) D. Family Involvement E. Interdisciplinary Teaming F. Healthcare Workforce Leadership G. Policy H. Prevention I. Systems Development/ Improvement	List B (select all that apply) 1. CSHCN/ Developmental Disabilities 2. Autism 3. Prenatal Care 4. Perinatal/ Postpartum Care 5. Well Woman Visit/ Preventive Health Care 6. Depression Screening 7. Safe Sleep 8. Breastfeeding 9. Newborn Screening 10. Quality of Well Child Visit 11. Child Well Visit 12. Injury Prevention 13. Family Engagement 14. Medical Home (Access to and use of medical home) 15. Transition 16. Adolescent Well Visit 17. Injury Prevention 18. Screening for Major Depressive Disorder 19. Health Equity 20. Adequate health insurance coverage 21. Tobacco and eCigarette Use 22. Oral Health 23. Nutrition 24. Respiratory Health 25. Adolescent Health 26. Other	A. Other Divisions/ Departments in a University B. Title V (MCH Programs) C. State Health Dept. D. Health Insurance/ Organization E. Education F. Medicaid agency G. Social Service Agency H. Mental Health Agency I. Juvenile Justice or other Legal Entity J. State Adolescent Health K. Developmental Disability Agency L. Early Intervention M. Other Govt. Agencies N. Mixed Agencies O. Professional Organizations/ Associations P. Family and/or Consumer Group Q. Foundations R. Clinical Programs/ Hospitals S. Other (specify)	1. One time brief (single contact) 2. One time extended (multi-day contact provided one time) 3. On-going infrequent (3 or less contacts per year) 4. On-going frequent (more than 3 contacts per year)	1. Local 2. Title V 3. Within State 4. Another State 5. Regional 6. National 7. International
1	Example	G- Policy	21- Oral Health	E - Education	2	2

C. In the past year have you provided technical assistance on emerging issues that are not represented in the topic list above? YES/ NO.

If yes, specify the topic(s):_____

Products, Publications and Submissions Data Collection Form

Part 1

Instructions: Please list the number of products, publications and submissions addressing maternal and child health that have been published or produced with grant support (either fully or partially) during the reporting period. Count the original completed product, not each time it is disseminated or presented.

Type	Number
In Press peer-reviewed publications in scholarly journals *Please include peer reviewed publications addressing maternal and child health that have been published by project faculty and/or staff during the reporting period. Faculty and staff include those listed in the budget form and narrative and others that your program considers to have a central and ongoing role in the project whether they are supported or not supported by the grant.*	
Submission(s) of peer-reviewed publications to scholarly journals	
Books	
Book chapters	
Reports and monographs (including policy briefs and best practices reports)	
Conference presentations and posters presented	
Web-based products (Blogs, podcasts, Web-based video clips, wikis, RSS feeds, news aggregators, social networking/social mediasites)	
Electronic products (CD-ROMs, DVDs, audio or videotapes)	
Press communications (TV/Radio interviews, newspaper interviews, public service announcements, and editorial articles)	
Newsletters (electronic or print)	
Pamphlets, brochures, or fact sheets	
Academic course development	
Distance learning modules	
Doctoral dissertations/ Master's theses	
Other	

Part 3

Instructions: For each product, publication and submission listed in Part 1, complete all elements marked with an "*."

Data collection form for: primary author in peer-reviewed publications in scholarly journals – published

*Title: _____

*Author(s): _____

*Publication: _____

*Volume: _____ *Number: _____ Supplement: _____ *Year: _____ *Page(s):_____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL): _____

*Dissemination Vehicles: TV/ Radio Interview___ Newspaper/ Print Interview___ Press Release___

Social Networking / Social Media Sites___ Listservs___ Conference Presentation___

Key Words (No more than 5): _____

Notes: _____

Data collection form for: contributing author in peer-reviewed publications in scholarly journals – published

*Title: _____

*Author(s): _____

*Publication: _____

*Volume: _____ *Number: _____ Supplement: _____ *Year: _____ *Page(s):_____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL): _____

*Dissemination Vehicles: TV/ Radio Interview___ Newspaper/ Print Interview___ Press Release___

Social Networking / Social Media Sites___ Listservs___ Conference Presentation___

Key Words (No more than 5): _____

Notes: _____

Data collection form: Peer-reviewed publications in scholarly journals – submitted, not yet published

*Title: _____

*Author(s): _____

*Publication: _____

*Year Submitted: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

Key Words (No more than 5): _____

Notes: _____

Data collection form: Books

*Title: _____

*Author(s): _____

*Publisher: _____

*Year Published: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

Key Words (No more than 5): _____

Notes: _____

Data collection form for: Book chapters

Note: If multiple chapters are developed for the same book, list them separately.

*Chapter Title: _____

*Chapter Author(s): _____

*Book Title: _____

*Book Author(s): _____

*Publisher: _____

*Year Published: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Reports and monographs

*Title: _____

*Author(s)/Organization(s): _____

*Year Published: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Conference presentations and posters presented

(This section is not required for MCHB Training grantees.)

*Title: _____

*Author(s)/Organization(s): _____

*Meeting/Conference Name: _____

*Year Presented: _____

*Type: ☐ Presentation ☐ Poster

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Web-based products

*Product: _____

*Year: _____

*Type: ☐ Blogs ☐ Podcasts ☐ Web-based video clips
☐ Wikis ☐ RSS feeds ☐ News aggregators
☐ Social Networking / Social Media Sites ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Electronic Products

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ CD-ROMs ☐ DVDs ☐ Audio tapes ☐ Videotapes ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Press Communications

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ TV interview ☐ Radio interview ☐ Newspaper interview ☐ Public service announcement ☐ Editorial article ☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Newsletters

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ Electronic ☐ Print ☐ Both

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

*Frequency of distribution: ☐ Weekly ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other (Specify)

Number of subscribers: _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Pamphlets, brochures or fact sheets

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: ☐ Pamphlet ☐ Brochure ☐ Fact Sheet

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Academic course development

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Distance learning modules

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Media Type:

☐ Blogs	☐ Podcasts	☐ Web-based video clips
☐ Wikis	☐ RSS feeds	☐ News aggregators
☐ Social netowkring / Social media sites	☐ CD-ROMs	☐ DVDs
☐ Audio tapes	☐ Videotapes	☐ Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Doctoral dissertations/Master's theses

*Title: _____

*Author: _____

*Year Completed: _____

*Type: ☐ Doctoral dissertation ☐ Master's thesis

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Other

(Note, up to 3 may be entered)

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Describe product, publication or submission: _____

_____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

MCH TRAINING PROGRAM DATA FORMS

Faculty and Staff Information

List all personnel (faculty, staff, and others) contributing[1] to your training project, including those listed in the budget form and budget narrative and others that your program considers to have a central and ongoing role in the leadership training program whether they are supported or not supported by the grant.

Personnel (Do not list trainees)

Name	Ethnicity (Hispanic or Latino, Not Hispanic or Latino, Unrecorded)	Race (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, More than One Race, Unrecorded)	Gender (Male, Female, Transgender Man, Transgender Woman, Other (specify), Choose not to disclose/Unrecorded)[2]	Discipline	Year Hired in MCH Leadership Training Program	Former MCHB Trainee? (Yes/No)
Faculty						
Staff						

[1] A 'central' role refers to those that regularly participate in on-going training activities such as acting as a preceptors; teaching core courses; and participating in other core leadership training activities that would be documented in the progress reports.

