

Supporting Statement:
Discretionary Grant Information System (DGIS) Performance Measure Update

Submitted to

Office of Management and Budget
Office of Information and Regulatory Affairs

Submitted by

Department of Health and Human Services
Office of the Associate Administrator
Maternal and Child Health Bureau

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

**HEALTH RESOURCES AND SERVICES ADMINISTRATION
MATERNAL AND CHILD HEALTH BUREAU
PERFORMANCE MEASURES
FOR DISCRETIONARY GRANT INFORMATION SYSTEM (DGIS)**

1. Circumstances of Information Collection (Background)

The Health Resources and Services Administration (HRSA) is proposing to continue using reporting requirements for grant programs administered by the Maternal and Child Health Bureau (MCHB), including national performance measures, previously approved by the Office of Management and Budget (OMB), and in accordance with the “Government Performance and Results Act (GPRA) of 1993” (Pub. L. 103-62). This Act requires the preparation of an annual performance plan covering each program activity set forth in the agency's budget, which includes establishment of measurable goals and may be reported in an annual financial statement, which supports the linkage of funding decisions with performance. Performance measures for MCHB discretionary grants were initially approved in January 2003, and have been approved several times subsequently. Approval from OMB is being sought to continue the use of performance measures. Most of these measures are specific to certain types of programs and will not be required of all grantees. The measures will be categorized by domains (Adolescent Health, Capacity Building, and Child Health, Children with Special Health Care Needs, Lifecourse/Crosscutting, Maternal/Women Health, and Perinatal/Infant Health). Grant programs would be assigned domains based on their activities. In addition, there are three core measures and financial/demographic forms that will be utilized by all grantees. MCHB programs are authorized by Section 501 of Title V of the Social Security Act, PL 101-239 (see attachment A) and are administered by HRSA’s MCHB. This system, the Discretionary Grants Information System (DGIS), is used for grants related to program initiatives such as those listed above. The OMB number for this activity is 0915-0298 – Revision and the current expiration date is 3/31/2016.

Because MCHB discretionary grant programs are diverse, grant reporting forms and performance measures have been designed and revised to capture information across the variety of grants. The attached common grant documents include the entire set of forms to address the range of information needed from different MCHB discretionary grant programs. However, each grantee will only be required to complete forms in this package that are applicable to its initiative. Specific measures and forms will be assigned by the Project Officer when the grant competition is announced.

History and Legislative Requirements

The Maternal and Child Health Bureau evolved from the Children’s Bureau established in 1912. The enactment of Title V of the Social Security Act of 1935, specifically Section 509, which states that “the Secretary shall designate an identifiable administrative unit with expertise in maternal and child health within the Department of Health and Human Services, which ... shall be responsible for ... promoting coordination at the Federal level of the activities authorized under this Title [V],” sanctioned the Maternal and Child Health program (MCH) as well as

provided the foundation and overall structure for the MCHB.¹ Situated within the Health Resources and Services Administration (HRSA), MCHB continues to administer Title V and leads the nation in efforts to improve and promote the health of mothers and children.

With the establishment of Title V, many programs aimed at extending health and welfare services to mothers and children were enacted. These programs have evolved since 1935 with passage of many legislative amendments.

In 1981, the Omnibus Budget Reconciliation Act of 1981 (OBRA '81), Public Law (PL) 97-35, amended Title V of “the Social Security Act to establish a [block grant] program for maternal and child health services ... by consolidating specified [categorical] programs of Federal assistance to States.” This amendment resulted in the creation of the Maternal and Child Block Grant. The categorical programs consolidated under the block grant program included: Maternal and Child Health and Children with Special Needs Services, Lead-Based Paint Poisoning Prevention Program, Genetic Disease Programs, Sudden Infant Death Syndrome Programs, Hemophilia Treatment Centers, and Adolescent Pregnancy Grants. Additionally OBRA '81 authorized a set-aside of discretionary federal funds for SPRANS as part of the MCH Block Grant, “by setting forth provisions concerning: (1) the allotment of such funds; (2) payments to States; (3) use of grant money” in addition to other provisions. The set-aside of federal funds permits withholding of some of the MCH Block Grant appropriations each fiscal year to support certain categorical programs.

The Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Public Law (PL) 101-239 specifically defined two set-asides for discretionary programs, SPRANS and CISS, by amending Section 502 of Title V to state:

[The] Secretary shall retain an amount equal to 15 percent for the purpose of carrying out activities described in section 501(a) (2) [and] of the amounts appropriated under section 510(a) for the fiscal year in excess of \$600,000,000, and the Secretary shall retain an amount equal to 12 ¾ percent thereof for the projects described in subparagraphs (A) through (F) of section 501(a) (3)” respectively.

The MCHB Block Grant is the base on which SPRANS and CISS grants rest. The passage of OBRA '81 provided more discretion to states in using federal funds. State governments, the recipients of the MCH Block Grants, have the discretion to self-direct block grant funds to areas they identify as needing funding. The SPRANS and CISS grants, under MCHB, complement the state MCH Block Grants. They also enable MCHB to fulfill its leadership mission to facilitate research, policy, programs, and practice.

The common performance measures used for the discretionary grant programs meet mandated reporting requirements. The attached forms and performance measures are intended to cover all the discretionary grant programs managed by MCHB.

¹ Section 509, Title V: Maternal and Child Block Health Services Block Grant, Social Security Act (US Code §§701-710, subchapter V, chapter 7, Title 42)

Description of Reporting Forms

DGIS electronically captures data from the approximately 600 discretionary grant awardees made each year. Many of these grants are supported under the Title V Maternal and Child Health Block Grant Federal set-aside programs (SPRANS and CISS). The DGIS electronically captures performance measure, program, annual financial, and abstract data for the Bureau's discretionary grants. These data help to demonstrate the impact of these discretionary grants, assess the effectiveness of these programs, inform programmatic planning, and to ensure that quality health care is available to the Nation's maternal and child health populations. Originally released in October 2004, the DGIS is a web-based system that allows grantees to report their data online to the Maternal and Child Health Bureau through the Health Resources and Services Administration's Electronic Handbooks as part of the grant application and performance reporting processes. The data captured in the performance measures and the financial forms are aggregated to display program data.

The common performance measures used for the discretionary grant programs meet mandated reporting requirements. The attached forms and performance measures updates cover all the discretionary grant programs managed by MCHB.

MCHB Programs

The programs administered by MCHB fall into three major categories:

- **Maternal and Child Health Services Block Grants:** Large formula grants to state health departments to support basic MCH services, programs, and public health infrastructure.
- **SPRANS and CISS Programs:** "Set aside" discretionary grant programs under Title V.
- **Other Categorical Programs:** Additional funding programs administered by MCHB including the Healthy Start Initiative, Emergency Medical Services for Children, Heritable Disorders, Autism Cares, Family to Family, Sickle Cell, and Universal Newborn Hearing Screening.

Special Projects of Regional and National Significance (SPRANS)

SPRANS grants are awarded on a competitive basis to a variety of applicant organizations including public or private agencies engaged in demonstrations, research, training, and other projects to support efforts that provide quality health care to all mothers and children. Examples of grants funded through SPRANS include:

- **MCH research:** Research grants are intended to develop new knowledge and approaches to deliver and treat health problems of mothers and children, including children with special needs.
- **MCH training:** Training grants address the need to provide skilled leadership for maternal and child health programs. The grants support training for a variety of specialized clinical and laboratory services not routinely available; provide professional consultation and technical assistance; upgrade skills and competencies of state and local MCH personnel;

develop standards, procedures, and guidelines; disseminate program information; and ensure that academic training curricula include current content to serve MCHB program needs.

- **Genetics:** Genetics grants provide for the testing, counseling, referral, and follow-up of individuals and families at risk for affected by genetic disorders through broad-based programs. Projects include genetic disease education, testing, and counseling that are carried out in conjunction with other health service programs.
- **Newborn screening/follow-up:** initiatives help support State newborn screening and genetics programs, integrate newborn and genetic screening programs with other community services and medical homes, and strengthen existing newborn and genetic screening and service programs.
- **Sickle cell disease:** Sickle cell programs have established coordinated, comprehensive and family-centered networks to promote the integration of primary and subspecialty health care within medical homes for individuals across the life span that are affected by and living with sickle cell diseases and other hemoglobinopathies.
- **Hemophilia:** Hemophilia grants support the development of regional hemophilia programs (e.g., Hemophilia Diagnostic and Treatment Centers) and promote programs that are regionalized and applicable to other chronic and handicap conditions.

Community Integrated Services Systems (CISS)

Community Integrated Services Systems (CISS) is a federal discretionary grant program that seeks to reduce infant mortality and improve the health of mothers and children by funding projects for the development and expansion of integrated services at the community level. CISS funds six grant categories which include:

- Maternal and infant health home visiting programs;
- Projects to increase participation of obstetricians and pediatricians under Title V programs;
- Integrated maternal and child health service delivery systems;
- Maternal and child centers that provide pregnancy services and preventive and primary care for infants for not-for-profit hospitals;
- Maternal and child projects that serve rural populations; and
- Outpatient and community-based services programs for children with special needs provided through inpatient institutional care.

Funding preference is given to applicants who plan to carry out the grant project in geographic areas with high infant mortality rates. For maternal and child health centers that provide pregnancy and preventive services, grantees must designate matching funds equal to the Federal award that will be applied to the development or expansion of maternal and child health service centers.

Other Categorical Funding

MCHB also administers additional funding programs, which include:

- **Healthy Start Initiative:** Healthy Start supports the development of programs and strategies to reduce infant mortality in targeted high-risk communities and the replication of program successes across the Nation.
- **Emergency Medical Services for Children Program (EMSC):** Public health agencies/hospitals or emergency service programs receive grants to improve EMS programs for children with critical illnesses and life-threatening injuries.
- **Heritable Disorders:** This program aims to improve or expand the ability of States and local public health agencies to provide screening, counseling or health care services to newborns and children having or at risk for heritable disorders. Universal newborn screening provides early identification and follow-up for treatment of infants affected by certain genetic, metabolic, hormonal and/or functional conditions.
- **Autism:** This program aims to increase awareness, reduce barriers to screening and diagnosis, support research that advances the evidence base on interventions, promotes evidence-based guideline development for interventions and trains professionals to utilize valid screening tools to diagnose and provide evidence-based interventions.
- **Family to Family:** This program aims to provide information, education, technical assistance and peer support to families of children and youth with special health care needs (CSHCN). This program accomplishes this intent by assisting families and professionals so that “families of CSHCN will partner in decision making at all levels” of health care decision making
- **Sickle Cell:** This program aims to improve care for individuals with sickle cell disease through the establishment of systemic mechanisms to improve the prevention and treatment of Sickle Cell Disease and its complications, including the coordination of service delivery for individuals with Sickle Cell Disease; genetic counseling and testing; bundling of technical services related to the prevention and treatment of sickle cell disease; training of health professionals; and identifying and establishing efforts related to the expansion and coordination of education, treatment, and continuity of care for individuals with Sickle Cell Disease as authorized in Public Law 108-357, Section 712(c).
- **Universal Newborn Hearing Screening Program:** This program supports grants to states and agencies to improve early identification and intensive intervention for infants with hearing impairment.

Domain Specific Measures and Program-Specific Measures (Attachment B):

This is a central set of performance measures. The performance measures reflect MCHB’s strategic and priority areas. Collectively, they communicate the MCHB “story” to a broad range of stakeholders on the role of the Bureau in addressing the needs of maternal and child health populations. Individual grantees will respond to only a limited number of performance measures that are specifically relevant to their program.

A performance measure detail sheet defines and describes each performance measure. The detail sheet includes: a performance measurement and goal statement, an operational definition including the tier structure for the performance measure, relevance to Healthy People 2020 Objectives, data source and issues surrounding data collection, and a statement on the significance of the performance measure in the maternal and child health field. These detail sheets assure consistent understanding and reporting among all grantees and when appropriate, allow for national data aggregation. In many cases, data forms are included as attachments to assist the grantee in reporting on the measure.

Financial and Demographic Data Forms (Attachment C):

These forms are completed by all grantees to report financial and demographic information. The forms capture grantee annual budget details, project funding profile, budget details by types of individuals served, project budget expenditures by types of services, number of individuals served by type of individual served, project budget and expenditures, number of individuals served, and project performance/outcome measure detail sheet. This type of information is currently provided by grantees of all programs. These forms consolidate and streamline this information and make data collection and reporting consistent across all of the grant programs.

Part 3: Other Data Elements (Attachment D):

This section includes other data requested by MCHB divisions and offices and captures information that grantees are already reporting for program administration and management purposes for certain grant categories. The information highlights unique characteristics of discretionary grant projects that are not captured in Parts 1 or 2. Forms capture grantee technical assistance/collaboration, whether there were any products, publications and submissions from their program and additional workforce development form.

2. Purpose and Use of Information

The performance data will serve several purposes including grantee monitoring, program planning, performance reporting, and the ability to demonstrate alignment between MCHB discretionary programs and where possible the MCH Title V Block Grant program to support the ability to quantify the outcomes across MCHB. The overall number of performance measures has been reduced from what is currently used, and the structure of the system has been redesigned for the purpose of comparison and aggregation across time and program. This redesign of performance measures will allow a more accurate, objective and detailed picture of the full scope of services provided by grant programs administered by MCHB.

Federal Uses of Information

The data and attendant information that are collected from the discretionary grant recipients allow the Bureau to monitor grantee performance and progress toward achieving both short-term and long-term goals. The information provides the Bureau with timely information not only on grantee progress toward achieving goals, but also serves as a mechanism to identify technical assistance needs required by grantees to meet specified objectives.

MCHB uses the information to monitor and assess grantee progress, report on Bureau activities, and support budget planning.

Grantee Uses of Information

States, local agencies, and other grantees use the data to respond to other Federal, State, and local performance requirements/requests; to set priorities for their maternal and child health populations; and to develop and justify efforts to advance MCHB-related agendas within States and communities.

Because of the diversity of grant categories administered by the MCH Bureau, the grant reporting forms and set of performance measures forms appears extensive. However, each grantee only responds to certain applicable portions that are appropriate to their grant, as assigned by project officers. Also, with the redesigned performance measure format that utilizes a tiered approach, grantees are able to demonstrate the full breadth of the work that their programs are doing in increasing levels of detail, regardless of proximity to the final outcome.

The common set of measures still preserves the ability of grantees to highlight their own program needs and characteristics by allowing grantees to choose performance measures that pertain to their specific program. It also allows for standardized accountability across all grantee sites in measuring program progress and impact toward stated goals. Further, this consolidated effort collects consistent and comparable information across all sites and different program areas.

Information Collection

3. Use of Improved Information Technology

This activity is fully electronic. To accommodate the recognized need for better access to data, the states' demands for an electronic version of the forms, and in compliance with GPRA, grantees use an Electronic Reporting Package (ERP) to report data and to disseminate performance reports via the web. The (ERP) enables states to submit information and report data in a universal format. The ERP provides pre-formatted and interactive data entry that helps assure standardized data across States and greatly simplifies the data entry process. All calculations (e.g., ratios, rates, percentages, and totals) are automated, tables are interlocked where data overlap, and historical data are preserved so that only the annual data for the year in question needs to be newly entered.

4. Efforts to Identify Duplication

Efforts have been made to align with other data collection efforts of other Federal agencies, as required by Section 509(a) (5) of Title V of the Social Security Act. The data requested in these measures are unique to the discretionary programs, required by statute, and are not available elsewhere.

5. Involvement of Small Entities

This project does not have a significant impact on small entities.

6. Consequences if Information Collected Less Frequently

Annual submission of grant reporting requirements is required by law to entitle grantees to receive federal grant funds for each year of their grant award.

7. Consistency with the Guidelines in 5 CFR 1320.5(d) (2)

This data collection request is fully consistent with the guidelines in 5 CFR 1320.5(d) (2).

8. Consultation outside the Agency

The notice required in 5 CFR 1320.8(d) was published in the *Federal Register* on November 6, 2015, Document 80 FR 68871, on page number 68871. 302 individual comments were received during the public comment period and were taken in to account in the final preparation of these performance measures and forms. The collaborative process carried out to develop changes to these measures and forms involved group interviews with staff from MCHB's divisions and offices to discuss how to make the measures and forms more applicable to the activities of the discretionary grantees and ensure value to Bureau, divisions, and individual grantees.

9. Remuneration of Respondents

Respondents will not be remunerated.

10. Assurance of Confidentiality

The information that is collected does not identify any individuals by name or collect any individual information.

11. Questions of a Sensitive Nature

There are no questions of a sensitive nature.