[2] Male: Cisgender man, describes a person who was assigned male at birth and whose gender identity is a man/male.
Female: Cisgender woman, describes a person who was assigned female at birth and whose gender identity is a woman/female.
Transgender Man/Transgender Male/Transgender Masculine: Describes a person who is transgender and whose gender identity is boy/man/male.
Transgender Woman/Transgender Female/Transgender Feminine: Describes a person who is transgender and whose gender identity is girl/woman/female.
Other (specify): A gender identity that does not fit into the above categories, such as nonbinary (a person whose gender identity falls outside of the traditional gender binary structure of girl/woman and boy/man), agender (a person who identifies as having no gender, or who does not experience gender as a primary identity component), or another identity.

Other						

Trainee Information (Long–term Trainees Only)

Definition: Long-term trainees (those with greater than or equal to 300 contact hours within the training program) benefiting from the training grant (including those who received MCH funds and those who did not).

Total Number of long-term trainees participating in the training program* _____
Name
Ethnicity
Race
Gender

Gender[3]	Male _____	Transgender Man _____
(number not	Female _____	Transgender Woman _____
percent)	Other (specify) ____	Choose not to disclose/unknown _____

Address (For supported trainees ONLY)
City
State
Country
Discipline(s) upon Entrance to the Program
Degree(s)
Degree Program in which enrolled
Received financial MCH support? [ ] Yes [ ] No Amount: $_____
If yes…. [ ] Stipend [ ] Tuition [ ] Stipend and Tuition [ ] Other
Type: [ ] Non-Degree Seeking [ ] Undergraduate [ ] Masters
[ ] Pre-doctoral [ ] Doctoral [ ] Post-doctoral
Student Status: [ ] Part-time student [ ] Full-time student

Postdoctoral Fellows and Epidemiology Doctoral Training Program fellows, please specify: Length of time receiving support: _____
Research Topic or Title_____

*All long-term trainees participating in the program, whether receiving MCH stipend support or not.

[3] Male: Cisgender man, describes a person who was assigned male at birth and whose gender identity is a man/male.
Female: Cisgender woman, describes a person who was assigned female at birth and whose gender identity is a woman/female.
Transgender Man/Transgender Male/Transgender Masculine: Describes a person who is transgender and whose gender identity is boy/man/male.
Transgender Woman/Transgender Female/Transgender Feminine: Describes a person who is transgender and whose gender identity is girl/woman/female.
Other (specify): A gender identity that does not fit into the above categories, such as nonbinary (a person whose gender identity falls outside of the traditional gender binary structure of girl/woman and boy/man), agender (a person who identifies as having no gender, or who does not experience gender as a primary identity component), or another identity.

Former Trainee Information

The following information is to be provided for each long-term trainee who completed the Training Program 2 years and 5 years prior to the current reporting year.

Definition of Former Trainee = Long-term trainees who completed a long-term (greater than or equal to 300 contact hours) MCH Training Program 2 years and 5 years ago, including those who received MCH funds and those who did not.

☐ Project does not have any trainees who have completed the Training Program **2 years** prior to current reporting year.

☐ Project does not have any trainees who have completed the Training Program **5 years** prior to current reporting year.

Name	Year Graduated	Gender[4]	Ethnicity[5]	Race[6]	Degree(s) Earned with MCH support (if applicable)	Was University able to contact the trainee?	City of Residence	State of Residence	Country of Residence	Current Employment Setting [7]	Working in Public Health organization or agency (including Title V)? (Yes/No)	Working in MCH? (Yes/No)	Working with populations that are underserved or have been marginalized[8]?(Yes/No)	Met criteria for Leadership in Performance Measure Training 10? (Yes/No)	Met criteria for interdisciplinary practice in Performance Measure Training 12? (Yes/No)

[4] Gender Pick List: Male, Female, Transgender Man, Transgender Woman, Other (specify), Choose not to disclose/unknown

[5] Ethnicity Pick List: Hispanic or Latino, Not Hispanic or Latino, Unrecorded

[6] Race Pick List: American Indian and Alaska Native, Asian, Black or African American, Native Hawaiian and other Pacific Islander, White, More than One Race, Unrecorded

[7] Employment Pick List: Student; Schools or school sustem (includes early intervention programs, elementary, and secondary); Post-secondary setting; Government agency; Clinical health care setting (includes hospitals, health centers and clinics); Private sector; Other (specify)

[8] Populations that are underserved or have been marginalized refer to groups of individuals at higher risk for health disparities by virtue of their race or ethnicity, socioeconomic status, geography, gender, age, disability status, or other risk factors including those associated with sex and gender.

MCH TRAINING PROGRAM TRAINEE FOLLOW-UP SURVEY

Contact / Background Information

***Name** (first, middle, last): _____
Previous Name (if used while enrolled in the training program): _____
***Address**: _____

_____
City State Zip

Phone: _____
Primary Email: _____

***Permanent* Contact Information** (someone at a different address who will know how to contact you in the future, e.g., parents)

***Name of Contact**: _____
Relationship: _____
***Address**: _____

_____
City State Zip

Phone: _____

What year did you complete the MCH Training Program? _____

Degree(s) earned while participating in the MCH Training Program _____

***Gender*[9]:** (choose one)
__ Male
__Female
__Transgender Man
__Transgender Woman
__Choose not to disclose/unrecorded
Other, please specify:_____

Ethnicity: (choose one)
Hispanic is an ethnic category for people whose origins are in the Spanish-speaking countries of Latin America or who identify with a Spanish-speaking culture. Individuals who are Hispanic may be of any race.

[9] Male: Cisgender man, describes a person who was assigned male at birth and whose gender identity is a man/male.
Female: Cisgender woman, describes a person who was assigned female at birth and whose gender identity is a woman/female.
Transgender Man/Transgender Male/Transgender Masculine: Describes a person who is transgender and whose gender identity is boy/man/male.
Transgender Woman/Transgender Female/Transgender Feminine: Describes a person who is transgender and whose gender identity is girl/woman/female.
Other (specify): A gender identity that does not fit into the above categories, such as nonbinary (a person whose gender identity falls outside of the traditional gender binary structure of girl/woman and boy/man), agender (a person who identifies as having no gender, or who does not experience gender as a primary identity component), or another identity.

__ **Hispanic or Latino**
__ **Not Hispanic or Latino**
__ **Prefer not to say**

Race: (choose one)
__ **American Indian and Alaskan Native** includes all individuals who identify with any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. It includes people who identify as "American Indian" or "Alaska Native" and includes groups such as Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, and Nome Eskimo Community.
__ **Asian** includes all individuals who identify with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia, or the Indian subcontinent. Examples of these groups include, but are not limited to, Chinese, Filipino, Asian Indian, Vietnamese, Korean, and Japanese. The category also includes groups such as Pakistani, Cambodian, Hmong, Thai, Bengali, Mien, etc.
__ **Black or African American** includes all individuals who identify with one or more nationalities or ethnic groups originating in any of the black racial groups of Africa. Examples of these groups include, but are not limited to, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali. The category also includes groups such as Ghanaian, South African, Barbadian, Kenyan, Liberian, and Bahamian.
__ **Native Hawaiian and Other Pacific Islander** includes all individuals who identify with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or other Pacific Islands. Examples of these groups include, but are not limited to, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, and Marshallese. The category also includes groups such as Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese, Yapese, etc.
__ **White** includes all individuals who identify with one or more nationalities or ethnic groups originating in Europe, the Middle East, or North Africa. Examples of these groups include, but are not limited to, German, Irish, English, Italian, Lebanese, Egyptian, Polish, French, Iranian, Slavic, Cajun, and Chaldean.
__ **More than One Race** includes individuals who identify with more than one racial designation.
__ **Prefer not to say** is included for individuals who do not indicate their racial category.