12. Estimates of Annualized Hour Burden (example below)

Form	Number of Respondents	Responses per Respondent	Total Responses	Burden hours per response	Total burden hours
Grant Report	600	1	600	36	21,600
Total	600	1	600	36	21,600

13. Estimates of Annualized Cost Burden to Respondents

There are no capital or startup costs associated with this data collection.

14. Estimates of Annualized Cost to the Government

This activity requires approximately 1 FTE GS-14 at 20% time for an average annual cost of \$32,000. In addition, about \$750,000 in contract costs is required annually for the operation of the system for automated reporting and analysis of data. On this basis, the estimated average annual cost to the Federal Government is \$782,000.

15. Changes in Burden

The current inventory for this activity is 21,600 hours. With the proposed revisions, there is a reduction in the estimated annual burden, as the number of programs reporting is anticipated to be lower than it has been historically. Further, most programs will have a limited number of measures assigned (3 to 5 measures), with only Training programs, Emergency Medical Services for Children programs, and Healthy Start programs continuing to additional report program-specific measures as part of these discretionary grant performance measures.

16. Time Schedule, Publication, and Analysis Plans

This activity is an annual data collection. Submission of all documents by grantees will take place at different grant cycles throughout the year depending on the program for which the grantee is reporting. See <https://perf-data.hrsa.gov/MCHB/DGISReports/> for more information.

17. Exception for display of expiration date

The expiration date will be displayed.

18. Certifications

This project meets all of the requirements in 5 CFR 1320.9. The certifications are included in this package.

ATTACHMENTS TO SUPPORTING STATEMENT

Attachment A	Section 501 of Title V of the Social Security Act
Attachment B	Domain-Specific Measures and Program-Specific Measures
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Updated DGIS Performance Measures, Numbering by Domain
(All Performance Measures are revised from prior OMB package)

Health Resources and Services
Administration
Maternal and Child Health Bureau

Discretionary Grant Performance Measures

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

Attachment B
Part 1- Detail Sheets
OMB Clearance Package

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

Core 1 Performance Measure

The percent of programs meeting the stated aims of their grant at the end of the current grant cycle

Goal: Grant Impact

Level: Grantee

Domain: Core

GOAL

To ensure that planned grant impact was met.

MEASURE

The percent of MCHB funded projects meeting their stated objectives.

DEFINITION

Tier 1: Have you met the planned objectives as stated at the beginning of the grant cycle?

Prepopulated with the objectives from FOA:

- Did you meet objective 1 _____? Y/N
- Did you meet objective 2 _____? Y/N

BENCHMARK DATA SOURCES

N/A

GRANTEE DATA SOURCES

Grantee self-reported

SIGNIFICANCE

Core 2 Performance Measure

The percent of programs engaging in quality improvement and through what means, and related outcomes.

Goal: Quality Improvement
Level: Grantee
Domain: Core

GOAL

To measure quality improvement initiatives.

MEASURE

The percent of MCHB funded projects implementing quality improvement initiatives.

DEFINITION

Tier 1: Are you implementing quality improvement (QI) initiatives in your program?

- Yes
- No

Tier 2: QI initiative:

What type of QI structure do you have? (Check all that apply)

- Team established within a division, office, department, etc. of an organization to improve a process, policy, program, etc.
- Team within and across an organization focused on organizational improvement
- Cross sectorial collaborative across multiple organizations

What types of aims are included in your QI initiative? (Check all that apply)

- Population health
- Improve service delivery (process or program)
- Improve client satisfaction/ outcomes
- Improve work flow
- Policy improvement
- Reducing variation or errors

Tier 3: Implementation

Are QI goals directly aligned with organization's strategic goals? Y/ N

Has the QI team received training in QI? Y/N

Do you have metrics to track improvement? Y/N

Which methodology are you utilizing for quality improvement? (Check all that apply)

- Plan, Do, Study, Act Cycles
- Lean
- Six Sigma
- Other: _____

Tier 4: What are the related outcomes?

Is there data to support improvement in population health as a result of the QI activities? Y/N

Is there data to support organizational improvement as a result of QI activities? Y/N

Is there data to support improvement in cross sectorial collaboration as a result of QI activities? Y/N

BENCHMARK DATA SOURCES

N/A

GRANTEE DATA SOURCES

Grantee self-reported.

SIGNIFICANCE

Core 3 Performance Measure	The percent of programs promoting and/ or facilitating improving health equity.
Goal: Health Equity	
Level: Grantee	
Domain: Capacity Building	
GOAL	To ensure MCHB grantees have established specific aims related to improving health equity.
MEASURE	The percent of MCHB funded projects with specific measurable aims related to promoting health equity.
DEFINITION	<p>Tier 1: Are you promoting and/ or facilitating health equity in your program?</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes<input type="checkbox"/> No <p>Tier 2: Please select within which of the following domains your program addresses health equity (check all that apply):</p> <ul style="list-style-type: none"><input type="checkbox"/> Income<input type="checkbox"/> Race<input type="checkbox"/> Ethnicity<input type="checkbox"/> Language<input type="checkbox"/> Socioeconomic Status<input type="checkbox"/> Health Status<input type="checkbox"/> Disability<input type="checkbox"/> Sexual Orientation<input type="checkbox"/> Sex<input type="checkbox"/> Gender<input type="checkbox"/> Age<input type="checkbox"/> Geography – Rural/ Urban<input type="checkbox"/> Other: _____ <p>Tier 3: Implementation Has your program set stated goal/ objectives for health equity? Y/N If yes, what are those aims? _____</p> <p>Tier 4: What are the related outcomes? % of programs that met stated goals/ objectives around health equity Numerator: # of programs that met stated specific aims around health equity Denominator: # of programs that set specific aims around health equity</p> <p><i>* Health equity exists when challenges and barriers have been removed for those groups who experience greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.</i></p>
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	Health equity is achieved when every individual has the opportunity to attain his or her full health potential and no one is “disadvantaged from achieving this potential because of social position or socially determined consequences.” Achieving health equity is a top priority in the United States.

CB 1 Performance Measure

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

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

Level: Grantee

Domain: Capacity Building

GOAL

To ensure adequate and increasing state capacity for advancing the health of MCH populations.

MEASURE

The percent of MCHB-funded projects of a national scale promoting and facilitating state capacity for advancing the health of MCH populations, and through what processes.

DEFINITION

Tier 1: Are you promoting and facilitating state capacity for advancing the health of MCH populations for _____'s* priority topic?

- Yes
- No

***prepopulated with program focus**

Tier 2: Through what activities are you promoting and facilitating state capacity for advancing the health of MCH populations?

- Delivery of training on program priority topic
- Support state strategic planning activities
- Serve as expert and champion on the priority topic
- Facilitate state level partnerships to advance priority topics
- Maintain consistent state-level staffing support for priority topic (State-level programs only)
- Collect data to track changes in prevalence of program priority issues
- Utilize available data to track changes in prevalence of program priority issue on national/ regional level
- Issue model standards of practice for use in the clinical setting

Tier 3: Implementation

- # of professionals trained on program priority topic
- How frequently are data collected and analyzed to monitor status and refine strategies?:
 - Less frequently than annually
 - Bi-annual
 - Quarterly
 - Monthly
- # of MOUs between State agencies addressing priority area
- # of State agencies/departments participating on priority area. This includes the following key state agencies (check all that apply):
 - Commissions/ Task Forces
 - MCH/CSHCN
 - Genetics
 - Newborn Screening
 - Early Hearing and Detection
 - EMSC
 - Oral Health
 - Developmental Disabilities
 - Medicaid
 - Mental & Behavioral Health
 - Housing

CB 1 Performance Measure

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

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

Level: Grantee

Domain: Capacity Building

- 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?

(National Programs Only)

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

BENCHMARK DATA SOURCES

N/A

GRANTEE DATA SOURCES

Grantee Self-Reported.

CB 2 Performance Measure

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

Goal: Technical Assistance

Level: Grantee

Domain: Capacity Building

GOAL

To ensure supportive programming for technical assistance.

MEASURE

The percent of MCHB funded projects providing technical assistance, on which MCH priority topics, and to whom.

DEFINITION

Tier 1: Are you providing technical assistance (TA) through your program?

- Yes
- No

Tier 2: To whom are you providing TA (check all that apply)?

- Participants/ Public
- Providers/ Health Care Professionals
- Local/ Community Partners
- State/ National Partners

**Technical Assistant refers to collaborative problem solving on a range of issues, which may include program development, program evaluation, needs assessment, and policy or guideline formulation. It may include administrative services, site visitation, and review or advisory functions. TA may be a one-time or ongoing activity of brief or extended frequency.*

Tier 3: Implementation (populated from prior domain questions)

- # CSHCN/Developmental Disabilities TA
- # Autism TA
- # Prenatal Care TA
- # Perinatal/ Postpartum Care TA
- # Maternal and Women's Depression Screening TA
- # Safe Sleep TA
- # Breastfeeding TA
- # Newborn Screening TA
- # Genetics TA
- # Quality of Well Child Visit TA
- # Well Visit TA
- # Injury Prevention TA
- # Family Engagement TA
- # Medical Home TA
- # Transition TA
- # Adolescent Major Depressive Disorder Screening TA
- # Health Equity TA
- # Adequate health insurance coverage TA
- # Tobacco and eCigarette Use TA
- # Oral Health TA
- # Nutrition TA
- # Data Research and Evaluation TA
- # Other TA

(Please specify additional topics:_____)

Tier 4: What are the related outcomes?

(populated from prior questions)

- # receiving TA
- # technical assistance activities
- # TA activities by target audience (Local, Title V, Other state agencies, partners, Regional, National, International)

GRANTEE DATA SOURCES

Grantee self-reported.

SIGNIFICANCE

National Resource Centers, Policy Centers, leadership training

CB 2 Performance Measure

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

Goal: Technical Assistance

Level: Grantee

Domain: Capacity Building

institutes and many other MCHB discretionary grantees provide technical assistance and training to various target audiences, including grantees, health care providers, state agencies, community-based programs, program beneficiaries, and the public as a way of improving skills, increasing the MCH knowledge base, and thus improving capacity to adequately serve the needs of MCH populations and improve their outcomes.

Data Collection Form for #CB 2

The form below will be prepopulated by TA selected in domain-specific measures.

All measures for which a grantee reported that they provide TA will be triggered in this table.

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

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

CB 3 Performance Measure

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

Goal: Impact Measurement
Level: Grantee
Domain: Capacity Building

GOAL

To ensure supportive programming for impact measurement.

MEASURE

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

DEFINITION

Tier 1: Are you collecting and analyzing data related to impact measurement in your program?

- Yes
- No

Tier 2: How are you measuring impact?

- Conduct participant surveys
- Collect client level data
- Qualitative assessments
- Case reports
- Other: _____

Tier 3: Implementation

- List of tools used
- Outcomes of qualitative assessment
- # of participant surveys
- # of clients whose level data collected
- # of case reports

Tier 4: What are the related outcomes?

% of grantees that collect data on the impact of their grants on the field (and methods used to collect data)

Numerator: # of grantees that collect data on the impact of their grants on the field

Denominator: # of grantees

How is data collected: _____

% of grantees that collect and analyze data on the impact of their grants on the field (and methods used to analyze data)

Numerator: # of grantees that analyze data on the impact of their grants on the field

Denominator: # of grantees

How is data analyzed: _____

GRANTEE DATA SOURCES

Grantee self-reported.

SIGNIFICANCE

Impact as referenced here is a change in condition or status of life. This can include a change in health, social, economic or environmental condition. Examples may include improved health for a community/population or a reduction in disparities for a specific disease or increased adoption of a practice.

CB 4 Performance Measure	The percent of MCHB funded initiatives working to promote sustainability of their programs or initiatives beyond the life of MCHB funding.
Goal: Sustainability	
Level: Grantee	
Domain: Capacity Building	
GOAL	To ensure sustainability of programs or initiatives over time, beyond the duration of MCHB funding.
MEASURE	The percent of MCHB funded initiatives working to promote sustainability of their programs or initiatives beyond the life of MCHB funding, and through what methods.
DEFINITION	<p>Tier 1: Are you addressing sustainability in your program?</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes<input type="checkbox"/> No <p>Tier 2: Through what processes/ mechanisms are you addressing sustainability?</p> <ul style="list-style-type: none"><input type="checkbox"/> 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<input type="checkbox"/> 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<input type="checkbox"/> 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<input type="checkbox"/> 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<input type="checkbox"/> 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<input type="checkbox"/> The grantee identified, actively sought out, and obtained other funding sources and in-kind resources to sustain the entire MCHB-funded program or initiative<input type="checkbox"/> 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<input type="checkbox"/> 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<input type="checkbox"/> 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 <p>Tier 3: Implementation N/A</p> <p>Tier 4: What are the related outcomes? % of grants that have sustainability plans</p>
BENCHMARK DATA SOURCES	N/A

CB 4 Performance Measure

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

Goal: Sustainability

Level: Grantee

Domain: Capacity Building

GRANTEE DATA SOURCES

Grantee self-reported.

SIGNIFICANCE

In recognition of the increasing call for recipients of public funds to sustain their programs after initial funding ends, MCHB encourages grantees to work toward sustainability throughout their grant periods. A number of different terms and explanations have been used as operational components of sustainability. These components fall into four major categories, each emphasizing a distinct focal point as being at the heart of the sustainability process: (1) adherence to program principles and objectives, (2) organizational integration, (3) maintenance of health benefits, and (4) State or community capacity building. Specific recommended actions that can help grantees build toward each of these four sustainability components are included as the Tier 2 data elements for this measure.

CB 5 PERFORMANCE MEASURE

The percent of programs supporting the production of scientific publications and through what means, and related outcomes.

Goal: Scientific Publications
Level: Grantee
Domain: Capacity Building

GOAL

To ensure supportive programming for the production of scientific publications.

MEASURE

The percent of MCHB funded projects programs supporting the production of scientific publications.

DEFINITION

Tier 1: Are you supporting the production of scientific publications in your program?

- Yes
- No

Tier 2: Indicate the categories of scientific publication that have been produced with grant support (either fully or partially) during the reporting period.

- Submitted
- In press
- Published

Tier 3: How many are reached through those activities?
of scientific/ peer-reviewed publications

Tier 4: How, if at all, have these publications been disseminated (check all that apply)?

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	The percent of programs supporting the development of informational products and through what means, and related outcomes.
Goal: Products	
Level: Grantee	
Domain: Capacity Building	
GOAL	To ensure supportive programming for the development of informational products.
MEASURE	The percent of MCHB funded projects supporting the development of informational products, and through what processes.
DEFINITION	<p>Tier 1: Are you creating products as part of your MCHB-supported program?</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes<input type="checkbox"/> No <p>Tier 2: Indicate the categories of products that have been produced with grant support (either fully or partially) during the reporting period. <i>Count the original completed product, not each time it is disseminated or presented.</i></p> <ul style="list-style-type: none"><input type="checkbox"/> Books<input type="checkbox"/> Book chapters<input type="checkbox"/> Reports and monographs (including policy briefs, best practice reports, white papers)<input type="checkbox"/> Conference presentations and posters presented<input type="checkbox"/> Web-based products (website, blogs, webinars, newsletters, distance learning modules, wikis, RSS feeds, social networking sites) <i>Excluding video/ audio products that are posted online post-production</i><input type="checkbox"/> Audio/ Video products (podcasts, produced videos, video clips, CD-ROMs, CDs, or audio)<input type="checkbox"/> Press communications (TV/ Radio interviews, newspaper interviews, public service announcements, and editorial articles)<input type="checkbox"/> Newsletters (electronic or print)<input type="checkbox"/> Pamphlets, brochures, or fact sheets<input type="checkbox"/> Academic course development<input type="checkbox"/> Distance learning modules<input type="checkbox"/> Doctoral dissertations/ Master's theses<input type="checkbox"/> Other: _____ <p>Tier 3: Implementation of products # products created in each category</p> <p>Tier 4: What are the related outcomes? N/A</p>
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.