Survey

Please answer all of the following questions as thoroughly as possible. When you have filled out the entire survey, return it to your Center/Program.

1. What best describes your current employment setting:

__ Student
__ Schools or school system (includes early intervention programs, elementary and secondary)
__ Post-secondary setting
__ Government agency
__ Clinical health care setting (includes hospitals, health centers and clinics)
__ Private sector
__ Other: please specify: _____

2. Do you currently work in a public health organization or agency (including Title V)? Y/N

3. Does your current work focus on Maternal and Child Health (MCH) populations (i.e., women, infants and children, adolescents, young adults, and their families including fathers, and children or young adults with special health care needs?)

__ yes
__ no

4. Does your current work focus on populations that are underserved or have been marginalized [10]

__ yes
__ no

5. Have you done any of the following activities since completing your training program? ***(check all that apply)***

__ a. Participated on any of the following as a group leader, initiator, key contributor or in a position of influence/authority: committees of state, national or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
__ b. Served in a clinical position of influence (e.g. director, senior therapist, team leader, etc.)
__ c. Provided consultation or technical assistance in MCH areas
__ d. Taught/mentored in my discipline or other MCH related field
__ e. Conducted research or quality improvement on MCH issues
__ f. Disseminated information on MCH Issues (e.g., Peer reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
__ g. Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process) (ac, c)
__ h. Procured grant and other funding in MCH areas
__ i. Conducted strategic planning or program evaluation
__ j. Participated in public policy development activities (e.g., Participated in community engagement or coalition building efforts, written policy or guidelines, provided testimony, educated policymakers, etc.)
__ k. None

[10] Populations that are underserved or have been marginzlised refers to groups of individuals at higher risk for health disparities by virtue of their race or ethnicity, socio-economic status, geography, gender, age, disability status, or other risk factors including those associated with sex and gender.

6. If you checked <u>any</u> of the activities above, in which of the following settings or capacities would you say these activities occurred? (*check all that apply*)

__ a. Academic
__ b. Clinical
__ c. Public Health
__ d. Public Policy & Advocacy

7. Have you done any of the following interdisciplinary activities since completing your training program? (*check all that apply*)

☐ a. Sought input or information from other professions or disciplines to address a need in your work
☐ b. Provided input or information to other professions or disciplines.
☐ c. Developed a shared vision, roles and responsibilities within an interdisciplinary group.
☐ d. Utilized that information to develop a coordinated, prioritized plan across disciplines to address a need in your work
☐ e. Established decision-making procedures in an interdisciplinary group.
☐ f. Collaborated with various disciplines across agencies/entities
☐ g. Advanced policies & programs that promote collaboration with other disciplines or professions
☐ h. None

(end of survey)

<u>Confidentiality Statement</u>

Thank you for agreeing to provide information that will enable your training program to track your training experience and follow up with you after the completion of your training. Your input is critical to our own improvement efforts and our compliance with Federal reporting requirements. Please know that your participation in providing information is entirely voluntary. The information you provide will only be used for monitoring and improvement of the training program. Please also be assured that we take the confidentiality of your personal information very seriously. We very much appreciate your time and assistance in helping to document outcomes of the Training Program. We look forward to learning about your academic and professional development.

Medium-Term Trainees

DEFINITION: Medium-term trainees are trainees with 40 - 299 contact hours in the current reporting year.

Medium-term Trainees with 40-149 contact hours during the past 12-month grant period

Total Number _____

Disciplines (check all that apply):

☐ Audiology
☐ Dentistry-Pediatric
☐ Dentistry – Other
☐ Education/Special Education
☐ Family Member/Community Member
☐ Genetics/Genetic Counseling
☐ Health Administration
☐ Medicine-General
☐ Medicine-Adolescent Medicine
☐ Medicine-Developmental-Behavioral Pediatrics
☐ Medicine-Neurodevelopmental Disabilities
☐ Medicine-Pediatrics
☐ Medicine-Pediatric Pulmonology
☐ Medicine – Other
☐ Nursing-General
☐ Nursing-Family/Pediatric Nurse Practitioner
☐ Nursing-Midwife
☐ Nursing – Other
☐ Nutrition
☐ Occupational Therapy
☐ Person with a disability or special health care need
☐ Physical Therapy
☐ Psychiatry
☐ Psychology
☐ Public Health
☐ Respiratory Therapy
☐ Social Work
☐ Speech-Language Pathology
☐ Other (Specify)

Medium-Term Trainees with 150-299 contact hours

The totals for gender, ethnicity, race and discipline must equal the total number of medium-term trainees with 150-299 contact hours

Total Number	_____		
Gender [11]	Male _____	Female _____	
(number not	Transgender Man _____	Transgender Woman _____	
percent)	Other (specify) _____	Choose not to disclose/unrecorded _____	
Ethnicity[12]	Hispanic or Latino _____	Not Hispanic or Latino _____	Unrecorded _____
(number not			
percent)			
Race [13]	American Indian or Alaska Native: _____		
(number not	Asian: _____		
percent)	Black or African American: _____		
	Native Hawaiian or Other Pacific Islander: _____		
	White: _____		

[11] Male: Cisgender man, describes a person who was assigned male at birth and whose gender identity is a man/male.
Female: Cisgender woman, describes a person who was assigned female at birth and whose gender identity is a woman/female.
Transgender Man/Transgender Male/Transgender Masculine: Describes a person who is transgender and whose gender identity is boy/man/male.
Transgender Woman/Transgender Female/Transgender Feminine: Describes a person who is transgender and whose gender identity is girl/woman/female.
Other (specify): A gender identity that does not fit into the above categories, such as nonbinary (a person whose gender identity falls outside of the traditional gender binary structure of girl/woman and boy/man), agender (a person who identifies as having no gender, or who does not experience gender as a primary identity component), or another identity.

[12] **Hispanic or Latino:** includes all individuals of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. People who identify as Hispanic, Latino, or Spanish may be any race.

[13] **American Indian or Alaska Native:** includes all individuals who identify with any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. It includes people who identify as "American Indian" or "Alaska Native" and includes groups such as Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, and Nome Eskimo Community.

Asian: includes all individuals who identify with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia, or the Indian subcontinent. Examples of these groups include, but are not limited to, Chinese, Filipino, Asian Indian, Vietnamese, Korean, and Japanese. The category also includes groups such as Pakistani, Cambodian, Hmong, Thai, Bengali, Mien, etc.

Black or African American: includes all individuals who identify with one or more nationalities or ethnic groups originating in any of the black racial groups of Africa. Examples of these groups include, but are not limited to, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali. The category also includes groups such as Ghanaian, South African, Barbadian, Kenyan, Liberian, and Bahamian.