Table 1: Activity Data Collection Form for Selected Measures

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

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

WHM 1 PERFORMANCE MEASURE	The percent of programs promoting and/or facilitating timely prenatal care.
Goal: Prenatal Care	
Level: Grantee	
Domain: Women's/ Maternal Health	
GOAL	To ensure supportive programming for prenatal care.
MEASURE	The percent of MCHB funded projects addressing prenatal care. The percent of pregnant program participants who receive prenatal care beginning in the first trimester.
DEFINITION	<p>Tier 1: Are you addressing prenatal care in your program?</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes<input type="checkbox"/> No <p>Tier 2: Through what processes/ mechanisms are you addressing prenatal care?</p> <ul style="list-style-type: none"><input type="checkbox"/> Technical Assistance<input type="checkbox"/> Training<input type="checkbox"/> Product Development<input type="checkbox"/> Research/ Peer-reviewed publications<input type="checkbox"/> Outreach/ Information Dissemination/ Education<input type="checkbox"/> Tracking/ Surveillance<input type="checkbox"/> Screening/ Assessment<input type="checkbox"/> Referral/ care coordination<input type="checkbox"/> Direct Service<input type="checkbox"/> Quality improvement initiatives <p>Tier 3: How many are reached through those activities? <i>(Report in Table 1: Activity Data Collection Form)</i></p> <ul style="list-style-type: none"># 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 <p>Tier 4: What are the related outcomes?</p> <ul style="list-style-type: none">% of pregnant women who receive prenatal care beginning in the first trimesterNumerator: Pregnant program participants who began prenatal care in the first trimester of pregnancy.Denominator: Pregnant program participants who were enrolled prenatally.
BENCHMARK DATA SOURCES	Related to MICH Objective #10: Increase the proportion of pregnant women who receive prenatal care beginning in the first trimester (Baseline: 70.8% in 2007, Target: 77.9%)
GRANTEE DATA SOURCES	Title V Ntnl Outcome Measure #1, Healthy People 2020 MICH-10
SIGNIFICANCE	Entry of prenatal care during the first trimester is important to ensuring a healthy pregnancy for both the mother and child. Women who receive delayed prenatal care (entry after the first 12 weeks) are at risk for having undetected complications in pregnancy that can result in undesirable consequences for both mother and baby.

WMH 2 PERFORMANCE MEASURE	The percent of programs promoting and/ or facilitating timely postpartum care.
Goal: Perinatal/ Postpartum Care	
Level: Grantee	
Domain: Women's/ Maternal Health	
GOAL	To ensure supportive programming for postpartum care.
MEASURE	The percent of MCHB funded projects addressing perinatal and postpartum care. The percent of pregnant women with a postpartum visit within 8 weeks of delivery.
DEFINITION	<p>Tier 1: Are you promoting and/ or facilitating timely postpartum care in your program?</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes<input type="checkbox"/> No <p>Tier 2: Through what processes/ mechanisms are you promoting and/ or facilitating perinatal and postpartum care?</p> <ul style="list-style-type: none"><input type="checkbox"/> Technical Assistance<input type="checkbox"/> Training<input type="checkbox"/> Product Development<input type="checkbox"/> Research/ Peer-reviewed publications<input type="checkbox"/> Outreach/ Information Dissemination/ Education<input type="checkbox"/> Tracking/ Surveillance<input type="checkbox"/> Screening/ Assessment<input type="checkbox"/> Referral/ care coordination<input type="checkbox"/> Direct Service<input type="checkbox"/> Quality improvement initiatives <p>Tier 3: How many are reached through those activities? <i>(Report in Table 1: Activity Data Collection Form)</i></p> <ul style="list-style-type: none"># 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 <p>Tier 4: What are the related outcomes?</p> <ul style="list-style-type: none">% of pregnant women with a postpartum visit within 4 to 6 weeks of deliveryNumerator: Program participants included in the denominator who had a postpartum visit within 4 to 6 weeks of deliveryDenominator: Women program participants who enrolled before 6 weeks post-delivery and who delivered 6 weeks or more prior to the end of the reporting period.
BENCHMARK DATA SOURCES	Related to Healthy People 2020 MICH- 19: Increase the proportion of women giving birth who attend a postpartum care visit with a health worker.
GRANTEE DATA SOURCES	Pregnancy Risk Assessment Monitoring System
SIGNIFICANCE	Perinatal care is important for mothers to receive to ensure they are getting adequate reproductive health services from trained

WHM 1 PERFORMANCE MEASURE

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

Goal: Prenatal Care

Level: Grantee

Domain: Women's/ Maternal Health

professionals. Families should be trained on family planning, pre-conceptual counseling, newborn care, and care for the woman in the postpartum period. Postpartum care is important for the mother and new baby following birth following the many new changes that occur; physically, physiologically, psychologically, and mentally. Postpartum care is targeted to promote maternal well-being and help transition to motherhood along with family planning to include significant others.

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.

WMH 3 Performance Measure

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

Goal: Well Woman Visit/ Preventive Health Care

Level: Grantee

Domain: Women's/ Maternal Health

GOAL

To ensure supportive programming for well woman visits/ preventive health care.

MEASURE

The percent of MCHB funded projects promoting and/ or facilitating well woman visits/ preventive health care and through what processes.

DEFINITION

Tier 1: Are you promoting and/ or facilitating well woman visits/ preventive health care in your program?

- Yes
- No

Tier 2: Through what activities are you promoting and/ or facilitating well woman visits/ preventive health care?

- Technical Assistance
- Training
- Product Development
- Research/ Peer-reviewed publications
- Outreach/ Information Dissemination/ Education
- Tracking/ Surveillance
- Screening/ Assessment
- Referral/ care coordination
- Direct Service
- Quality improvement initiatives

Tier 3: How many are reached through those activities?

(Report in Table 1: Activity Data Collection Form)

- # receiving TA
- # receiving training
- # products developed
- # peer-reviewed publications published
- # receiving information and education through outreach
- # receiving screening/ assessment
- # referred/care coordinated
- # received direct service
- # participating in quality improvement initiatives

Tier 4: What are the related outcomes?

% of women with a well woman/ preventative visit in the past year.

Numerator: Women program participants who received a well-woman or preventive visit in the past 12 months (includes prenatal and postpartum visit)

Denominator: Women program participants

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

BENCHMARK DATA SOURCES

Behavioral Risk Factor Surveillance System (BRFSS) Last Check Up within Prior Year (Nationwide, 2013): 68.2%

WMH 3 Performance Measure

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

Goal: Well Woman Visit/ Preventive Health Care

Level: Grantee

Domain: Women's/ Maternal Health

GRANTEE DATA SOURCES

Title V National Performance Measure #1

SIGNIFICANCE

A well woman visit is a way to make sure an individual is staying healthy. These include a full checkup, separate from a visit for sickness or injury. The focus is on preventive care which includes, but is not limited to, appropriate assessment, immunizations, screenings, education, and counseling.

WMH 4 Performance Measure

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

Goal: Depression Screening

Level: Grantee

Domain: Women's/ Maternal Health

GOAL

To ensure supportive programming for depression screening.

MEASURE

The percent of MCHB funded projects promoting and/ or facilitating depression screening and through what processes.

DEFINITION

Tier 1: Are you promoting and/ or facilitating depression screening in your program?

- Yes
- No

Tier 2: Through what activities are you promoting and/ or facilitating depression screening?

- Technical Assistance
- Training
- Product Development
- Research/ Peer-reviewed publications
- Outreach/ Information Dissemination/ Education
- Tracking/ Surveillance
- Screening/ Assessment
- Referral/ care coordination
- Direct Service
- Quality improvement initiatives

Tier 3: How many are reached through those activities?

(Report in Table 1: Activity Data Collection Form)

- # receiving TA
- # receiving training
- # products developed
- # peer-reviewed publications published
- # receiving information and education through outreach
- # receiving screening/ assessment
- # referred/care coordinated
- # received direct service
- # participating in quality improvement initiatives

Tier 4: What are the related outcomes?

% of women screened for depression using a validated tool

Numerator: Program participants included in the denominator who were screened for depression using a validated tool within the reporting period

Denominator: Women program participants

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

Numerator: Women program participants who screened positive for depression who received a referral for services.

Denominator: Women program participants who screened positive for depression.

BENCHMARK DATA SOURCES

Related to Healthy People 2020 MICH #34 Objective: (Developmental) Decrease the proportion of women delivering a live birth who experience postpartum depressive symptoms.

GRANTEE DATA SOURCES

Home Visiting Performance Measure

SIGNIFICANCE

Fewer than half the cases of postpartum depression are

WMH 4 Performance Measure

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

Goal: Depression Screening

Level: Grantee

Domain: Women's/ Maternal Health

recognized every year. Yet, postpartum depression occurs in nearly 20% of women who have recently given birth. Screening is important not only for the mother, but for children's outcomes as well. Children with depressed mothers are likely to have delayed social and behavioral development.

PIH 1 Performance Measure	The percent of program participants who engage in safe sleep practices.
Goal: Safe Sleep	
Level: Grantee	
Domain: Perinatal Infant Health	
GOAL	To ensure supportive programming for safe sleep practices.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating safe sleep practices.
DEFINITION	<p>Tier 1: Are you promoting and/ or facilitating safe sleep in your program?</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes<input type="checkbox"/> No <p>Tier 2: Through what activities are you promoting and/ or facilitating safe sleep?</p> <ul style="list-style-type: none"><input type="checkbox"/> Technical Assistance<input type="checkbox"/> Training<input type="checkbox"/> Product Development<input type="checkbox"/> Research/ Peer-reviewed publications<input type="checkbox"/> Outreach/ Information Dissemination/ Education<input type="checkbox"/> Tracking/ Surveillance<input type="checkbox"/> Screening/ Assessment<input type="checkbox"/> Referral/ care coordination<input type="checkbox"/> Direct Service<input type="checkbox"/> Quality improvement initiatives <p>Tier 3: How many are reached through those activities? <i>(Report in Table 1: Activity Data Collection Form)</i></p> <ul style="list-style-type: none"># 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 <p>Tier 4: What are the related outcomes?</p> <ul style="list-style-type: none">% of infants placed to sleep following safe sleep practices <p>Numerator: Number of child program participants (aged 0-12 months) whose parent reports that they are most often or always placed to sleep following safe sleep practices.</p> <p>Denominator: Number of child program participants aged 0 to 12 months old.</p> <p>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 placed to sleep on their back and with no bed-sharing.</p>
BENCHMARK DATA SOURCES	Related to MICH Objective #20: Increase the proportion of infants placed to sleep on their backs (Baseline: 69.0%, Target: 75.9%), Pregnancy Risk Assessment Monitoring System (PRAMS).
GRANTEE DATA SOURCES	Title V National Performance Measure #5, Home Visiting Performance Measure
SIGNIFICANCE	Sleep-related infant deaths, called Sudden Unexpected Infant Deaths

PIH 1 Performance Measure

The percent of program participants who engage in safe sleep practices.

Goal: Safe Sleep

Level: Grantee

Domain: Perinatal Infant Health

(SUIDS), are the leading cause of infant death after the first month of life. Risk of SUIDS increases when babies are placed on their side or stomach to sleep. Placing babies on their back, on a firm surface without loose bedding or soft objects, as well as no bed-sharing are the recommended practices to follow according to American Assoc. of Pediatrics.

PIH 2 PERFORMANCE MEASURE

The percent of programs promoting and/ or facilitating breastfeeding.

Goal: Breastfeeding

Level: Grantee

Domain: Perinatal Infant Health

GOAL

To ensure supportive programming for breastfeeding.

MEASURE

The percent of MCHB funded projects promoting and/ or facilitating breastfeeding.

DEFINITION

Tier 1: Are you promoting and/ or facilitating breastfeeding in your program?

- Yes
- No

Tier 2: Through what activities are you promoting and/ or facilitating breastfeeding?

- Technical Assistance
- Training
- Product Development
- Research/ Peer-reviewed publications
- Outreach/ Information Dissemination/ Education
- Tracking/ Surveillance
- Screening/ Assessment
- Referral/ care coordination
- Direct Service
- Quality improvement initiatives

Tier 3: How many are reached through those activities?
(Report in Table 1: Activity Data Collection Form)

- # receiving TA
- # receiving training
- # products developed
- # peer-reviewed publications published
- # receiving information and education through outreach
- # receiving screening/ assessment
- # referred/care coordinated
- # received direct service
- # participating in quality improvement initiatives

Tier 4: What are the related outcomes?

% of infants who are ever breastfed

Numerator: Infant participants whose parent/ caregiver reports they ever breastfed or fed breastmilk to their infant.

Denominator: Infant children <24 months of women program participants who were enrolled prenatally or at the time of birth.

% of infants breastfed through 6 months

Numerator: Infant participants whose parent/ caregiver reports they were breastfed or fed breast milk at 6 months of age.

Denominator: Child participants aged 6 -24 months whose mother was enrolled prenatally or at the time of birth.

BENCHMARK DATA SOURCES

Objective # MICH-21.1: Increase the proportion of children who are ever breastfed. (Baseline: 74% in 2006, Target: 81.9%).
MICH-21.2: Increase the proportion of infants who are breastfed at 6 months (Baseline: 43.5% in 2006, Target: 60.6%). MICH-21.3: Increase the proportion of infants who are breastfed at 1 year (Baseline: 34.1% in 2006, Target: 34.1%). MICH-21.4: Increase

PIH 2 PERFORMANCE MEASURE

The percent of programs promoting and/ or facilitating breastfeeding.

Goal: Breastfeeding

Level: Grantee

Domain: Perinatal Infant Health

the proportion of infants who are breastfed exclusively through 3 months (Baseline: 33.6% in 2006, Target: 46.2%). MICH-21.5: Increase the proportion of infants who are breastfed exclusively at 6 months (Baseline: 14.1% in 2006, Target: 25.5%).

GRANTEE DATA SOURCES

Title V NPM #4, Home Visiting Performance Measure, Healthy Start Benchmark, Healthy People 2020, MICH-21.5, National Immunization Survey (NIS).

SIGNIFICANCE

Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits.

PIH 3 Performance Measure

Percent of programs promoting newborn screenings and follow-up.

Goal: Newborn Screening

Level: Grantee

Domain: Perinatal Infant Health

GOAL

To ensure supportive programming for newborn screenings.

MEASURE

The percent of MCHB funded projects promoting and/ or facilitating newborn screening and follow-up.

DEFINITION

Tier 1: Are you promoting and/or facilitating newborn screening and follow-up in your program?

- Yes
- No

Tier 2: Through what processes/ mechanisms are you promoting or facilitating newborn screening and follow-up?

- Technical Assistance
- Training
- Product Development
- Research/ Peer-reviewed publications
- Outreach/ Information Dissemination/ Education
- Tracking/ Surveillance
- Screening/ Assessment
- Referral/ care coordination
- Direct Service
- Quality improvement initiatives

Tier 3: How many are reached through those activities?

(Report in Table 1: Activity Data Collection Form)

- # receiving TA
- # receiving training
- # products developed
- # peer-reviewed publications published
- # receiving information and education through outreach
- # receiving screening/ assessment
- # referred/care coordinated
- # received direct service
- # participating in quality improvement initiatives

Tier 4: What are the related outcomes?

% of eligible newborns screened with timely notification for out of range screens

Numerator: # of eligible newborns screened with out of range results whose caregivers receive timely notification

Denominator: # of eligible newborns screened with out of range results

% of eligible newborns screened with timely notification for out of range screens who are followed up in a timely manner

Numerator: # of eligible newborns screened with out of range results whose caregivers receive timely notification and receive timely follow up

Denominator: # of eligible newborns screened with out of range results whose caregivers receive timely notification

BENCHMARK DATA SOURCES

Objective # MICH-32: Increase appropriate newborn-blood spot screening and follow-up testing (Baseline: 98.3% in 2006, Target: 100%)

GRANTEE DATA SOURCES

Title V National Outcome Measure #12

PIH 3 Performance Measure

Percent of programs promoting newborn screenings and follow-up.

Goal: Newborn Screening

Level: Grantee

Domain: Perinatal Infant Health

SIGNIFICANCE

Newborn screening detects thousands of babies each year with potentially devastating, but treatable disorders. The benefits of newborn screening depend upon timely collection of the newborn blood-spots or administration of a point-of-care test (pulse oximeter for critical congenital heart disease), receipt of the newborn blood spot at the laboratory, testing of the newborn blood spot, and reporting out all results. Timely detecting prevents death and other significant health complications.