Native Hawaiian and Pacific Islander: includes all individuals who identify with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or other Pacific Islands. Examples of these groups include, but are not limited to, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, and Marshallese. The category also includes groups such as Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese, Yapese, etc.

White: includes all individuals who identify with one or more nationalities or ethnic groups originating in Europe, the Middle East, or North Africa. Examples of these groups include, but are not limited to, German, Irish, English, Italian, Lebanese, Egyptian, Polish, French, Iranian, Slavic, Cajun, and Chaldean.

More than one Race: includes individuals who identify with more than one race.

More than One Race: _____
Unrecorded:_____

Discipline

Number	Discipline
____	Audiology
____	Dentistry-Pediatric
____	Dentistry – Other
____	Education/Special Education
____	Family Member/Community Member
____	Genetics/Genetic Counseling
____	Health Administration
____	Medicine-General
____	Medicine-Adolescent Medicine
____	Medicine-Developmental-Behavioral Pediatrics
____	Medicine-Neurodevelopmental Disabilities
____	Medicine-Pediatrics
____	Medicine-Pediatric Pulmonology
____	Medicine – Other
____	Nursing-General
____	Nursing-Family/Pediatric Nurse Practitioner
____	Nursing-Midwife
____	Nursing – Other
____	Nutrition
____	Occupational Therapy
____	Person with a disability or special health care need
____	Physical Therapy
____	Psychiatry
____	Psychology
____	Public Health
____	Respiratory Therapy
____	Social Work
____	Speech-Language Pathology
____	Other (Specify)_____

TOTAL Number of Medium-term Trainees: _____

Short-Term Trainees

DEFINITION: Short-term trainees are trainees with less than 40 contact hours in the current reporting year. (**Continuing Education participants are not counted in this category**)

Total number of short term trainees during the past 12-month grant period_____

Indicate disciplines (check all that apply)

- ☐ Audiology
- ☐ Dentistry-Pediatric
- ☐ Dentistry – Other
- ☐ Education/Special Education
- ☐ Family Member/Community Member
- ☐ Genetics/Genetic Counseling
- ☐ Health Administration
- ☐ Medicine-General
- ☐ Medicine-Adolescent Medicine
- ☐ Medicine-Developmental-Behavioral Pediatrics
- ☐ Medicine-Neurodevelopmental Disabilities
- ☐ Medicine-Pediatrics
- ☐ Medicine-Pediatric Pulmonology
- ☐ Medicine – Other
- ☐ Nursing-General
- ☐ Nursing-Family/Pediatric Nurse Practitioner
- ☐ Nursing-Midwife
- ☐ Nursing – Other
- ☐ Nutrition
- ☐ Occupational Therapy
- ☐ Person with a disability or special health care need
- ☐ Physical Therapy
- ☐ Psychiatry
- ☐ Psychology
- ☐ Public Health
- ☐ Respiratory Therapy
- ☐ Social Work
- ☐ Speech-Language Pathology
- ☐ Other (Specify)

Continuing Education Form

Continuing Education is defined as continuing education programs or trainings 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. Additional details about CE activities will be collected in the annual progress report.

NOTE: Short-term trainees are **not** considered CE participants.

A. Provide information related to the total number of CE activities provided through your training program last year.

Total Number of CE Participants _____
Total Number of CE Sessions/ Activities _____

Number of CE Sessions/Activities by Primary Target Audience

_____
Number of **Within Your State** CE Activities _____
Number of CE Activities **With Another State** _____
Number of **Regional** CE Activities _____
Number of **National** CE Activities _____
Number of **International** CE Activities _____

Number of CE Sessions/Activities for which Credits are Provided _____

B. Topics Covered in CE Activities *Check all that apply*

A. Clinical Care-Related (including medical home)
B. Diversity or Cultural Responsiveness-Related
C. Data, Research, Evaluation Methods (Knowledge Translation)
D. Family Involvement
E. Interdisciplinary Teaming
F. Healthcare Workforce Leadership
G. Policy
H. Prevention
I. Systems Development/ Improvement

- Women's Reproductive/ Perinatal Health
- Early Childhood Health/ Development (birth to school age)
- School Age Children
- Adolescent Health
- CSHCN/ Developmental Disabilities
- Autism
- Emergency Preparedness
- Health Information Technology
- Mental Health
- Nutrition
- Oral Health
- Patient Safety
- Respiratory Health
- Health Equity
- Health care financing
- Other (specify) _____

MCH LEAP PROGRAM GRADUATE FOLLOW-UP QUESTIONS

Please answer all of the following questions as thoroughly as possible. When you have filled out the entire survey, return it to your LEAP Program Director.

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

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

   ☐ Yes
   ☐ No

   1b. 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):_____

   1c. If yes, did the MCH LEAP Training Program help in your admission to and/or being 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 are underserved or have been marginalized since graduating from the MCH LEAP Training program?**

   ☐ Yes
   ☐ No

MATERNAL AND CHILD HEALTH LEADERSHIP, EDUCATION, AND ADVANCEMENT IN UNDERGRADUATE PATHWAYS (LEAP) TRAINING PROGRAM: TRAINEE INFORMATION FORM

Please provide aggregate data on medium-, and long-term LEAP trainees[14] who are participating in the LEAP training program during the 12-month reporting period.

Total Number of LEAP Trainees: _____

Ethnicity:

Number of LEAP trainees who identify as:

- Hispanic/Latino: _____
- Non-Hispanic/Latino: _____
- Unrecorded: _____

Race[15]:

Number of LEAP trainees who identify as:

- American Indian or Alaska Native: _____
- Asian: _____
- Black or African American: _____

[14] LEAP Trainees are defined as medium-term (40-299 program hours) and long-term (300+ hours) trainees enrolled in the LEAP training program.

[15] **American Indian or Alaska Native:** includes all individuals who identify with any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. It includes people who identify as "American Indian" or "Alaska Native" and includes groups such as Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, and Nome Eskimo Community.

Asian: includes all individuals who identify with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia, or the Indian subcontinent. Examples of these groups include, but are not limited to, Chinese, Filipino, Asian Indian, Vietnamese, Korean, and Japanese. The category also includes groups such as Pakistani, Cambodian, Hmong, Thai, Bengali, Mien, etc.

Black or African American: includes all individuals who identify with one or more nationalities or ethnic groups originating in any of the black racial groups of Africa. Examples of these groups include, but are not limited to, African American, Jamaican, Haitian, Nigerian, Ethiopian, and Somali. The category also includes groups such as Ghanaian, South African, Barbadian, Kenyan, Liberian, and Bahamian.

Native Hawaiian and Pacific Islander: includes all individuals who identify with one or more nationalities or ethnic groups originating in Hawaii, Guam, Samoa, or other Pacific Islands. Examples of these groups include, but are not limited to, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, and Marshallese. The category also includes groups such as Palauan, Tahitian, Chuukese, Pohnpeian, Saipanese, Yapese, etc.

White: includes all individuals who identify with one or more nationalities or ethnic groups originating in Europe, the Middle East, or North Africa. Examples of these groups include, but are not limited to, German, Irish, English, Italian, Lebanese, Egyptian, Polish, French, Iranian, Slavic, Cajun, and Chaldean.

More than one Race: includes individuals who identify with more than one race.

- Native Hawaiian or Pacific Islander: _____
- White: ____
- More than one race:____
- Unrecorded: ____

Gender[16]:

Number of LEAP trainees who identify as:

- Male: _____
- Female: _____
- Transgender Man: _____
- Transgender Woman: _____
- Other (specify): _____
- Choose not to disclose/Unrecorded: _____

Age:

- 15 – 19: _____
- 20 – 24: _____
- 25 – 29: _____
- 30 – 34: _____
- 35 and older**: ____**

Number of LEAP trainees who are enrolled in college:

- Part-time: _____
- Full-time: _____
- Unrecorded: _____

Number of LEAP trainees who:

- Are the first in their family to attend college[17]: _____
- Work full-time (>35 hours/week) while enrolled in college[18]: _____
- Have a dependent(s) other than spouse: _____

[16] **Male**: Cisgender man, describes a person who was assigned male at birth and whose gender identity is a man/male.

Female: Cisgender woman, describes a person who was assigned female at birth and whose gender identity is a woman/female.

Transgender Man/Transgender Male/Transgender Masculine: Describes a person who is transgender and whose gender identity is boy/man/male.

Transgender Woman/Transgender Female/Transgender Feminine: Describes a person who is transgender and whose gender identity is girl/woman/female.

Other (specify): A gender identity that does not fit into the above categories, such as nonbinary (a person whose gender identity falls outside of the traditional gender binary structure of girl/woman and boy/man), agender (a person who identifies as having no gender, or who does not experience gender as a primary identity component), or another identity.

[17] First-generation college students are students who enrolled in postsecondary education and whose parents do not have any postsecondary education experience.

[18] Includes LEAP trainees who have worked full-time (>35 hours/week) at any point during the 12-month reporting period.

HEALTHY START SITE FORM

Section 1. Grantee Primary Organization Information

Grant #_____

Grantee Name _____

Street Address_____

City_____ State _____ ZIP Code_____

Select the state(s) in this organization's service area (select all that apply)

Service area primarily defined by: ☐ County ☐ Zip Code

Enter the names of all of the counties covered by this organization's service area:

Select all that apply.

Enter all of the ZIP codes covered by this organization's service area:

Select all that apply.

Please check all services provided by this organization:

☐ Adolescent Population	☐ Doula Services	☐ Interconception
☐ Breastfeeding Support	☐ Fatherhood – Case Management	☐ Mental & Behavioral Health (beyond screening)
☐ Case Management	☐ Fatherhood – Group Services/Health Education	☐ Outreach
☐ Children/Youth w/Special Health Care Needs	☐ Food Insecurity Services	☐ Preconception
	☐ Health Education	
☐ Direct Clinical Services	☐ Incarcerated/Justice-System Involved Population	☐ Prenatal

Section 2. Healthy Start Site Information

Please complete the section below for each service delivery site:

Site 1

Project Manager Name_____

Project Name_____

Street Address_____

City_____ State_____ ZIP Code_____

Site 2

Project Manager Name_____

Project Name_____

Street Address_____

City_____ State_____ ZIP Code_____

OMB Number: 0915-0298
Expiration Date: 8/31/2025

Health Resources and Services Administration
Maternal and Child Health Bureau

Discretionary Grant Performance Measures

OMB No. 0915-0298
Expires: 8/ 31/ 2025

Attachment C:
Financial and Demographic Data Elements

OMB Clearance Package

Attachment C:
Financial and Demographic Data Elements

OMB Number: 0915-0298
Expiration Date: 8/31/2025

FORM 1
MCHB PROJECT BUDGET DETAILS FOR FY _____

1.	**MCHB GRANT AWARD AMOUNT**		$
2.	**MATCHING FUNDS**		$
	(Required: Yes [ ] No [ ] If yes, amount)		
	A. Local funds	$	
	B. State funds	$	
	C. Program Income	$	
	D. Applicant/Grantee Funds	$	
	E. Other funds: _____	$	
3.	**OTHER PROJECT FUNDS** (Not included above)		$
	A. Local funds	$	
	B. State funds	$	
	C. Program Income (Clinical or Other)	$	
	D. Applicant/Grantee Funds (includes in-kind)	$	
	E. Other funds (including private sector, e.g., Foundations)	$	
4.	**TOTAL PROJECT FUNDS** (Total lines 1 through 4)		$
5.	**FEDERAL COLLABORATIVE FUNDS**		$
	(Source(s) of additional Federal funds contributing to the project including Other MCHB Funds, Other HRSA Funds, and Other Federal Funds)		

INSTRUCTIONS FOR COMPLETION OF FORM 1
MCH BUDGET DETAILS FOR FY ____

Line 1. Enter the amount of the Federal MCHB grant award for this project.

Line 2. If matching funds are required for this grant program list the amounts by source on lines 2A through 2E as appropriate. Where appropriate, include the dollar value of in-kind contributions.

Line 3. Enter the amount of other funds received for the project, by source on Lines 3A through 3E, specifying amounts from each source. Also include the dollar value of in-kind contributions.

Line 4. Displays the sum of lines 1 through 3.

Line 5. Enter the total amount of other Federal funds received on Line 5 **other** than the MCHB grant award for the project. Such funds would include those from other Departments, other components of the Department of Health and Human Services, or other MCHB grants or contracts

OMB Number: 0915-0298
Expiration Date: 8/31/2025

FORM 3

BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED
For Projects Providing Direct Health Care, Enabling, or Population-based Services

	FY_____
Target Population(s)	$ Budgeted
Pregnant Women (All Ages)	
Infants <1 year	
Children 1 through 21 years	
CSHCN 0 through 21 years	
Non-pregnant Women (Age 22 and over)	
Other	
TOTAL	

INSTRUCTIONS FOR COMPLETION OF FORM 3
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED

For Projects Providing Direct Services, Enabling, or Public Health Services and Systems

If the project provides direct services, complete all required data cells for all years of the grant. If an actual number is not available make an estimate. Please explain all estimates in a note.

All ages are to be read from x to y, not including y. For example, infants are those from birth to 1, and children and youth are from age 1 to 21.

Enter the budgeted amounts for the appropriate fiscal year, for each targeted population group. CSHCN should be reported as a subset of all infants and children ages zero (0) through 21. The budgeted amount for CSHCN will not be added to the overall total because their inclusion would result in a duplicated count.

FORM 5

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)
By Type of Individual and Source of Primary Insurance Coverage
For Projects Providing Direct Health Care, Enabling or Population-based Services

Reporting Year_____

Table 1

Individuals Served	(a) **Total Served**	(b) **Title XIX %**	(c) **Title XXI %**	(d) **Private/ Other %**	(e) **None %**	(f) **Unknown %**
Pregnant Women (All Ages)						
Infants <1 year						
Children 1 through 21 years						
CSHCN 0 through 21 years						
Non-pregnant Women (Age 22 and over)						
Other						
Unknown						

TOTAL SERVED: _____

OMB Number: 0915-0298
Expiration Date: 8/31/2025

INSTRUCTIONS FOR THE COMPLETION OF FORM 5

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)
By Type of Individual and Source of Primary Insurance Coverage
For Projects Providing Direct Health Care, Enabling or Population-based Services

Enter data into all required (unshaded) data cells. If an actual number is not available, make an estimate. Please explain all estimates, in a note.