CH 1 Performance Measure	The percent of programs promoting and/ or facilitating well-child visits.
Goal: Well-Child Visit	
Level: Grantee	
Domain: Child Health	
GOAL	To ensure supportive programming for well-child visits.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating well-child visits.
DEFINITION	<p>Tier 1: Are you promoting and/ or facilitating well-child visits in your program?</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes<input type="checkbox"/> No <p>Tier 2: Through what activities are you promoting and/ or facilitating well-child visits?</p> <ul style="list-style-type: none"><input type="checkbox"/> Technical Assistance<input type="checkbox"/> Training<input type="checkbox"/> Product Development<input type="checkbox"/> Research/ Peer-reviewed publications<input type="checkbox"/> Outreach/ Information Dissemination/ Education<input type="checkbox"/> Tracking/ Surveillance<input type="checkbox"/> Screening/ Assessment<input type="checkbox"/> Referral/ care coordination<input type="checkbox"/> Direct Service<input type="checkbox"/> Quality improvement initiatives <p>Tier 3: How many are reached through those activities? <i>(Report in Table 1: Activity Data Collection Form)</i></p> <ul style="list-style-type: none"># 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 <p>Tier 4: What are the related outcomes?</p> <ul style="list-style-type: none">% of children who received a well care visit in the reporting year<ul style="list-style-type: none">Numerator: Child program participants who received a well care visit in the reporting yearDenominator: Child program participants in the reporting year% of children enrolled in Medicaid/ CHIP with at least one well care visit in the past year<ul style="list-style-type: none">Numerator: Medicaid/ CHIP-enrolled child program participants who received a well-child visit in the reporting year.Denominator: Medicaid/ CHIP-enrolled child program participants in the reporting year
BENCHMARK DATA SOURCES	National Survey of Children’s Health K4Q20
GRANTEE DATA SOURCES	Title V National Performance Measure #10,
SIGNIFICANCE	As childhood is a time of growth and development, it is important that children are seeing their pediatrician on a regular basis.

CH 2 Performance Measure	The percent of programs promoting and/ or facilitating quality of well-child visits.
Goal: Quality of Well Child Visit	
Level: Grantee	
Domain: Child Health	
GOAL	To ensure supportive programming for quality of well child visits.
MEASURE	The percent of MCHB funded projects promoting or facilitating quality of well child visits.
DEFINITION	<p>Tier 1: Are you addressing the quality of well child visits in your program?</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes<input type="checkbox"/> No <p>Tier 2: Through what activities are you addressing quality of well child visits?</p> <ul style="list-style-type: none"><input type="checkbox"/> Technical Assistance<input type="checkbox"/> Training<input type="checkbox"/> Product Development<input type="checkbox"/> Research/ Peer-reviewed publications<input type="checkbox"/> Outreach/ Information Dissemination/ Education<input type="checkbox"/> Quality improvement initiatives <p>Tier 3: How many are reached through those activities?</p> <ul style="list-style-type: none"># receiving TA# receiving professional/organizational development training# product disseminated# reached while guideline setting <p>Tier 4: What are the related outcomes?</p> <ul style="list-style-type: none">% providers trained in conducting a quality well-child visit <p>Numerator: # of providers trained Denominator: # of providers targeted through the program</p>
BENCHMARK DATA SOURCES	N/A
GRANTEE DATA SOURCES	Grantee self-reported.
SIGNIFICANCE	Children grow and develop very rapidly so it is important they see a pediatrician on a regular basis. Each visit should include a complete physical examination, record of height and weight, and information regarding hearing, vision, and annual screenings.

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

CH 3 Performance Measure

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

Goal: Developmental Screening

Level: Grantee

Domain: Child Health

SIGNIFICANCE

Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home and an appropriate responsibility of all pediatric health care professionals. The early identification of developmental problems should lead to further developmental and medical evaluation, diagnosis, and treatment, including early developmental intervention. Children diagnosed with developmental disorders should be identified as children with special health care needs, and chronic-condition management should be initiated. Identification of a developmental disorder and its underlying etiology may also drive a range of treatment planning, from medical treatment of the child to family planning for his or her parents.

CH 4 Performance Measure

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

Goal: Injury Prevention
Level: Grantee
Domain: Child Health

GOAL

To ensure supportive programming for injury prevention among children.

MEASURE

The percent of MCHB funded projects addressing injury prevention and through what processes.

DEFINITION

Tier 1: Are you promoting and/ or facilitating injury prevention among children in your program?

- Yes
- No

Tier 2: Through what processes/ mechanisms are you addressing injury-prevention? *See data collection form.*

- Technical Assistance
- Training
- Research/ dissemination
- Peer-reviewed publications
- Outreach/ Information Dissemination/ Education
- Referral/ care coordination
- Quality improvement initiatives
- Use of fatality review data

Please check which child safety domains which program activities were designed to impact:

- Motor Vehicle Traffic
- Suicide/ Self-Harm
- Falls
- Bullying
- Child Maltreatment
- Unintentional Poisoning
- Prescription drug overdose
- Traumatic Brain Injury
- Drowning
- Other

Tier 3: How many are reached through those activities?

- # receiving TA
 - # receiving professional/organizational development training
 - # of peer-reviewed publications published
 - # receiving information and education through outreach
 - # referred/ managed
 - % using fatality review data
- See data collection form.*

Tier 4: What are the related outcomes?

Rate of injury-related hospitalization to children ages 1-9.

Numerator: Injury-related hospitalizations to children ages 1-9

Denominator: Children ages 1-9 in the target population

Target Population: _____

Percent of children ages 6-11 missing 5 or more days of school because of illness or injury.

Numerator: # of children ages 6-11 missing 5 or more days of school

Denominator: Total number of children ages 6-11 represented in National Survey of Children's Health results Dataset reporting from:

BENCHMARK DATA SOURCES

Related to Healthy People 2020 Injury and Violence Prevention objectives 1 through 39.

CH 4 Performance Measure

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

Goal: Injury Prevention

Level: Grantee

Domain: Child Health

GRANTEE DATA SOURCES

Title V National Performance Measure #7 Child Injury, AHRQ Healthcare Cost and Utilization Project: National Inpatient Sample or State Inpatient Database; National Survey of Children's Health, Question G1 in the 6-11 year old survey

SIGNIFICANCE

Two dozen children die every day in the United States from an unintentional or intentional injury. In addition, millions of children survive their injury and have to live the rest of their lives with negative health effects. Although there has been much progress in the United States in reducing child injuries, more is needed.

Data Collection Form for Detail Sheet # CH 4

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

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

CSHCN 1 Performance Measure

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

Goal: Family Engagement

Level: Grantee

Domain: CSHCN

GOAL

To ensure supportive programming for family engagement among children and youth with special health care needs.

MEASURE

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

DEFINITION

Tier 1: 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

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CSHCN 1 Performance Measure

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

Goal: Family Engagement

Level: Grantee

Domain: CSHCN

DEFINITION (continued)

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

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

Numerator: # participating in information exchange forums

Denominator: # CSHCN in catchment area

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

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

Denominator: # of CSHCN in catchment area

Definitions:

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

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

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

BENCHMARK DATA SOURCES

Related to Healthy People 2020 Family Planning Objectives

GRANTEE DATA SOURCES

Title V National Performance Measure #2

CSHCN 1 Performance Measure

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

Goal: Family Engagement

Level: Grantee

Domain: CSHCN

SIGNIFICANCE

In recent years, policy makers and program administrators have emphasized the central role of family engagement in policy-making activities. In accordance with this philosophy, MCHB is facilitating such partnerships at the local, state and national levels.

While there has been a significant increase in the level and types of family engagement, there is still a need to share strategies and mechanisms to recruit, train, monitor, and evaluate family engagement as a key component for CSHCN.

CSHCN 2 Performance Measure

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

Goal: Access to and Use of Medical Home

Level: Grantee

Domain: CSHCN

GOAL

To ensure supportive programming medical home access and use among children and youth with special health care needs.

MEASURE

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

DEFINITION

Tier 1: Are you promoting and/ or facilitating medical home access and use among children and youth with special health care needs?

- Yes
- No

Tier 2: Through what processes/ mechanisms are you addressing medical home access and use?

- Technical Assistance
- Training
- Product Development
- Research/ Peer-reviewed publications
- Outreach/ Information Dissemination/ Education
- Tracking/ Surveillance
- Screening/ Assessment
- Referral/ care coordination
- Direct Service
- Quality improvement initiatives

Tier 3: How many are reached through those activities?

(Report in Table 1: Activity Data Collection Form)

- # receiving TA
- # receiving training
- # products developed
- # peer-reviewed publications published
- # receiving information and education through outreach
- # receiving screening/ assessment
- # referred/care coordinated
- # received direct service
- # participating in quality improvement initiatives

Tier 4: What are the related outcomes?

% of target population that demonstrate a direct linkage to a coordinated medical home community as a direct result of activities conducted by project

Numerator: Target population with a demonstrated direct linkage to a coordinated medical home.

Denominator: Target population (as identified in grantee application)

Definitions: Medical Home: The pediatric medical home can be defined by the AAP as having the following characteristics: the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care.

BENCHMARK DATA SOURCES

Objective # MICH-30.2: Increase the proportion of children with special health care needs who have access to a medical home

CSHCN 2 Performance Measure

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

Goal: Access to and Use of Medical Home

Level: Grantee

Domain: CSHCN

(Baseline: 47.1% in 2005-2006, Target: 51.8%)

GRANTEE DATA SOURCES

NSCH Indicator 4.8, NSCH Indicator 4.9d, Title V National Performance Measure #3

SIGNIFICANCE

Medical homes are a cultivated partnership between patients, family, and primary care providers in coordination with support from the community. These models ensure that care must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.

CSHCN 3 Performance Measure

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

Goal: Transition
Level: Grantee
Domain: CSHCN

GOAL

To ensure supportive programming for transition to adult health care for youth with special health care needs.

MEASURE

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

DEFINITION

Tier 1: Are you addressing the transitional needs to adult health care for youth with special health care needs in your program?

- Yes
- No

Tier 2: Through what activities are you promoting or facilitating the transition to adult health care for youth with special health care needs?

- Technical Assistance
- Training
- Product Development
- Research/ Peer-reviewed publications
- Outreach/ Information Dissemination/ Education
- Tracking/ Surveillance
- Screening/ Assessment
- Referral/ care coordination
- Direct Service
- Quality improvement initiatives

Tier 3: How many are reached through those activities?

(Report in Table 1: Activity Data Collection Form)

- # receiving TA
- # receiving training
- # products developed
- # peer-reviewed publications published
- # receiving information and education through outreach
- # receiving screening/ readiness assessment
- # referred/ care coordinated
- # received direct service
- # participating in quality improvement initiatives

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CSHCN 3 Performance Measure

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

Goal: Transition
Level: Grantee
Domain: CSHCN

DEFINITION (Continued)

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

Numerator: Number of Grantees promoting transition planning early in adolescence

Denominator: Total number of grantees reporting transition performance measure

% of grantees linking transition efforts with medical home initiatives

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

Denominator: Total number of grantees reporting transition performance measure

% of grantees linking transition efforts with adolescent preventive care efforts

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

Denominator: Total number of grantees reporting transition performance measure

Definitions: The terms “assessed for readiness” and “deemed ready” used here refer to language utilized by gottransition.org. **Health care transition:** is the process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.

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

BENCHMARK DATA SOURCES

NA

CSHCN 3 Performance Measure

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

Goal: Transition

Level: Grantee

Domain: CSHCN

GRANTEE DATA SOURCES

Title V National Performance Measure #6 and #12, NS-CSHCN Survey Outcome #6

SIGNIFICANCE

Transitioning of children to adolescent services to adult services is important to ensure that growth and development is adequately and accurately screened throughout all stages. These stages of life represent a time of rapid development and it is important to make sure changes are documented and children and receiving appropriate treatment, preventive services, and screenings.

AH 1 Performance Measure

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

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

GOAL

To ensure supportive programming for adolescent well visits.

MEASURE

The percent of MCHB funded projects promoting and/ or facilitating adolescent well visits.

DEFINITION

Tier 1: Are you promoting and/ or facilitating adolescent well visits in your program?

- Yes
- No

Tier 2: Through what processes/ mechanisms are you promoting and/ or facilitating adolescent well visits?

- Technical Assistance
- Training
- Product Development
- Research/ Peer-reviewed publications
- Outreach/ Information Dissemination/ Education
- Tracking/ Surveillance
- Screening/ Assessment
- Referral/ care coordination
- Direct Service
- Quality improvement initiatives

Tier 3: How many are reached through those activities?

(Report in Table 1: Activity Data Collection Form)

- # receiving TA
- # receiving training
- # products developed
- # peer-reviewed publications published
- # receiving information and education through outreach
- # receiving screening/ assessment training
- # referred/care coordinated
- # received direct service
- # participating in quality improvement initiatives

Tier 4: What are the related outcomes?

% of adolescents with an adolescent well visit in the past year

Numerator: Adolescents reached by the program in reporting year who had an adolescent well visit during the reporting period.

Denominator: Adolescents reached by the program in reporting year

% of adolescents enrolled in Medicaid/ CHIP with at least one adolescent well visit in the past year

Numerator: Adolescents enrolled in Medicaid/ CHIP reached by the program in reporting year with at least one adolescent well visit in the reporting year

Denominator: Adolescents enrolled in Medicaid/ CHIP reached by the program in reporting year.

Age range of adolescents served: _____

BENCHMARK DATA SOURCES

Related to Adolescent Health Objective 1: Increase the proportion of adolescent who have had a wellness checkup in the past 12 months Baseline: 68.7%, Target: 75.6%).

GRANTEE DATA SOURCES

Title V National Performance Measure 10, Adolescent Health

AH 1 Performance Measure

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

Goal: Adolescent Well Visit

Level: Grantee

Domain: Adolescent Health

(AH), National Vital Statistics System (NVSS) Birth File, Home Visiting

SIGNIFICANCE

Adolescence is an important period of development physically, psychologically, and socially. As adolescents move from childhood to adulthood, they are responsible for their health including annual preventive well visits which help to maintain a healthy lifestyle, avoid damaging behaviors, manage chronic conditions, and prevent disease.

AH 2 Performance Measure

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

Goal: Injury Prevention

Level: Grantee

Domain: Adolescent Health

GOAL

To ensure supportive programming for adolescent injury prevention.

MEASURE

The percent of MCHB funded projects promoting and/ or facilitating injury prevention and through what processes.

DEFINITION

Tier 1: Are you promoting and/ or facilitating injury prevention in your program?

- Yes
- No

Tier 2: Through what processes/ mechanisms are you promoting and/ or facilitating injury-prevention? *See data collection form.*

- Technical Assistance
- Training
- Research/ dissemination
- Peer-reviewed publications
- Outreach/ Information Dissemination/ Education
- Referral/ care coordination
- Quality improvement initiatives
- Use of fatality review data

Please check which child safety domains which program activities were designed to impact:

- Motor Vehicle Traffic
- Suicide/ Self-Harm
- Falls
- Bullying
- Youth Violence (other than bullying)
- Child Maltreatment
- Unintentional Poisoning
- Prescription drug overdose
- Traumatic Brain Injury
- Drowning
- Other

Tier 3: How many are reached through those activities?

- # receiving TA
 - # receiving professional/organizational development training
 - # of peer-reviewed publications published
 - # receiving information and education through outreach
 - # referred/ managed
 - % using fatality review data
- See data collection form.*

Tier 4: What are the related outcomes?

Rate of injury-related hospitalization to children ages 10-19.

Numerator: # of injury-related hospitalizations to children ages 10-19

Denominator: # of children ages 10-19 in the target population

Target Population: _____

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

AH 2 Performance Measure

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

Goal: Injury Prevention

Level: Grantee

Domain: Adolescent Health

represented in National Survey of Children’s Health result

Dataset used: _____

BENCHMARK DATA SOURCES

Related to Healthy People Injury and Violence Prevention objectives 1 through 39.

GRANTEE DATA SOURCES

AHRQ Healthcare Cost and Utilization Project: National Inpatient Sample or State Inpatient Database

National Survey of Children’s Health, 6-11 year old survey, Question G1

SIGNIFICANCE

Two dozen children die every day in the United States from an unintentional or intentional injury. In addition, millions of children survive their injury and have to live the rest of their lives with negative health effects. Although there has been much progress in the United States in reducing child injuries, more is needed.

Data Collection Form for Detail Sheet # AH 2

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

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

AH 3 Performance Measure

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

Goal: Screening for Major Depressive Disorder

Level: Grantee

Domain: Adolescent Health

GOAL

To ensure supportive programming for screening for major depressive disorder.

MEASURE

The percent of MCHB funded projects promoting and/ or facilitating screening for major depressive disorder for adolescents and through what processes.

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 injury prevention?

- Technical Assistance
- Training
- Research/ dissemination
- Peer-reviewed publications
- Outreach/ Information Dissemination/ Education
- Referral/ care coordination
- Quality improvement initiatives
- Use of fatality review data

Tier 3: How many are reached through those activities?

- # receiving TA
- # receiving professional/organizational development training
- # products disseminated
- # peer-reviewed publications published
- # receiving information and education through outreach
- # referred/ managed
- % using fatality review data

DEFINITION

Tier 4: What are the related outcomes?

% of 12-17 year olds screened for MDD in the past year in community level or school health settings

Numerator: Adolescents involved with your program in the reporting year who were screened for MDD in a community-level or school health setting.

Denominator: Adolescents involved with your program in the reporting year.