Note that ages are expressed as either x to y, (i.e., 1 to 25, meaning from age 1 up to age 25, but not including 25) or x – y (i.e., 1 – 4 meaning age 1 through age 4). Also, symbols are used to indicate directions. For example, <1 means less than 1, or from birth up to, but not including age 1.

1. At the top of the Form, the Line Reporting Year displays the year for which the data applies.

2. In Column (a), enter the unduplicated count of individuals who received a direct service from the project regardless of the primary source of insurance coverage. These services are those that are done by any non-capacity building services and would include individuals served by total dollars reported on Form 3, Line 7. Counts of Pregnant women and Non-pregnant women should be unduplicated and reported separately in their respective lines. Counts for CSHCN can be duplicative counts of Children 1 to 21 years. CSHCN should be reported as a subset of all infants and children ages zero (0) through 21. The count for CSHCN will not be added to the overall total because their inclusion would result in a duplicated count.

3. In the remaining columns, report the percentage of those individuals receiving direct health care, enabling or population-based services, who have as their primary source of coverage:
   - Column (b): Title XIX (includes Medicaid expansion under Title XXI)
   - Column (c): Title XXI
   - Column (d): Private or other coverage
   - Column (e): None
   - Column (f): Unknown

   These may be estimates. If individuals are covered by more than one source of insurance, they should be listed under the column of their primary source.

OMB Number: 0915-0298
Expiration Date: 8/31/2025

FORM 6

MATERNAL & CHILD HEALTH DISCRETIONARY GRANT
PROJECT ABSTRACT
FOR FY____

PROJECT:_____

I. PROJECT IDENTIFIER INFORMATION

1. Project Title:
2. Project Number:
3. Project Director/Principal Investigator on NoA:
4. E-mail address:

II. BUDGET

1. MCHB Grant Award $_____
   (Line 1, Form 1)
2. Matching Funds (if applicable) $_____
   (Line 2, Form 1)
3. Other Project Funds $_____
   (Line 3, Form 1)
4. Total Project Funds $_____
   (Line 4, Form 1)

III. TYPE(S) OF SERVICE PROVIDED (Choose all that apply)

[ ] Direct Services
Percent of Budget for Direct Services ____
[ ] Enabling Services
Percent of Budget for Enabling Services
[ ] Public Health Services and Systems
Percent of Budget for Public Health Services and Systems ____

IV. DOMAIN SERVICES ARE PROVIDED TO

[ ] **Maternal/ Women's' Health**
[ ] **Perinatal/ Infant Health**
[ ] **Child Health**
[ ] **Children with Special Health Care Needs**
[ ] **Adolescent Health**
[ ] **Life Course/ All Population Domains**
[ ] **Local/ State/ National Capacity Building**

V. PROJECT DESCRIPTION OR EXPERIENCE TO DATE

A. Project Description
   1. Problem (in 50 words, maximum):

2. Program Objectives and Key Activities: (List up to 5 major objectives and key related activities for the project. These should reflect the objectives from the NOFO, also these will be used for Grant Impact measurement at the end of your grant period.)

Objective 1:

Related Activity 1:

Related Activity 2:

Objective 2:

Related Activity 1:

Related Activity 2:

Objective 3:

Related Activity 1:

Related Activity 2:

Objective 4:

Related Activity 1:

Related Activity 2:

Objective 5:

Related Activity 1:

Related Activity 2:

3. Specify the primary *Healthy People 2030* objectives(s) (up to three) which this project addresses:

a.
b.
c.

4. Coordination (List the State, local health agencies or other organizations involved in the project and their roles)
5. Evaluation (briefly describe the methods which will be used to determine whether process and outcome objectives are met, be sure to tie to evaluation from NOFO.)
6. Quality Improvement Activities

B. Continuing Grants and Ending Grants ONLY

1. Progress Towards Objectives to Date :
   a. Did you make measurable progress towards Objective 1 in the past year?
      □ Yes □ No
      i. Provide data that support this: _____
   b. Did you make measurable progress towards Objective 2 in the past year?
      □ Yes □ No
      i. Provide data that support this: _____
   c. Did you make measurable progress towards Objective 3 in the past year?
      □ Yes □ No
      i. Provide data that support this: _____
   d. Did you make measurable progress towards Objective 4 in the past year?
      □ Yes □ No

i. Provide data that support this: _____

e. Did you make measurable progress towards Objective 5 in the past year?
□ Yes □ No

i. Provide data that support this: _____

2. Website URL and annual number of hits
   a. _____ Number of web hits
   b. _____ Number of unique visitors

VI. KEY WORDS

VII. ANNOTATION

INSTRUCTIONS FOR THE COMPLETION OF FORM 6
PROJECT ABSTRACT

NOTE: All information provided should fit into the space provided in the form. The completed form should be no more than 3 pages in length. Where information has previously been entered in forms 1 through 5, the information will automatically be transferred electronically to the appropriate place on this form.

Section I – Project Identifier Information

Project Title: Displays the title for the project.
Project Number: Displays the number assigned to the project (e.g., the grant number)
E-mail address: Displays the electronic mail address of the project director

Section II – Budget - These figures will be transferred from Form 1, Lines 1 through 4.

Section III - Types of Services

Indicate which type(s) of services your project provides, checking all that apply. For each type of service selected, indicated the percent of the Budget that is dedicated to that type of service. Percents for all three service types should sum to 100%.

Direct Health Care Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Direct Health Care Services are those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Enabling Services allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Public Health Services and Systems - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Public Health Services and Systems include preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-

on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not. The other critical aspect of Public Health Services and Systems are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems and resources such as health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Section IV – Program Description OR Current Status (DO NOT EXCEED THE SPACE PROVIDED)

A. New Projects only are to complete the following items:

1. A brief description of the project and the problem it addresses, such as preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for Children with Special Health Care Needs.

2. System displays up to 5 objectives of the project, in priority order. Examples are: To reduce the barriers to the delivery of care for pregnant women, to reduce the infant mortality rate for minorities and "services or system development for children with special healthcare needs." MCHB will capture annually every project's top objectives in an information system for comparison, tracking, and reporting purposes; you must list at least 1 and no more than 5 objectives. For each goal, list the key related activities. The objectives and activities must be specific and time limited (i.e., Objective 1: increase providers in area trained in providing quality well-child visits by 10% by 2017 through 1. trainings provided at state pediatric association and 2. on-site technical assistance).

3. Displays the primary Healthy People 2030 goal(s) that the project addresses.

4. Describe the programs and activities used to reach objectives, and comment on innovation, cost, and other characteristics of the methodology, proposed or are being implemented. Lists with numbered items can be used in this section.

5. Describe the coordination planned and carried out, in the space provided, if applicable, with appropriate State and/or local health and other agencies in areas(s) served by the project.

6. Briefly describe the evaluation methods that will be used to assess the success of the project in attaining its objectives and implementing activities.

B. For continuing and ending projects ONLY:

1. For each program objective, select Yes/No to indicate if measurable progress towards the objective was made during the reporting period. Provide data and a brief description that supports the Yes/No selection. (not to exceed 200 words).
2. If applicable, provide the number of hits by unique visitors to the website (or section of website) funded by MCHB for the past year.