% of adolescent well care visits that include screening for MDD

Numerator: Adolescents involved with your program in the reporting year that had a well-child that included a screening for MDD, in the reporting year.

Denominator: Adolescents involved with your program in the reporting year that had a well-child visit in the reporting year.

% of adolescents identified with a MDD that receive treatment

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

AH 3 Performance Measure

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

Goal: Screening for Major Depressive Disorder

Level: Grantee

Domain: Adolescent Health

during the reporting year identified as having an MDD

Denominator: Adolescents involved with your program in the reporting year.

Age range of adolescents served: _____

BENCHMARK DATA SOURCES

Healthy People 2020, MHMD 11.2 – Increase the proportion of primary care physician office visits where youth aged 12 to 18 years are screened for depression (Baseline 2.1 in 2007, Target: 2.3%); Healthy People 2020 Objective MHMD-4.1. Percent of adolescents aged 12 to 17 years experienced a major depressive episode (Baseline: 8.3% in 2008, Target: 7.5%)

GRANTEE DATA SOURCES

SIGNIFICANCE

Major depression is becoming more and more common in the United States. Major depression entails interference with the ability to work, sleep, study, eat, and enjoy life. Screening for this disorder can identify individuals and effectively treat them.

LC 1 Performance Measure

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

Goal: Adequate Health Insurance Coverage

Level: Grantee

Domain: Life Course/ Cross Cutting

GOAL

To ensure supportive programming for adequate health insurance coverage.

MEASURE

The percent of MCHB funded projects promoting and/ or facilitating adequate health insurance coverage.

DEFINITION

Tier 1: Are you promoting and/ or facilitating adequate health insurance coverage in your program?

- Yes
- No

Tier 2: Through what activities are you promoting and/ or facilitating adequate health insurance coverage?

- Technical Assistance
- Training
- Product Development
- Research/ Peer-reviewed publications
- Outreach/ Information Dissemination/ Education
- Tracking/ Surveillance
- Screening/ Assessment
- Referral to insurance enrollment
- Quality improvement initiatives

Tier 3: How many are reached through those activities?

See data LC 1 Data Collection Form.

Tier 4: What are the related outcomes?

% with health insurance

Numerator: Program participants with health insurance during the reporting period

Denominator: Program participants during the reporting period

A participant is considered to have insurance if they have any kind of health insurance that covers medical care, including prepaid plans such as HMOs, government plans such as Medicaid, and private coverage including coverage purchased through the Health Care Marketplace.

% with adequate health insurance in the reporting year

Numerator: Program participants who reported having adequate insurance coverage during the reporting period

Denominator: Program participants during the reporting period

BENCHMARK DATA SOURCES

Related to HP2020 Access to Health Services Objective 1: Increase the proportion of persons with health insurance. (Baseline: 83.2% persons had medical insurance in 2008, Target: 100%)

GRANTEE DATA SOURCES

Title V National Performance Measure #15, Title V National Outcome Measure #21

SIGNIFICANCE

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

LC 1 Performance Measure

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

Goal: Adequate Health Insurance Coverage

Level: Grantee

Domain: Life Course/ Cross Cutting

avoidable hospitalizations, improved asthma outcomes and fewer missed school days.

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	Infants	Children	CSHCN	Adolescents	Non- pregnant Adults	Partners/ Other Organizations	Providers	Other
Technical Assistance									
Training									
Product Development									
Research/ Peer-reviewed publications									
Outreach/ Information Dissemination/ Education									
Tracking/ Surveillance									
Screening/ Assessment									
Referral									
Direct Service									
Quality improvement initiatives									

LC 2 Performance Measure	The percent of programs promoting and/ or facilitating tobacco and eCigarette cessation.
Goal: Tobacco and eCigarette Use	
Level: Grantee	
Domain: Life Course/ Cross Cutting	
GOAL	To ensure supportive programming promoting and/ or facilitating tobacco and eCigarette cessation.
MEASURE	The percent of MCHB funded projects promoting and/ or facilitating tobacco and eCigarette cessation, and through what processes.
DEFINITION	<p>Tier 1: Are you addressing tobacco and eCigarette cessation in your program?</p> <ul style="list-style-type: none"><input type="checkbox"/> Yes<input type="checkbox"/> No <p>Tier 2: Through what activities are you promoting and/ or facilitating tobacco and eCigarette cessation?</p> <ul style="list-style-type: none"><input type="checkbox"/> Technical Assistance<input type="checkbox"/> Training<input type="checkbox"/> Product Development<input type="checkbox"/> Research/ Peer-reviewed publications<input type="checkbox"/> Outreach/ Information Dissemination/ Education<input type="checkbox"/> Tracking/ Surveillance<input type="checkbox"/> Screening/ Assessment<input type="checkbox"/> Referral/ care coordination<input type="checkbox"/> Direct Service<input type="checkbox"/> Quality improvement initiatives <p>Tier 3: How many are reached through those activities? <i>See data LC 2 Data Collection Form.</i></p> <p>Tier 4: What are the related outcomes?</p> <p>% of prenatal women who abstain from smoking during pregnancy</p> <p>Numerator: Number of program prenatal participants who abstained from smoking cigarettes (including all tobacco products and e-cigarettes) for their entire pregnancy.</p> <p>Denominator: Number of program prenatal participants.</p> <p>% of prenatal women who stopped smoking during pregnancy</p> <p>Numerator: Number of program participants who stopped smoking cigarettes (including all tobacco products and e-cigarettes) during their pregnancy.</p> <p>Denominator: Number of program prenatal participants who smoked at the beginning of their pregnancy.</p>
BENCHMARK DATA SOURCES	Related to Tobacco Use Objective 6: Increase smoking cessation during pregnancy (Target: 30.0%) and related to Tobacco Use Objective 11.1L Reduce to proportion of children aged 3 to 11 years exposed to secondhand smoke (Baseline: 52.2%, Target: 47%).
GRANTEE DATA SOURCES	Title V National Performance Measure #14, NSCH 12-13

LC 2 Performance Measure

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

Goal: Tobacco and eCigarette Use

Level: Grantee

Domain: Life Course/ Cross Cutting

SIGNIFICANCE

Secondhand smoke is a mixture of mainstream smoke and the more toxic side stream smoke which is classified as a “known human carcinogen” by the US Environmental Protection Agency, the US National Toxicology Program, and the International Agency for Research on Cancer. In addition, women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby.

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	Infants	Children	CSHCN	Adolescents	Non- pregnant Adults	Partners/ Other Organizations	Providers	Other
Technical Assistance									
Training									
Product Development									
Research/ Peer-reviewed publications									
Outreach/ Information Dissemination/ Education									
Tracking/ Surveillance									
Screening/ Assessment									
Referral									
Direct Service									
Quality improvement initiatives									

LC 3 Performance Measure

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

Goal: Oral Health

Level: Grantee

Domain: Life Course/ Cross Cutting

GOAL

To ensure supportive programming for oral health.

MEASURE

The percent of MCHB funded projects promoting and/ or facilitating oral health, and through what activities.

DEFINITION

Tier 1: Are you promoting and/ or facilitating oral health in your program?

- Yes
- No

Tier 2: Through what activities are you promoting and/ or facilitating oral health?

- Technical Assistance
- MCH Workforce Development
- Community Outreach
- Care coordination / Referral
- Provision of services
- Research/ Peer-reviewed publication

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?

% of program participants receiving an oral health risk assessment

Numerator: Number of program participants who received an oral health risk assessment in the reporting year

Denominator: All program participants

% of women in program population who had a dental visit during pregnancy

Numerator: Program participants who were pregnant during the reporting year who had a dental visit

Denominator: Program participants who were pregnant during the reporting year

% of those aged 1 through 17 who had preventative oral health visit during the last year

Numerator: Infants and children involved with the program who received a preventative oral health visit in the reporting year

Denominator: Infants and children involved with the program during the reporting year.

BENCHMARK DATA SOURCES

Related to Oral Health Objective 7: Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year (Baseline: 30.2%, Target: 49.0%). Related to Oral Health Objective 8: Increase the proportion of low-income children and adolescents who receive any preventive dental service during the past year (Baseline: 30.2%, Target: 33.2%).

GRANTEE DATA SOURCES

Title V National Performance Measure #13

LC 3 Performance Measure

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

Goal: Oral Health

Level: Grantee

Domain: Life Course/ Cross Cutting

SIGNIFICANCE

Oral health is a vital component of overall health. Access to oral health care, good oral hygiene and adequate nutrition are essential components of oral health to help ensure individuals achieve and maintain oral health. Those with limited preventive oral health services access are at a greater risk for oral diseases.

Data Collection Form for #LC 3

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

	Pregnant/ Perinatal Women	Infants	Children	CSHCN	Adolescents	Non- pregnant Adults	Partners/ Other Organizations	Providers	Other
Technical Assistance									
Training									
Product Development									
Research/ Peer-reviewed publications									
Outreach/ Information Dissemination/ Education									
Tracking/ Surveillance									
Screening/ Assessment									
Referral									
Direct Service									
Quality improvement initiatives									

DIVISION OF MCH WORKFORCE DEVELOPMENT:

PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

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

Training 01 PERFORMANCE MEASURE

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

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

Level: Grantee

Domain: MCH Workforce Development

GOAL

To increase family, youth, and/or community member participation in MCH Training and Healthy Tomorrows programs.

MEASURE

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

DEFINITION

Attached is a table of five elements that demonstrate family member/youth/community member participation, including an emphasis on partnerships and building leadership opportunities for family members/youth/community members in MCH Training or Healthy Tomorrows programs. Please check yes or no to indicate if your MCH Training Program or Healthy Tomorrows program has met each element.

BENCHMARK DATA SOURCES

PHI-3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs, and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula

GRANTEE DATA SOURCES

Attached data collection form to be completed by grantee.

SIGNIFICANCE

Over the last decade, policy makers and program administrators have emphasized the central role of families and other community members as advisors and participants in program and policy-making activities. In accordance with this philosophy, MCH Training Programs and Healthy Tomorrows Programs are facilitating such partnerships at the local, State and national levels.

MCH Training programs support interdisciplinary/interprofessional graduate education and training programs that emphasize leadership, and family-centered, community-based, and culturally competent systems of care. Training programs are required to incorporate family members/youth/community members as faculty, trainees, and partners.

The Healthy Tomorrows program supports community initiated and community-based projects that apply principles of health promotion, disease prevention, and the benefits of coordinated health care to the provision of services that improve access to comprehensive, community-based, family-centered, culturally/linguistically competent, and coordinated care. Healthy Tomorrows projects are required to incorporate family members/youth/community members as project staff, advisors, volunteers, and partners.

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

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

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

NOTES/COMMENTS:

Training 02 PERFORMANCE MEASURE

Goal: Cultural Competence in MCH Training and Healthy Tomorrows Programs

Level: Grantee

Domain: MCH Workforce Development

The percent of MCHB training and Healthy Tomorrows programs that have incorporated cultural and linguistic competence elements into their policies, guidelines, and training.

GOAL

To increase the percentage of MCH Training and Healthy Tomorrows programs that have integrated cultural and linguistic competence into their policies, guidelines, and training.

MEASURE

The percent of MCHB training and Healthy Tomorrows programs that have integrated cultural and linguistic competence into their policies, guidelines, and training.

DEFINITIONS

Attached is a checklist of 6 elements that demonstrate cultural and linguistic competency. Please check yes or no to indicate if your MCH Training or Healthy Tomorrows program has met each element. Please keep the completed checklist attached.

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989; cited from National Center for Cultural Competence

(<http://nccc.georgeto.wn.edu/foundations/frameworks.html>)

DEFINITIONS (cont...)

Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. (Goode, T. and W. Jones, 2004. National Center for Cultural Competence;

<http://www.nccc-curricula.info/linguisticcompetence.html>)

Cultural and linguistic competency is a process that occurs along a developmental continuum. A culturally and linguistically competent program is characterized by elements including the following: written strategies for advancing cultural competence; cultural and linguistic competency policies and practices; cultural and linguistic competence knowledge and skills building efforts; research data on populations served according to racial, ethnic, and linguistic groupings; faculty and other instructors are racially and ethnically diverse; faculty and staff participate in professional development activities related to cultural and linguistic competence; and periodic

Training 02 PERFORMANCE MEASURE

Goal: Cultural Competence in MCH Training and Healthy Tomorrows Programs

Level: Grantee

Domain: MCH Workforce Development

The percent of MCHB training and Healthy Tomorrows programs that have incorporated cultural and linguistic competence elements into their policies, guidelines, and training.

assessment of trainees' progress in developing cultural and linguistic competence.

BENCHMARK DATA SOURCES

Related to the following HP2020 Objectives:
PHI-3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs, and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula
PHI-12: Increase the proportion of public health laboratory systems (including State, Tribal, and local) which perform at a high level of quality in support of the 10 Essential Public Health Services
ECBP-11: Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs

GRANTEE DATA SOURCES

Attached data collection form is to be completed by grantees.
There is no existing national data source to measure the extent to which MCHB supported programs have incorporated cultural competence elements into their policies, guidelines, and training.

SIGNIFICANCE

Over the last decade, researchers and policymakers have emphasized the central influence of cultural values and cultural/linguistic barriers: health seeking behavior, access to care, and racial and ethnic disparities. In accordance with these concerns, cultural competence objectives have been: (1) incorporated into the Division of MCH Workforce Development strategic plan; and (2) in guidance materials related to the MCH Training and Healthy Tomorrows Programs.
The Division of MCH Workforce Development provides support to programs that address cultural and linguistic competence through development of curricula, research, learning and practice environments

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

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

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

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

NOTES/COMMENTS:

Training 03 PERFORMANCE MEASURE

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

Goal: Healthy Tomorrow's Partnership

Level: Grantee

Domain: MCH Workforce Development

GOAL

To assure that the Healthy Tomorrows program has collaborative interactions related to professional development, policy development and product development and dissemination with relevant national, state and local MCH programs, agencies and organizations.

MEASURE

The degree to which a Healthy Tomorrows program collaborates with State Title V agencies, other MCH or MCH-related programs and other professional organizations.

DEFINITION

Attached is a list of the 7 elements that describe activities carried out by Healthy Tomorrows programs for or in collaboration with State Title V and other agencies on a scale of 0 to 1 (0=no; 1=yes). If a value of '1' (yes) is selected, provide the number of activities for the element. The total score for this measure will be determined by the sum of those elements noted as '1.'

BENCHMARK DATA SOURCES

ECBP-11(Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs ...
ECPB-2: Increase the proportion of elementary, middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems.
ECBP-12 Increase the inclusion of core clinical prevention and population health content in M.D.-granting medical schools.
ECBP-13: Increase the inclusion of core clinical prevention and population health content in in D.O.-granting medical schools.
ECBP-15: Increase the inclusion of core clinical prevention and population health content in in nurse practitioner training.
ECBP-17: Increase the inclusion of core clinical prevention and population health content in in Doctor of Pharmacy (PharmD) granting colleges and schools of pharmacy
PHI-2(Developmental) Increase the proportion of Tribal, State, and local public health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals

GRANTEE DATA SOURCES

The Healthy Tomorrows program completes the attached table which describes the categories of collaborative activity.

Training 03 PERFORMANCE MEASURE

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

Goal: Healthy Tomorrow's Partnership

Level: Grantee

Domain: MCH Workforce Development

SIGNIFICANCE

As a SPRANS grantee, a training program enhances the Title V State block grants that support the MCHB goal to promote comprehensive, coordinated, family-centered, and culturally-sensitive systems of health care that serve the diverse needs of all families within their own communities. Interactive collaboration between a training program and Federal, Tribal, State and local agencies dedicated to improving the health of MCH populations will increase active involvement of many disciplines across public and private sectors and increase the likelihood of success in meeting the goals of relevant stakeholders.

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

- 1) collaborate with State Title V and other agencies (at a systems level) to support achievement of the MCHB Strategic Goals and Healthy People 2020 action plan;
- 2) make the needs of MCH populations more visible to decision-makers and can help states achieve best practice standards for their systems of care;
- 3) internally use this data to assure a full scope of these program elements in all regions.

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

Indicate the degree to which the Healthy Tomorrows program collaborates with State Title V (MCH Block Grant) agencies and other MCH-related programs* using the following values:

0= Does not collaborate on this element

1= Does collaborate on this element.

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

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

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

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

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

Training 04 PERFORMANCE MEASURE	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs.
Goal: Collaborative Interactions	
Level: Grantee	
Domain: MCH Workforce Development	
GOAL	To assure that a training program has collaborative interactions related to training, technical assistance, continuing education, and other capacity-building services with relevant national, state and local programs, agencies and organizations.
MEASURE	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs and other professional organizations.
DEFINITION	Attached is a list of the 6 elements that describe activities carried out by training programs for or in collaboration with State Title V and other agencies on a scale of 0 to 1. If a value of '1' is selected, provide the number of activities for the element. The total score for this measure will be determined by the sum of those elements noted as '1.'
BENCHMARK DATA SOURCES	ECBP-11(Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs. ECPB-2: Increase the proportion of elementary, middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems. ECBP-12 Increase the inclusion of core clinical prevention and population health content in M.D.-granting medical schools. ECBP-13: Increase the inclusion of core clinical prevention and population health content in in D.O.-granting medical schools. ECBP-15: Increase the inclusion of core clinical prevention and population health content in in nurse practitioner training. ECBP-17: Increase the inclusion of core clinical prevention and population health content in in Doctor of Pharmacy (PharmD) granting colleges and schools of pharmacy PHI-2(Developmental) Increase the proportion of Tribal, State, and local public health personnel who receive continuing education consistent with the Core Competencies for Public Health Professionals
GRANTEE DATA SOURCES	The training program completes the attached table which describes the categories of collaborative activity.
SIGNIFICANCE	As a SPRANS grantee, a training program enhances the Title V State block grants that support the MCHB goal to promote comprehensive, coordinated, family-centered, and culturally-sensitive systems of health care that serve the diverse needs of all families within their own communities. Interactive collaboration between a training program and Federal, Tribal, State and local agencies

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.

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

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

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

Training 05 PERFORMANCE MEASURE	The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.
Goal: Policy Development	
Level: Grantee	
Domain: MCH Workforce Development	
GOAL	To increase the number of MCH long-term training programs that actively promote the transfer and utilization of MCH knowledge and research to the policy arena through the work of faculty, trainees, alumni, and collaboration with Title V.
MEASURE	The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.
DEFINITION	Attached is a list of six elements that demonstrate policy engagement. Please check yes or no to indicate which the elements have been implemented. Please keep the completed checklist attached. Policy development, implementation and evaluation in the context of MCH training programs relates to the process of translating research to policy and training for leadership in the core public health function of policy development. Actively – mutual commitment to policy-related projects or objectives within the past 12 months.
BENCHMARK DATA SOURCES	Related to PHI-3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs, and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula.
GRANTEE DATA SOURCES	<ul style="list-style-type: none">• Attached data collection form to be completed by grantee.• Data will be collected from competitive and continuation applications as part of the grant application process and annual reports. The elements of training program engagement in policy development, implementation, and evaluation need to be operationally defined with progress noted on the attached list with an example described more fully in the narrative application.
SIGNIFICANCE	Policy development is one of the three core functions of public health as defined by the Institute of Medicine in The Future of Public Health (National Academy Press, Washington DC). In this landmark report by the IOM, the committee recommends that “every public health agency exercise its responsibility to serve the public interest in the development of comprehensive public health policies by promoting use of the scientific knowledge base in decision-making about public health and by leading in developing public health policy.” Academic institutions such as schools of public health and research universities have the dual responsibility to develop knowledge and to produce well-trained professional practitioners. This national performance measure relates directly to Goal 4 of the Division of MCH Workforce Development Strategic Plan to “generate and translate new knowledge for the MCH field in order to advance science-based practice, innovation, and quality improvement in MCH training, policies and programs.”

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

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

CATEGORY #1: Training on Policy and Advocacy

Element	No 0	Yes 1
1. Your MCHB-funded Training Program provides didactic opportunities for training on policy development and advocacy to increase understanding of how the policy process works at the federal, state and/or local levels.		
2. Your MCHB-funded Training Program provides an opportunity for application of policy and advocacy knowledge through one or more of the following educational experiences If Yes, check all that apply: <ul style="list-style-type: none"> <input type="checkbox"/> Write a policy brief about an emerging local MCH public health issue <input type="checkbox"/> Attend a meeting of a local MCH stakeholder group, provide a written summary of their approach <input type="checkbox"/> Attend a professional association meeting and actively participate on a committee <input type="checkbox"/> Educate Policymakers <input type="checkbox"/> Provide written and/or oral testimony to the state legislature <input type="checkbox"/> Write an article on an MCH topic for a lay audience <input type="checkbox"/> Observe a legislative hearing on CSPAN, or if possible, attend a legislative hearing on an MCH topic <input type="checkbox"/> Track a bill over the Internet over the course of a legislative session <input type="checkbox"/> Interview an agency or organization-based MCH policy maker, administrator, or advocate and prepare written and/or oral mock testimony from the perspective of the agency/association interviewed <input type="checkbox"/> Other, please describe _____ 		
3. A pre/post assessment is in place to measure increased policy knowledge and skills of long-term trainees (NOTE: Long-term trainees are defined as those who have completed a long-term [greater than or equal to 300 contact hours] MCH Training Program, including those who received funds and those who did not). If Yes, report: a. % of current trainees reporting increased policy knowledge _____ b. % of current trainees reporting increased policy skills _____		

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

Element	No 0	Yes 1
<p>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.</p> <p>If yes, indicate all policy arenas to which they have contributed:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Local <input type="checkbox"/> State <input type="checkbox"/> National 		
<p>5. Trainees, faculty and/or staff participate in local, state and/or national MCH advocacy networks and initiatives</p> <p>If yes, indicate all policy arenas to which they have contributed :</p> <ul style="list-style-type: none"> <input type="checkbox"/> Local <input type="checkbox"/> State <input type="checkbox"/> National 		
<p>6. Trainees, faculty and/or staff participate in disseminating and communicating research findings (both original and non-original) directly to public health agency leaders and/or policy officials.</p> <p>If yes, indicate all policy arenas to which they have contributed:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Local <input type="checkbox"/> State <input type="checkbox"/> National 		

Training 06 Performance Measure	The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups.
Goal: Long Term Training Programs	
Level: Grantee	
Domain: MCH Workforce Development	
GOAL	To increase the percentage of trainees participating in MCHB long-term training programs who are from underrepresented racial and ethnic groups.
MEASURE	The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups.
DEFINITION	<p>Numerator: Total number of long-term trainees (≥ 300 contact hours) participating in MCHB training programs reported to be from underrepresented racial and ethnic groups. (Include MCHB-supported and non-supported trainees.)</p> <p>Denominator: Total number of long-term trainees (≥ 300 contact hours) participating in MCHB training programs. (Include MCHB-supported and non-supported trainees.)</p> <p>Units: 100</p> <p>Text: Percentage</p> <p>The definition of “underrepresented racial and ethnic groups” is based on the categories from the U.S. Census.</p>
BENCHMARK DATA SOURCES	<p>Related to Healthy People 2020 Objectives:</p> <p>AHS-4: Increase the number of practicing primary care providers</p> <p>ECBP-11: (Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs</p>
GRANTEE DATA SOURCES	<p>Data will be collected annually from grantees about their trainees.</p> <p>MCHB does not maintain a master list of all trainees who are supported by MCHB long-term training programs.</p> <p>References supporting Workforce Diversity:</p> <ul style="list-style-type: none">● In the Nation’s Compelling Interest: Ensuring Diversity in the Healthcare Workforce (2004). Institute of Medicine.● Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2002). Institute of Medicine.
SIGNIFICANCE	HRSA’s MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. Training a diverse group of professionals is necessary in order to provide a diverse public health workforce to meet the needs of the changing demographics of the U.S. and to ensure access to culturally competent and effective services. This performance measure provides the necessary data to report on HRSA’s initiatives to reduce health disparities.

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

Report on the percentage of long-term trainees (≥ 300 contact hours) who are from any underrepresented racial/ethnic group (i.e., Hispanic or Latino, American Indian or Alaskan Native, Asian, Black or African-American, Native Hawaiian or Pacific Islander, two or more race (OMB). Please use the space provided for notes to detail the data source and year of data used.

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

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

Ethnic Categories

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

Racial Categories

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

Number of long-term trainees who are of Asian descent

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

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

Number of long-term trainees who are two or more races

Notes/Comments:

Training 07 PERFORMANCE MEASURE

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

Goal: MCH Pipeline Programs

Level: Grantee

Domain: MCH Workforce Development

GOAL

To increase the percent of graduates of MCH Pipeline Programs who have been/are engaged in work focused on MCH populations.

MEASURE

The percent of MCHB Pipeline Program graduates who have been engaged in work focused on MCH populations since graduating from the MCH Pipeline Training Program.

DEFINITION

Numerator: Number of pipeline graduates reporting they have been engaged in work focused on MCH populations since graduating from the MCH Pipeline Training Program.

Denominator: The total number of trainees responding to the survey

Units: 100

Text: Percent

MCH Pipeline trainees are defined as undergraduate students from economically and educationally disadvantaged backgrounds (including underrepresented racial and ethnic minorities: African American, Hispanic/Latino, Asian, Hawaiian/Pacific Islanders, American Indian/Alaskan) who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related fields

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

BENCHMARK DATA SOURCES

Related to Healthy People 2020:

Access Goal: Improve access to comprehensive, high-quality health care services

Educational Community Based Program Goal: Increase the quality, availability and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health and enhance quality of life. Specific objectives: 10-11

Related to Public Health Infrastructure: To ensure that Federal, Tribal, State, and local health agencies have the necessary infrastructure to effectively provide essential public health services. Specific objectives: 2, 3, and 5

Training 07 PERFORMANCE MEASURE

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

Goal: MCH Pipeline Programs

Level: Grantee

Domain: MCH Workforce Development

GRANTEE DATA SOURCES

A pipeline program follow-up survey will be used to collect these data.

Data Sources Related to Training and Work

Settings/Populations:

Rittenhouse Diane R, George E. Fryer, Robert L. Phillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps Participation. *Ann Fam Med* 2008;6:397-405. DOI: 10.1370/afm.885.

Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career Choices Regarding Internal Medicine *JAMA*. 2008;300(10):1154-1164 (doi:10.1001/jama.300.10.1154)

SIGNIFICANCE

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

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

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

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

2 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

- A. The total number of graduates, 2 years following completion of program _____
- B. The total number of graduates lost to follow-up _____
- C. The total number of respondents (A-B) = denominator _____
- D. Number of respondents who report working with an MCH population since graduating from the MCH Pipeline Training Program _____
- E. Percent of respondents who report working with an MCH population Since graduating from the MCH Pipeline Training Program _____

5 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

- A. The total number of graduates, 5 years following completion of program _____
- B. The total number of graduates lost to follow-up _____
- C. The total number of respondents (A-B) = denominator _____
- D. Number of respondents who report working with an MCH population since graduating from the MCH Pipeline Training Program _____
- E. Percent of respondents who report working with an MCH population since graduating from the MCH Pipeline Training Program _____

Training 08 PERFORMANCE MEASURE

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

Goal: MCH Pipeline Program

Level: Grantee

Domain: MCH Workforce Development

GOAL

To increase the percent of graduates of MCH Pipeline Programs who have been engaged in work with populations considered to be underserved or vulnerable.

MEASURE

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

DEFINITION

Numerator: Number of pipeline graduates reporting they have been engaged in work with populations considered underserved or vulnerable since graduating from the MCH Pipeline Training Program.

Denominator: The total number of trainees responding to the survey

Units: 100 **Text:** Percent

DEFINITION (cont...)

MCH Pipeline trainees are defined as undergraduate students from economically and educationally disadvantaged backgrounds (including underrepresented racial and ethnic minorities: African American, Hispanic/Latino, Asian, Hawaiian/Pacific Islanders, American Indian/Alaskan) who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related fields

The term “underserved” refers to “Medically Underserved Areas and Medically Underserved Populations with shortages of primary medical care, dental or mental health providers. Populations may be defined by geographic (a county or service area) or demographic (low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services) factors. The term "vulnerable groups," refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life.

This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. (i.e, Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, etc) *Source: Center for Vulnerable Populations Research. UCLA.*
<http://www.nursing.ucla.edu/orgs/cvpr/who-are-vulnerable.html>

Training 08 PERFORMANCE MEASURE

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

Goal: MCH Pipeline Program

Level: Grantee

Domain: MCH Workforce Development

BENCHMARK DATA SOURCES

Related to Healthy People 2020:

Access Goal: Improve access to comprehensive, high-quality health care services

Educational Community Based Program Goal: Increase the quality, availability and effectiveness of educational and community-based programs designed to prevent disease and injury, improve health and enhance quality of life. Specific objectives: 10-11

Related to Public Health Infrastructure: To ensure that Federal, Tribal, State, and local health agencies have the necessary infrastructure to effectively provide essential public health services. Specific objectives: 2, 3, and 5

GRANTEE DATA SOURCES

A pipeline program follow-up survey will be used to collect these data.

Data Sources Related to Training and Work

Settings/Populations:

Rittenhouse Diane R, George E. Fryer, Robert L. Phillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps Participation. *Ann Fam Med* 2008;6:397-405. DOI: 10.1370/afm.885.

Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career Choices Regarding Internal Medicine *JAMA*. 2008;300(10):1154-1164 (doi:10.1001/jama.300.10.1154)

SIGNIFICANCE

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

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

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

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

2 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

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

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

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

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

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

5 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

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

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

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

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

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

Training 09 PERFORMANCE MEASURE

Goal: Graduate Program Enrollment

Level: Grantee

Domain: MCH Workforce Development

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

GOAL

To increase the number of pipeline graduates that enter graduate programs preparing them to work with the MCH population.

MEASURE

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

DEFINITION

Numerator: Total number of MCH Pipeline trainees enrolled in or who have completed a graduate school program* preparing them to work with the MCH population, 2 or 5 years after graduating from the MCH Pipeline program.

*Graduate programs preparing students to work with the MCH population include: pediatric medicine, public health, pediatric nutrition, public health social work, pediatric nursing, pediatric dentistry, psychology, health education, health administration, pediatric occupational/physical therapy, or speech language pathology.

Denominator: Total number of MCH Pipeline Trainees who graduated from the MCH pipeline program 2 or 5 years previously.

BENCHMARK DATA SOURCES

Related to Healthy People 2020 Objectives:

ECBP-12: Increase the inclusion of core clinical preventive and population health content in M.D.-granting medical schools

ECBP-13: Increase the inclusion of core clinical preventive and population health content in D.O.-granting medical schools

ECBP-14: Increase the inclusion of core clinical preventive and population health content in undergraduate nursing

ECBP-15: Increase the inclusion of core clinical preventive and population health content in nurse practitioner training

ECBP-16: Increase the inclusion of core clinical preventive and population health content in physician assistant training

PHI-1: Increase the proportion of Federal, Tribal, State, and local public health agencies that incorporate Core Competencies for Public Health Professionals into job descriptions and performance evaluations

GRANTEE DATA SOURCES

Attached data collection form to be completed by grantees.

SIGNIFICANCE

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

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

2 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

- A. The total number of Pipeline Trainees, 2 years following graduation from the program _____
- B. The total number of graduates lost to follow-up _____
- C. The total number of respondents (A-B) = denominator _____
- D. Number of respondents that are enrolled in or have completed graduate Programs preparing them work with the MCH population** _____
- E. Percent of respondents that are enrolled in or have completed graduate Programs preparing them work with the MCH population _____

5 YEARS AFTER GRADUATING FROM MCH PIPELINE PROGRAM

- A. The total number of Pipeline Trainees, 5 years following graduation from the program _____
- B. The total number of graduates lost to follow-up _____
- C. The total number of respondents (A-B) = denominator _____
- D. Number of respondents that are enrolled in or have completed graduate Programs preparing them work with the MCH population** _____
- E. Percent of respondents that are enrolled in or have completed graduate Programs preparing them work with the MCH population _____

**Graduate programs preparing graduate students to work in the MCH population include: Pediatric medicine, public health, pediatric nutrition, public health social work, pediatric nursing, pediatric dentistry, psychology, health education, health administration, pediatric occupational/physical therapy, speech language pathology.

Training 10 PERFORMANCE MEASURE

The percent of long term trainees that have demonstrated field leadership after completing an MCH training program.

Goal: Field Leadership

Level: Grantee

Domain: MCH Workforce Development

GOAL

To increase the percentage of long term trainees that have demonstrated field leadership two and five years after completing their MCH Training Program.

MEASURE

The percentage of long-term trainees that have demonstrated field leadership after completing an MCH Training Program.

DEFINITION

Attached is a checklist of four elements that demonstrate field leadership. For each element, identify the number of long-term trainees that have demonstrated field leadership two and five years after program completion. Please keep the completed checklist attached.

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

“Field leadership” refers to but is not limited to providing MCH leadership within the clinical, advocacy, academic, research, public health, public policy or governmental realms. Refer to attachment for complete definition.