Section V – Key Words

Provide up to 10 key words to describe the project, including populations served. Choose key words from the included list.

Section VI – Annotation

Provide a three- to five-sentence description of your project that identifies the project's purpose, the needs and problems, which are addressed, the objectives of the project, the related activities which will be used to meet the objectives, and the materials, which will be developed.

FORM 7

DISCRETIONARY GRANT PROJECT
SUMMARY DATA

1. Project Service Focus

[ ] Urban/Central City [ ] Suburban [ ] Metropolitan Area (city & suburbs)
[ ] Rural [ ] Frontier [ ] Border (US-Mexico)

2. Project Scope

[ ] Local [ ] Multi-county [ ] State-wide
[ ] Regional [ ] National

3. Grantee Organization Type

[ ] State Agency
[ ] Community Government Agency
[ ] School District
[ ] University/Institution Of Higher Learning (Non-Hospital Based)
[ ] Academic Medical Center
[ ] Community-Based Non-Governmental Organization (Health Care)
[ ] Community-Based Non-Governmental Organization (Non-Health Care)
[ ] Professional Membership Organization (Individuals Constitute Its Membership)
[ ] National Organization (Other Organizations Constitute Its Membership)
[ ] National Organization (Non-Membership Based)
[ ] Independent Research/Planning/Policy Organization
[ ] Other _____

4. Project Infrastructure Focus (from MCH Pyramid) if applicable

[ ] Guidelines/Standards Development And Maintenance
[ ] Policies And Programs Study And Analysis
[ ] Synthesis Of Data And Information
[ ] Translation Of Data And Information For Different Audiences
[ ] Dissemination Of Information And Resources
[ ] Quality Assurance
[ ] Technical Assistance
[ ] Training
[ ] Systems Development
[ ] Other

5. Demographic Characteristics of Project Participants

Indicate the service level:

☐	**Direct Health Care Services**
☐	**Enabling Services**
☐	**Public Health Services and Systems**

	RACE (Indicate all that apply)								**ETHNICITY**			
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More than One Race	Unrecorded	Total	Hispanic or Latino	Not Hispanic or Latino	Unrecorded	Total
Pregnant Women (All Ages)												
Infants <1 year												
Children 1 to 12 years												
Adolescents 12-18 years												
Young Adults 18-21 years												
CSHCN 0 - 21 years												
Non-Pregnant Women 22+ years												
Other												
Unknown												
TOTALS												

6. Clients' Primary Language(s)

_____
_____
_____

7. Population Served

[ ] Homeless
[ ] Incarcerated
[ ] Severely Depressed
[ ] Migrant Worker/ Population
[ ] Uninsured
[ ] Adolescent Pregnancy
[ ] Food Stamp Eligible
[ ] Other

8. Resource/TA and Training Centers ONLY

Answer all that apply.

a. Characteristics of Primary Intended Audience(s)
   [ ] Providers/ Professionals
   [ ] Local/ Community partners
   [ ] Title V
   [ ] Other state agencies/ partners
   [ ] Regional
   [ ] National
   [ ] International
b. Number of Requests Received/Answered: ___/____
c. Number of Continuing Education credits provided: _____
d. Number of Individuals/ Participants Reached: _____
e. Number of Organizations Assisted: _____
f. Major Type of TA or Training Provided:
   [ ] continuing education courses,
   [ ] workshops,
   [ ] on-site assistance,
   [ ] distance learning classes
   [ ] one-on-one remote consultation
   [ ] other, Specify: _____

INSTRUCTIONS FOR THE COMPLETION OF FORM 7
PROJECT SUMMARY

Section 1 – Project Service Focus
Select all that apply

Section 2 – Project Scope
Choose the one that best applies to your project.

Section 3 – Grantee Organization Type
Choose the one that best applies to your organization.

Section 4 – Project Infrastructure Focus
If applicable, choose all that apply.

Section 5 – Demographic Characteristics of Project Participants
Indicate the service level for the grant program. Multiple selections may be made. Please fill in each of the cells as appropriate. CSHCN should be reported as a subset of all infants and children ages zero (0) through 21. The count for CSHCN will not be added to the overall total because their inclusion would result in a duplicated count.

Direct Health Care Services are those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Public Health Services and Systems include preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not. The other critical aspect of **Public Health Services and Systems** are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems and resources such as health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Section 6 – Clients Primary Language(s)
Indicate which languages your clients speak as their primary language, other than English, for the data provided in Section 6. List up to three languages.

Section 7 – Check all population served

Section 8 – Resource/TA and Training Centers (Only)
Answer all that apply.

OMB Number: 0915-0298
Expiration Date: 8/31/2025

FORM 8
(For Research Projects ONLY)

MATERNAL & CHILD HEALTH DISCRETIONARY GRANT
PROJECT ABSTRACT
FOR FY____

I. PROJECT IDENTIFIER INFORMATION

1. Project Title:
2. Project Number:
3. Project Director/Principal Investigator as shown on NoA :
4. Additional Principle Investigator(s), Discipline

II. BUDGET

1. MCHB Grant Award (Line 1, Form 1) $_____
2. Matching Funds (if applicable) (Line 2, Form 1) $_____
– Other Project Funds (Line 3, Form 1) $_____
– Total Project Funds (Line 4, Form 1) $_____

III. CARE EMPHASIS

[ ] Interventional
[ ] Non-interventional

IV. POPULATION FOCUS

[ ] Neonates
[ ] Infants
[ ] Toddlers
[ ] Preschool Children
[ ] School-Aged Children
[ ] Adolescents
[ ] Adolescents (Pregnancy Related)
[ ] Young Adults (>20)
[ ] Pregnant Women
[ ] Postpartum Women
[ ] Parents/Mothers/Fathers
[ ] Adolescent Parents
[ ] Grandparents
[ ] Physicians
[ ] Others

V. STUDY DESIGN

[ ] Experimental
[ ] Quasi-Experimental
[ ] Observational

VI. TIME DESIGN

[ ] Cross-sectional
[ ] Longitudinal
[ ] Mixed

VII. PRIORITY RESEARCH ISSUES AND QUESTIONS OF FOCUS

From the Maternal and Child Health Bureau (MCHB) Strategic Research Issues: Fiscal Years (FYs) 2004 – 2009.

Primary area addressed by research:

Secondary area addressed by research:

VIII. ABSTRACT

IX. KEY WORDS

X. ANNOTATION

INSTRUCTIONS FOR THE COMPLETION OF FORM 8
MATERNAL & CHILD HEALTH
RESEARCH PROJECT ABSTRACT

NOTE: All information provided should fit into the space provided in the form. Do not exceed the space provided.

Where information has previously been entered in forms 1 through 4, the information will automatically be transferred electronically to the appropriate place on this form.

Section I – Project Identifier Information

Project Title:	Displays the title for the project.
Project Number:	Displays the number assigned to the project (e.g., the grant number).
Project Director:	Displays the name and degree(s) of the project director as listed on the grant application.
Principal Investigator:	Enter the name(s) and discipline(s) of the principal investigator(s).

Section II – Budget

The amounts for Lines 1 through 4 will be transferred from Form 1, Lines 1 through 4.

Section III – Care Emphasis

Indicate whether the study is interventional or non-interventional.