Cohort is defined as those who have completed an MCHB-funded training program 2 years and 5 years prior to the reporting period. Data form for each cohort year will be collected for five years.

BENCHMARK DATA SOURCES

Related to Healthy People 2020 Objectives:

PHI-1: Increase the proportion of Federal, Tribal, State and local public health agencies that incorporate Core Competencies for Public Health Professionals into job descriptions and performance evaluations

PHI-3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs and schools of nursing (with public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula

GRANTEE DATA SOURCES

Attached data collection form to be completed by grantees.

SIGNIFICANCE

An MCHB trained workforce is a vital participant in clinical, administrative, policy, public health and various other arenas. MCHB long term training programs assist in developing a public health workforce that addresses MCH concerns and fosters field leadership in the MCH arena.

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

SECTION A: 2 YEAR FOLLOW-UP

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

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

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

- A. The total number of long-term trainees, **2 years** post program completion, included in this report _____
- B. The total number of program completers lost to follow-up _____
- C. Number of respondents (A-B) _____
- D. Number of respondents who have demonstrated field leadership in **at least** one of the following areas below _____
- E. Percent of long-term trainees (**2 years** post program completion) who have demonstrated field leadership in **at least one** of the following areas: _____

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

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

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

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

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

SECTION B: 5 YEAR FOLLOW-UP

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

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

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

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

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

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

- Disseminated information on MCH Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
- Conducted research or quality improvement on MCH issues
- Provided consultation or technical assistance in MCH areas
- Taught/mentored in my discipline or other MCH related field
- Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
- Procured grant and other funding in MCH areas
- Conducted strategic planning or program evaluation

2. **Number of trainees that have participated in clinical leadership activities** since _____

completing their MCH Training Program

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

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

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

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

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

NOTES/COMMENTS:

Training 11 PERFORMANCE MEASURE

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

Goal: Long-term trainees working with MCH populations

Level: Grantee

Domain: MCH Workforce Development

GOAL

To increase the percent of long-term trainees engaged in work focused on MCH populations two and five years after completing their MCH Training Program.

MEASURE

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

DEFINITION

Numerator:

Number of long-term trainees reporting they are engaged in work focused on MCH populations after completing their MCH Training Program.

Denominator:

The total number of trainees responding to the survey

Units: 100 Text: Percent

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

Cohort is defined as those who have completed an MCHB-funded training program 2 years and 5 years prior to the reporting period.

MCH Populations: Includes all of the Nation's women, infants, children, adolescents, young adults and their families, including and children with special health care needs.

BENCHMARK DATA SOURCES

Related to ECBP-10 Increase the number of community-based organizations (including local health departments, Tribal health services, nongovernmental organizations, and State agencies) providing population-based primary prevention services...

Related to ECBP-11(Developmental) Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.

Related to PHI-1 Increase the proportion of Federal, Tribal, State, and local public health agencies that incorporate Core Competencies for Public Health Professionals into job descriptions and performance

Training 11 PERFORMANCE MEASURE

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

Goal: Long-term trainees working with MCH populations

Level: Grantee

Domain: MCH Workforce Development

GRANTEE DATA SOURCES

A revised trainee follow-up survey that incorporates the new form for collecting data on the involvement of those completing an MCH training program in work related to MCH populations will be used to collect these data.

Data Sources Related to Training and Work Settings/Populations: Rittenhouse Diane R, George E. Fryer, Robert L. Phillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps Participation. *Ann Fam Med* 2008;6:397-405. DOI: 10.1370/afm.885.

Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career Choices Regarding Internal Medicine *JAMA*.2008;300(10):1154-1164 (doi:10.1001/jama.300.10.1154).

SIGNIFICANCE

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

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

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

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

2 YEAR FOLLOW-UP

- A. The total number of long-term trainees, 2 years following program completion _____
- B. The total number of long-term trainees lost to follow-up (2 years following program completion) _____
- C. The total number of respondents (A-B) = denominator _____
- D. Number of respondents 2 years following completion of program who report working with an MCH population _____
- E. Percent of respondents 2 years following completion of program who report working with an MCH population _____

5 YEAR FOLLOW-UP

- F. The total number of long-term trainees, 5 years following program completion _____
- G. The total number of long-term trainees lost to follow-up (5 years following program completion), _____
- H. The total number of respondents (F-G) = denominator _____
- I. Number of respondents 5 years following completion of program who report working with an MCH population _____
- J. Percent of respondents 5 years following completion of program who report working with an MCH population _____

Training 12 PERFORMANCE MEASURE

The percent of long-term trainees who, at 2, 5 and 10 years post training, have worked in an interdisciplinary manner to serve the MCH population (e.g., individuals with disabilities and their families, adolescents and their families, etc.).

Goal: Long-term Trainees

Level: Grantee

Domain: MCH Workforce Development

GOAL

To increase the percent of long-term trainees who, upon completing their training, work in an interdisciplinary manner to serve the MCH population.

MEASURE

The percent of long-term trainees who, at 2, 5 and 10 years post training have worked in an interdisciplinary manner to serve the MCH population.

DEFINITION

Numerator: The number of long-term trainees indicating that they have worked in an interdisciplinary manner serving the MCH population.

Denominator: The total number of long-term trainees responding to the survey

Units: 100 **Text:** Percent

In addition, data on the total number of the long-term trainees and the number of non-respondents for each year will be collected.

Long-term trainees are defined as those who have completed a long-term (300+ hours) MCH Training program, including those who received MCH funds and those who did not.

BENCHMARK DATA SOURCES

Related to Healthy People 2020 Objectives:

ECBP-12: Increase the inclusion of core clinical preventive and population health content in M.D.-granting medical schools

ECBP-13: Increase the inclusion of core clinical preventive and population health content in D.O.-granting medical schools

ECBP-14: Increase the inclusion of core clinical preventive and population health content in undergraduate nursing

ECBP-15: Increase the inclusion of core clinical preventive and population health content in nurse practitioner training

ECBP-16: Increase the inclusion of core clinical preventive and population health content in physician assistant training

PHI-3: Increase the proportion of Council on Education for Public Health (CEPH) accredited schools of public health, CEPH accredited academic programs and schools of nursing (with a public health or community health component) that integrate Core Competencies for Public Health Professionals into curricula

MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems

GRANTEE DATA SOURCES

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

Training 12 PERFORMANCE MEASURE

Goal: Long-term Trainees

Level: Grantee

Domain: MCH Workforce Development

The percent of long-term trainees who, at 2, 5 and 10 years post training, have worked in an interdisciplinary manner to serve the MCH population (e.g., individuals with disabilities and their families, adolescents and their families, etc.).

SIGNIFICANCE

Leadership education is a complex interdisciplinary field that must meet the needs of MCH populations. This measure addresses one of a training program's core values and its unique role to prepare professionals for comprehensive systems of care/practice. By providing interdisciplinary coordinated care, training programs help to ensure that all MCH populations receive the most comprehensive care that takes into account the complete and unique needs of the individuals and their families.

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

A. 2 YEAR FOLLOW-UP

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

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

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

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

Number of respondents (Denominator) _____

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

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

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

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

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

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

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

Collaborated with various disciplines across agencies/entities? _____%

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

B. 5 YEAR FOLLOW-UP

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

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

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

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

The number of long-term trainees who have worked in an interdisciplinary manner 5 years _____

following completion of an MCHB-funded training program, demonstrating at least one of the interdisciplinary skills listed

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

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

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

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

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

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

Collaborated with various disciplines across agencies/entities? _____%

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

C. 10 YEAR FOLLOW-UP

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

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

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

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

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

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

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

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

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

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

Collaborated with various disciplines across agencies/entities? _____%

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

Training 13 PERFORMANCE MEASURE

The degree to which the LEAH program incorporates adolescents and parents from diverse ethnic and cultural backgrounds as advisors and participants in program activities.

Goal: Diverse Adolescent Involvement

Level: Grantee

Domain: MCH Workforce Development

GOAL

To increase appropriate involvement of adolescents and parents as consumers of LEAH program activities.

MEASURE

The degree to which adolescents and parents are incorporated as consumers of LEAH program activities.

DEFINITION

Attached is a checklist of 4 elements that document adolescent and parent participation. Respondents will note the presence or absence of this participation on a scale of 0-1 for a total possible score of 4.

BENCHMARK DATA SOURCES

Related to Objective HC/HIT-2: Increase the proportion of persons who report that their health care providers have satisfactory communication skills.

GRANTEE DATA SOURCES

Grantees report using a data collection form. These data may be collected with the LEAH self-assessment activities. Participation should be defined to permit assessment of youth and young adult involvement.

SIGNIFICANCE

Over the last decade, policy makers and program administrators have emphasized the central role of consumer of health services as advisors and participants in program activities. Satisfaction with health care is related to satisfaction with the quality of the communication with health providers. In accordance with this philosophy, LEAH facilitates such partnerships and believes that consumers (adolescents and parents) from diverse backgrounds have important roles in the training of future leaders in adolescent health care delivery systems.

DATA COLLECTION FORM FOR DETAIL SHEET: Training 13 – Adolescent Involvement

Indicate the degree to which your training program has the active involvement of adolescents and parents in your program and planning activities using the following values:

0 = No 1 = Yes

Element	0	1
Adolescents from diverse ethnic backgrounds and cultures participate in an advisory capacity.		
Parents of adolescents from diverse ethnic backgrounds and cultures participate in an advisory capacity.		
Adolescents from diverse ethnic backgrounds and cultures participate in the planning, implementation and evaluation of program activities related to adolescents as consumers		
Parents of adolescents from diverse ethnic backgrounds and cultures participate in the planning, implementation and evaluation of program activities related to parents as consumers		

Total Score (possible 0-4 score) _____

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

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

Level I Medium Term Trainees - Knowledge

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

Level II Medium Term Trainees – Knowledge:

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

Level II Medium Term Trainees - Skills :

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

DIVISION OF CHILD ADOLESCENT, AND FAMILY HEALTH

Emergency Medical Services for Children Program

PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

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

EMSC 01 PERFORMANCE MEASURE

The degree to which EMS agencies submit NEMSIS compliant version 3.x data to the State EMS Office.

Goal: Submission of NEMSIS compliant version 3.x data

Level: Grantee

Domain: Emergency Medical Services for Children

GOAL

By 2018, baseline data will be available to assess the number of EMS agencies in the state/territory that submit National Emergency Medical Services Information System (NEMSIS) version 3.X compliant patient care data to the State Emergency Medical Services (EMS) Office for all 911 initiated EMS activations.

By 2021, 80% of EMS agencies in the state/territory submit NEMSIS version compliant patient care data to the State EMS Office for all 911 initiated EMS activations.

MEASURE

The degree to which EMS agencies submit NEMSIS compliant version 3.x data to the State EMS Office.

DEFINITION

Numerator:

The number of EMS agencies in the state/territory that submit NEMSIS version 3.X compliant patient care data to the State Emergency Medical Services Office.

Denominator:

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

Units: 100

Text: Percent

EMS: Emergency Medical Services

EMS Agency: A prehospital provider agency. An EMS agency is defined as an organization staffed with personnel who are actively rendering medical care in response to a 911 or similar emergency call. Data will be gathered from State EMS Offices for both transporting and non-transporting agencies (excludes air- and water-only EMS services).

NEMSIS: National EMS Information System. NEMSIS is the national repository that is used to store EMS data from every state in the nation.

NEMSIS Version 3.X compliant patient care data:
A national set of standardized data elements collected by EMS agencies.

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

NHTSA – National Highway Traffic Safety Administration

EMSC 01 PERFORMANCE MEASURE

The degree to which EMS agencies submit NEMSIS compliant version 3.x data to the State EMS Office.

Goal: Submission of NEMSIS compliant version 3.x data

Level: Grantee

Domain: Emergency Medical Services for Children

HRSA STRATEGIC OBJECTIVE

Improve Access to Quality Health Care and Services by strengthening health systems to support the delivery of quality health services.

Improve Health Equity by monitoring, identifying, and advancing evidence-based and promising practices to achieve health equity.

GRANTEE DATA SOURCES

State EMS Offices

EMSC 01 PERFORMANCE MEASURE

The degree to which EMS agencies submit NEMSIS compliant version 3.x data to the State EMS Office.

Goal: Submission of NEMSIS compliant version 3.x data

Level: Grantee

Domain: Emergency Medical Services for Children

SIGNIFICANCE

Access to quality data and effective data management play an important role in improving the performance of an organization's health care systems. Collecting, analyzing, interpreting, and acting on data for specific performance measures allows health care professionals to identify where systems are falling short, to make corrective adjustments, and to track outcomes. However, uniform data collection is needed to consistently evaluate systems and develop Quality Improvement programs. The NEMSIS operated by the National Highway Traffic Safety Administration, provides a basic platform for states and territories to collect and report patient care data in a uniform manner.

NEMSIS enables both state and national EMS systems to evaluate their current prehospital delivery. As a first step toward Quality Improvement (QI) in pediatric emergency medical and trauma care, the EMSC Program seeks to first understand the proportion of EMS agencies reporting to the state EMS office NEMSIS version 3.X compliant data, then use that information to identify pediatric patient care needs and promote its full use at the EMS agency level. In the next few years, NEMSIS will enable states and territories to evaluate patient outcomes and as a result, the next phase will employ full utilization of NEMSIS data on specific measures of pediatric data utilization. This will include implementing pediatric-specific EMS Compass measures in states, publishing results, publishing research using statewide EMS kids data, linking EMS data, providing performance information back to agencies, and building education programs around pediatric data, etc. This measure also aligns with the Healthy People 2020 objective PREP-19: Increase the number of states reporting 90% of emergency medical services (EMS) calls to National EMS Information System (NEMSIS) using the current accepted dataset standard.

While most localities collect and most states report NEMSIS version 2.X compliant data currently, NEMSIS version 3.x is available today and in use in several states. Version 3 includes an expanded data set, which significantly increases the information available on critically ill or injured children. NHTSA is encouraging states and localities to upgrade to version 3.X compliant software and submit version 3.X data by January 1, 2017.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 01

The percentage of EMS agencies in the state/territory that submit National Emergency Medical Services Information System (NEMSIS) version 3.X 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 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.	0
Our State EMS Office intends to transition to NEMSIS version 3.X compliant patient care data to submit to NEMSIS TAC by or before 2021.	1
Our State EMS Office submits NEMSIS version 3.X 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 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 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 compliant patient care data to NEMSIS TAC with at least 80% of the EMS agencies reporting.	5
<p>Numerator: The number of EMS agencies in the state/territory that submit National Emergency Medical Services Information System (NEMSIS) version 3.X compliant patient care data to the State Emergency Medical Services Office for all 911 initiated EMS activations</p>	
<p>Denominator: Total number of EMS agencies in the state/territory actively responding to 911 requests for assistance.</p>	
<p>Percent:</p>	

Proposed Survey Questions:

As part of the HRSA’s quest to improve the quality of healthcare, the EMSC Program is interested to hear about current efforts to collect NEMSIS version 3.X 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 compliant patient care data to the state EMS office.

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

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

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

Annual targets for this measure:

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

EMSC 02 PERFORMANCE MEASURE

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

Goal: Pediatric Emergency Care

Coordination Level: Grantee

Domain: Emergency Medical Services for Children

GOAL

By 2020, 30% of EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care.

By 2023, 60% of EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care.

By 2026, 90% of EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care.

MEASURE

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

DEFINITION

Numerator:

The number of EMS agencies in the state/territory that score a '3' on a 0-3 scale.

Denominator:

Total number of EMS agencies in the state/territory that provided data.

Units: 100 **Text:** Percent

Recommended Roles: Job related activities that a designated individual responsible for the coordination of pediatric emergency care might oversee for your EMS agency are:

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

EMS: Emergency Medical Services

EMS Agency: An EMS agency is defined as an organization staffed with personnel who render medical care in response to a 911 or similar emergency call. Data will be gathered from both transporting and non-transporting agencies.

IOM: Institute of Medicine

HRSA STRATEGIC OBJECTIVE

Strengthen the Health Workforce

GRANTEE DATA SOURCES

Survey of EMS agencies

EMSC 02 PERFORMANCE MEASURE

Goal: Pediatric Emergency Care

Coordination Level: Grantee

Domain: Emergency Medical Services for Children

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

SIGNIFICANCE

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

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

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

The Pediatric Emergency Care Coordinator (PECC) should be a member of the EMS agency and be familiar with the day-to-day operations and needs at the agency. However, some states/territories may use a variety of models to coordinate pediatric emergency care at the county or regional levels. If there is a designated individual who coordinates pediatric activities for a county or region, that individual could serve as the PECC for one or more individual EMS agencies within the county or region.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 02

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

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

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

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

Proposed Survey Questions:

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

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

- Ensure that the pediatric perspective is included in the development of EMS protocols
- Ensure that fellow providers follow pediatric clinical practice guidelines
- 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.