Section IV – Population Focus

Indicate which population(s) are the focus of the study. Check all that apply.

Section V – Study Design

Indicate which type of design the study uses.

Section VI – Time Design

Indicate which type of design the study uses.

Section VII – Priority Research Issues and Questions of Focus (DO NOT EXCEED THE SPACE PROVIDED)

Provide a brief statement of the primary and secondary (if applicable) areas to be addressed by the research. The topic(s) should be from those listed in the *Maternal and Child Health Bureau (MCHB) Strategic Research Issues: Fiscal Years (FYs) 2004 – 2009*).

Section VIII – Abstract

Section IX - -Key Words

Provide up to 10 key words to describe the project, including populations served. A list of key words used to classify active projects is included. Choose keywords from this list when describing your project.

Section X – Annotation

Provide a three- to five-sentence description of your project that identifies the project's purpose, the needs and problems which are addressed, the objectives of the project, the related activities which will be used to meet the stated objectives, and the materials, which will be developed.

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Expiration Date: 8/31/2025

FORM 9

TRACKING PROJECT PERFORMANCE MEASURES

Annual Objective and Performance Data

	FY___	FY___	FY___	FY___	FY___
PERFORMANCE MEASURE # 1					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 2					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
PERFORMANCE MEASURE # 3					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

OMB Number: 0915-0298
Expiration Date: 8/31/2025

INSTRUCTIONS FOR THE COMPLETION OF FORM 9
PERFORMANCE MEASURE TRACKING

General Instructions:

Complete all required data cells. If an actual number is not available, make an estimate. Please explain all estimates in a footnote. If neither actual data nor an estimate can be provided, the State must provide a footnote that describes a time framed plan for providing the required data. In such cases, the Annual Performance Objective and Annual Performance Indicator lines are to be left blank.

This form serves two purposes: 1) to show performance measures with 5-year planned performance objective targets for the application, and 2) the performance Annual Performance Indicator,@ values actually achieved each year for the annual report for each performance measure.

For each program (i.e., Healthy Start, Research, LEND, etc.) there are appropriate, required Performance Measures. Under the applicable AFY@ heading, each project will complete the Annual Performance Objectives, the Annual Performance Indicators, and numerator and denominator data for each measure as described below under Specific Instructions. For project developed additional performance measures, enter these data on the form beginning with the first blank Performance Measure area under the national measure(s).

Specific Instructions:

In the first available space under “Performance Measure" on the appropriate form, enter the brief title of the project performance measure that has been selected. The titles are to be numbered consecutively with notations of "PP 1, PP 2, etc. Titles are to be written exactly as they appear on Form 10, "Project Performance/Outcome Measure Detail Sheet."

For both national and project measures, in the lines labeled Annual Performance Objective enter a numerical value for the target the project plans to meet for the next 5 years. These values may be expressed as a number, a rate, a percentage, or yes - no

For both national and project measures, in the lines labeled Annual Performance Indicator, enter the numerical value that expresses the progress the project has made toward the accomplishment of the performance objective for the appropriate reporting year. Note that the indicator data are to go in the years column from which they were actually derived even if the data are a year behind the "reporting" year. This value is to be expressed in the same units as the performance objective: a number, a rate, a percentage, or a yes - no.

If there are numerator and denominator data for the performance measures, enter those data on the appropriate lines for the appropriate fiscal year. If there are no numerator and denominator data leave these lines empty. NOTE: Do not enter numerator and denominator data for scale measures.

Repeat this process for each performance measure. A continuation page is included. If the continuation page is used, be sure to enter the number for each listed performance measure. If there are more than six performance measures, make as many copies of the continuation page as necessary.

FORM 10
PROJECT PERFORMANCE/OUTCOME MEASURE
DETAIL SHEET

Form 10 - Option 1 (Single Measure):

PERFORMANCE MEASURE:

Level:

Domain:

GOAL:

MEASURE:

DEFINITIONS:

Numerator:
Denominator:
Units:
Number:
Text:

HEALTHY PEOPLE 2030 OBJECTIVE (or other benchmark data):

GRANTEE DATA SOURCES:

SIGNIFICANCE:

Form 10 - Option 2 (Tiered Measure):

PERFORMANCE MEASURE:

Level:

Domain:

GOAL:

MEASURE:

DEFINITION:

Tier 1:

Tier 2- Activities/ Activity Areas:

Tier 3- Process Measures:

Tier 4- Outcome Measures:

BENCHMARK DATA SOURCES:

GRANTEE DATA SOURCES:

SIGNIFICANCE:

FORM 10
DETAIL SHEET INSTRUCTIONS
PROJECT PERFORMANCE MEASURE

Instructions:

This form is to be used for both the required Program Performance Measures and any Project Outcome Measure the project chooses to add. The project can choose to add either a single component Performance measure, using **Option 1**, or a tiered measure, using **Option 2**. Complete each section as appropriate for the measure being described.

Performance Measure: Enter the narrative description of the performance or outcome measure**.**

Level: Select from National, State, or Grantee the most appropriate classification for the measure being described.

Category: Select from Women's and Maternal Health, Perinatal Infant Health, Child Health, Children with Special Health Care Needs, Adolescent Health, Life Course/ Crosscutting, or Capacity Building the most appropriate classification for the measure being described.

Goal: Enter a short statement indicating what the project hopes to accomplish by tracking this measure.

Measure: Enter a brief statement of the measure with information sufficient to interpret the meaning of a value associated with it (e.g., *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for needed services).* The measure statement should not indicate a desired direction (e.g., an increase).

Definition: Describe how the value of the measure is determined from the data. If the value of the measure is yes/no or some other narrative indicator such as a stage 1/stage 2/stage 3, a clear description of what those values mean and how they are determined should be provided.

If using Option 2:

Tier 1: Use dichotomous yes/no for respondents to state whether work is being done in the program

Tier 2: Enter a list of related process activities related to the area of measurement that projects can select from to demonstrate what activities are being done

Tier 3: Enter the same list as in Tier 2, but with space for reporting of numerical value for each process activity selected *(e.g. if Technical Assistance is selected in Tier 2, then in Tier 3, space should be provided to report number of technical assistance encounters provided)*

Tier 4 or Option 1: Enter the following for outcome measures to be reported.

- **Numerator:** If the measure is a percentage, rate, or ratio, provide a clear description of the numerator.
- **Denominator:** If the measure is a percentage, rate, or ratio, provide a clear description of the denominator.
- **Units:** If the measure is a percentage, rate, ratio, or scale, indicate the units in which the measure is to be expressed (e.g., 1,000, 100) on the **"Number"** line and type of measure (e.g., percentage, rate, ratio or scale) on **"Text"** line. If the measure is a narrative, indicate yes/no or stage 1, stage 2", etc. on the **"Text"** line and make no entry on the **"Number"** line.

Healthy People 2030 Objective: If the measure is related to a *Healthy People 2030* objective describe the objective and corresponding number. If it relates to another benchmark data source, please describe that and include relevant information.

Grantee Data Sources: Enter the source(s) of the data used in determining the value of the measure and any issues concerning the methods of data collection or limitations of the data used.

Significance: Briefly describe why this measure is significant, especially as it relates to the Goal.

Note that the Performance Measure title and numerator and denominator data are to appear on Form 8 exactly as they appear on this Form.