How many EMS agencies does this individual oversee?

Is this individual:

- located at your agency**
- located at the county level**
- located at a regional level**
- Other, please describe**

To guide in the coordination of pediatric emergency care, specific roles are recommended for this individual. At this time, these roles do not determine achievement of this performance measure. However, these roles do support a variety of segments in the coordination of pediatric emergency care. Does a designated 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

- Yes
- No

Promote pediatric continuing education opportunities

- Yes
- No

Oversee pediatric process improvement

- Yes
- No

Ensure the availability of pediatric medications, equipment, and supplies

- Yes
- No

Promote agency participation in pediatric prevention programs

- Yes
- No

Liaise with the emergency department pediatric emergency care coordinator

- Yes
- No

Promote family-centered care at the agency

- Yes
- No

Promote agency participation in pediatric research efforts

- Yes
- No

Other

- Yes
- No

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

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

EMSC 03 PERFORMANCE MEASURE

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

Goal: Use of pediatric-specific equipment

Level: Grantee

Domain: Emergency Medical Services for Children

GOAL

By 2020, 30% of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of '6' or more on a 0-12 scale.

By 2023: 60% of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of '6' or more on a 0-12 scale.

By 2026: 90% of EMS agencies will have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment, which is equal to a score of '6' or more on a 0-12 scale.

MEASURE

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

DEFINITION

Numerator:

The number of EMS agencies in the state/territory that score a '6' or more on a 0-12 scale.

Denominator:

Total number of EMS agencies in the state/territory that provided data.

Units: 100

Text: Percent

EMS: Emergency Medical Services

EMS Agency: An EMS agency is defined as an organization staffed with personnel who render medical care in response to a 911 or similar emergency call. Data will be gathered from both transporting and non-transporting agencies.

IOM: Institute of Medicine

EMS Providers: EMS providers are defined as people/persons who are certified or licensed to provide emergency medical services during a 911 or similar emergency call. There are four EMS personnel licensure levels: Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), and Paramedic. Reference the National Highway Traffic Safety Administration (NHTSA) National EMS Scope of Practice Model <http://www.ems.gov/education/EMSScope.pdf>

HRSA STRATEGIC OBJECTIVE

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

Goal II: Strengthen the Health Workforce

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 that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.

GRANTEE DATA SOURCES

Survey of EMS agencies

SIGNIFICANCE

The Institute of Medicine (IOM) report “Emergency Care for Children: Growing Pains” reports that because EMS providers rarely treat seriously ill or injured pediatric patients, providers may be unable to maintain the necessary skill level to care for these patients. For example, Lammers et al reported that paramedics manage an adult respiratory patient once every 20 days compared to once every 625 days for teens, 958 days for children and once every 1,087 days for infants. As a result, skills needed to care for pediatric patients may deteriorate. Another study by Su et al found that EMS provider knowledge rose sharply after a pediatric resuscitation course, but when providers were retested six months later; their knowledge was back to baseline.

Continuing education such as the Pediatric Advance Life Support (PALS) and Pediatric Education for Prehospital Professionals (PEPP) courses are vitally important for maintaining skills and are considered an effective remedy for skill atrophy. These courses are typically only required every two years. More frequent practice of skills using different methods of skill ascertainment are necessary for EMS providers to ensure their readiness to care for pediatric patients when faced with these infrequent encounters. These courses may be counted if an in-person skills check is required as part of the course.

Demonstrating skills using EMS equipment is best done in the field on actual patients but in the case of pediatric patients this can be difficult given how infrequently EMS providers see seriously ill or injured children. Other methods for assessing skills include simulation, case scenarios and skill stations. In the absence of pediatric patient encounters in the field. There is not definitive evidence that shows that one method is more effective than another for demonstrating clinical skills. But, Miller's Model of Clinical Competence posits via the skills complexity triangle that performance assessment can be demonstrated by a combination of task training, integrated skills training, and integrated team performance. In the EMS environment this can be translated to task training at skill stations, integrated skills training during case scenarios, and integrated team performance while treating patients in the field.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 03

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

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:

In the next set of questions we are asking about the process that EMS agencies use to evaluate their EMS providers' skills using pediatric-specific equipment. While there are multiple processes that might be used, we are interested in 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 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 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 which *REQUIRES* your EMS providers to be observed by a *FIELD TRAINING OFFICER* or *SUPERVISOR* to ensure the correct use of *PEDIATRIC-SPECIFIC* equipment?

- Yes
- No

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

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

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

EMSC 04 PERFORMANCE MEASURE

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

Goal: Emergency Department Preparedness

Level: Grantee

Domain: Emergency Medical Services for Children

GOAL

By 2022: 25% of hospitals are recognized as part of a statewide, territorial, or regional standardized program that are able to stabilize and/or manage pediatric medical emergencies.

MEASURE

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

DEFINITION

Numerator:

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

Denominator:

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

Units: 100

Text: Percent

Standardized system: A system of care provides a framework for collaboration across agencies, health care organizations/services, families, and youths for the purposes of improving access and expanding coordinated culturally and linguistically competent care for children and youth. The system is coordinated, accountable and includes a facility recognition program for pediatric medical emergencies. Recognizing the pediatric emergency care capabilities of hospitals supports the development of a system of care that is responsive to the needs of children and extends access to specialty resources when needed.

Hospital: Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department. Excludes Military and Indian Health Service hospitals.

EMSC STRATEGIC OBJECTIVE

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

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

GRANTEE DATA SOURCES

This performance measure will require grantees to determine how many hospitals participate in their facility recognition program (if the state has a facility recognition program) for medical emergencies.

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

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

Goal: Standardized System for Pediatric Trauma

Level: Grantee

Domain: Emergency Medical Services for Children

GOAL

By 2022: 50% of hospitals are recognized as part of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric trauma.

MEASURE

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

DEFINITION

Numerator:

Number of hospitals with an ED that are recognized through a statewide, territorial or regional standardized system that are able to stabilize and/or manage pediatric trauma.

Denominator:

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

Units: 100

Text: Percent

Standardized system:

A system of care provides a framework for collaboration across agencies, health care organizations/services, families, and youths for the purposes of improving access and expanding coordinated culturally and linguistically competent care for children and youth. The system is coordinated, accountable and includes a facility recognition program for pediatric traumatic injuries. Recognizing the pediatric emergency care capabilities of hospitals supports the development of a system of care that is responsive to the needs of children and extends access to specialty resources when needed.

Hospital: Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department. Excludes Military and Indian Health Service hospitals.

EMSC STRATEGIC OBJECTIVE

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

Develop a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage pediatric medical emergencies and trauma.

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

The performance measure emphasizes the importance of the existence of a standardized statewide, territorial, or regional system of care for children that includes a recognition program for hospitals capable of stabilizing and/or managing pediatric trauma emergencies. A standardized recognition and/or designation program, based on compliance with the current published pediatric emergency/trauma care guidelines, contributes to the development of an organized system of care that assists hospitals in determining their capacity and readiness to effectively deliver pediatric emergency/trauma and specialty care.

This measure addresses the development of a pediatric trauma recognition program. Recognition programs are based upon State-defined criteria and/or adoption of national current published pediatric emergency and trauma care consensus guidelines that address administration and coordination of pediatric care; the qualifications of physicians, nurses and other ED staff; a formal pediatric quality improvement or monitoring program; patient safety; policies, procedures, and protocols; and the availability of pediatric equipment, supplies and medications.

Additionally, EMSC 05 does not require that the recognition program be mandated. Voluntary facility recognition is accepted. However, the preferred status is to have a program that is monitored by the State/Territory.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 05

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

Numerator:	
Denominator:	
Percent	

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

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

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

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

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

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

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

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

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

EMSC 06 PERFORMANCE MEASURE

Goal: Inter-facility transfer guidelines

Level: Grantee

Domain: Emergency Medical Services for Children

The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer guidelines that cover pediatric patients and that contain all the components as per the implementation manual.

GOAL

By 2021: 90% of hospitals in the State/Territory have written inter-facility transfer guidelines that cover pediatric patients and that include specific components of transfer.

MEASURE

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

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

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.

DEFINITION

Numerator:

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

Denominator:

Total number of hospitals with an ED that provided data.

Units: 100

Text: Percent

Pediatric: Any person 0 to 18 years of age.

Inter-facility transfer guidelines: Hospital-to-hospital, including out of State/Territory, guidelines that outline procedural and administrative policies for transferring critically ill patients to facilities that provide specialized pediatric care, or pediatric services not available at the referring facility. Inter-facility guidelines do not have to specify transfers of pediatric patients only. A guideline that applies to all patients or patients of all ages would suffice, as long as it is not written only for adults.

Grantees should consult the EMSC Program representative if they have questions regarding guideline inclusion of pediatric patients. In addition, hospitals may have one document that comprises both the inter-facility transfer guideline and agreement. This is acceptable as long as the document meets the definitions for pediatric inter-facility transfer guidelines and agreements (i.e., the document contains all components of transfer).

All hospitals in the State/Territory should have guidelines to transfer to a facility capable of providing pediatric services not available at the referring facility. If a facility cannot provide a particular type of care (e.g., burn care), then it also should have transfer guidelines in place. Consult the NRC to ensure that the facility (facilities) providing the highest level of care in the state/territory is capable of definitive care for all pediatric needs. Also, note that being in compliance with EMTALA does not constitute having inter-facility transfer guidelines.

Hospital: Facilities that provide definitive medical and/or surgical assessment, diagnoses, and life and/or limb saving interventions for the ill and injured AND have an Emergency Department (ED). Excludes Military and Indian Health Service hospitals.

EMSC 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.

EMSC STRATEGIC OBJECTIVE

Ensure the operational capacity and infrastructure to provide pediatric emergency care

Develop written pediatric inter-facility transfer guidelines for hospitals.

GRANTEE DATA SOURCE(S)

- Surveys of hospitals with an emergency department.
- Hospital licensure rules and regulations

SIGNIFICANCE

In order to assure that children receive optimal care, timely transfer to a specialty care center is essential. Such transfers are better coordinated through the presence of inter-facility transfer agreements and guidelines.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 06

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

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

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

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

NUMERATOR: _____

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

DENOMINATOR: _____

Total number of hospitals with an ED that provided data.

EMSC 07 PERFORMANCE MEASURE	The percent of hospitals with an Emergency Department (ED) in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
Goal: Inter-facility Transfer Agreements	
Level: Grantee	
Domain: Emergency Medical Services for Children	
GOAL	By 2021: 90% of hospitals in the State/Territory have written inter-facility transfer agreements that cover pediatric patients.
MEASURE	The percentage of hospitals in the State/Territory that have written inter-facility transfer agreements that cover pediatric patients.
DEFINITION	<p>Numerator: Number of hospitals with an ED that have written inter-facility transfer agreements that cover pediatric patients according to the data collected.</p> <p>Denominator: Total number of hospitals with an ED that provided data.</p> <p>Units: 100 Text: Percent</p> <p>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.</p>
EMSC STRATEGIC OBJECTIVE	<p>Ensure the operational capacity and infrastructure to provide pediatric emergency care.</p> <p>Develop written pediatric inter-facility transfer agreements to facilitate timely movement of children to appropriate facilities.</p>
DATA SOURCE(S) AND ISSUES	<ul style="list-style-type: none">•• Surveys of hospitals with an emergency department.• Hospital licensure rules and regulations
SIGNIFICANCE	In order to assure that children receive optimal care, timely transfer to a specialty care center is essential. Such transfers are better coordinated through the presence of inter-facility transfer agreements and guidelines.

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 07

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

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

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

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

NUMERATOR: _____

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

DENOMINATOR: _____

Total number of hospitals with an ED that provided data.

EMSC 08 PERFORMANCE MEASURE

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

Goal: EMSC Permanence

Level: Grantee

Domain: Emergency Medical Service for Children

GOAL

To increase the number of States/Territories that have established permanence of EMSC in the State/Territory EMS system.

MEASURE

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

DEFINITION

Permanence of EMSC in a State/Territory EMS system is defined as:

- The EMSC Advisory Committee has the required members as per the implementation manual.
- The EMSC Advisory Committee meets at least four times a year.
- Pediatric representation incorporated on the State/Territory EMS Board.
- The State/Territory require pediatric representation on the EMS Board.
- One full time EMSC Manager is dedicated solely to the EMSC Program.

EMSC

The component of emergency medical care that addresses the infant, child, and adolescent needs, and the Program that strives to ensure the establishment and permanence of that component. EMSC includes emergent at the scene care as well as care received in the emergency department, surgical care, intensive care, long-term care, and rehabilitative care. EMSC extends far beyond these areas yet for the purposes of this manual this will be the extent currently being sought and reviewed.

EMS system

The continuum of patient care from prevention to rehabilitation, including pre-hospital, dispatch communications, out-of-hospital, hospital, primary care, emergency care, inpatient, and medical home. It encompasses every injury and illness

EMSC STRATEGIC OBJECTIVE

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

Establish an EMSC Advisory Committee within each State/Territory

Incorporate pediatric representation on the State/Territory EMS Board

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

GRANTEE DATA SOURCES

- Attached data collection form to be completed by grantee.

EMSC 08 PERFORMANCE MEASURE

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

Goal: EMSC Permanence

Level: Grantee

Domain: Emergency Medical Service for Children

SIGNIFICANCE

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

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 08

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

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

Yes = 1

No = 0

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

**EMSC 09 PERFORMANCE
MEASURE**

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

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

GOAL

By 2027, EMSC priorities will have been integrated into existing EMS or hospital/healthcare facility statutes/regulations.

MEASURE

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

DEFINITION

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

1. EMS agencies are required to submit NEMSIS compliant data to the State EMS Office.
2. EMS agencies in the state/territory have a designated individual who coordinates pediatric emergency care.
3. EMS agencies in the state/territory have a process that requires EMS providers to physically demonstrate the correct use of pediatric-specific equipment.
4. The existence of a statewide, territorial, or regional standardized system that recognizes hospitals that are able to stabilize and/or manage
 - pediatric medical emergencies
 - trauma

(continued on next page)

EMSC 09 PERFORMANCE MEASURE

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

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

DEFINITION (continued)

5. Hospitals in the State/Territory have written inter-facility transfer guidelines that cover pediatric patients and that include the following components of transfer:
 - Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center (including responsibilities for requesting transfer and communication).
 - Process for selecting the appropriate care facility.
 - Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.).
 - Process for patient transfer (including obtaining informed consent).
 - Plan for transfer of patient medical record
 - Plan for transfer of copy of signed transport consent
 - Plan for transfer of personal belongings of the patient
 - Plan for provision of directions and referral institution information to family
6. Hospitals in the State/Territory have written inter-facility transfer agreements that cover pediatric patients.
7. BLS and ALS pre-hospital provider agencies in the State/Territory are required to have on-line and off-line pediatric medical direction available.
8. BLS and ALS patient care units in the State/Territory have the essential pediatric equipment and supplies, as outlined in the nationally recognized and endorsed guidelines.
9. Requirements adopted by the State/Territory that requires pediatric continuing education prior to the renewal of BLS/ALS licensing/certification.

EMSC STRATEGIC OBJECTIVE

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

GRANTEE DATA SOURCES

Attached data collection form to be completed by grantee.

SIGNIFICANCE

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

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 09

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

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

Yes = 1
 No = 0

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

DIVISION OF HEALTHY START AND PERINATAL SERVICES

PERFORMANCE MEASURE DETAIL SHEET SUMMARY TABLE

Performance Measure	New/Revised Measure	Prior PM Number (if applicable)	Topic
HS 01	New		Reproductive Life Plan
HS 02	Revised	17, 20	Usual Source of Care
HS 03	New		Interconception Planning
HS 04	New		Early Elective Delivery
HS 05	New		Intimate Partner Violence Screening
HS 06	New		Father/ Partner Involvement during Pregnancy
HS 07	New		Father and/or Partner Involvement with Child 0-24 Months
HS 08	New		Daily Reading
HS 09	New		CAN implementation
HS 10	New		CAN Participation

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

¹ <http://www.cdc.gov/preconception/documents/reproductivelifeplan-worksheet.pdf>

HS 02 PERFORMANCE MEASURE	The percent of Healthy Start women and child participants that have a usual source of care.
Goal: Usual Source of Care Level: Grantee Domain: Healthy Start	
GOAL	To increase the percent of Healthy Start women and child participants who have a usual source of care to 80%.
MEASURE	The percent of Healthy Start women and child participants that have a usual source of care.
DEFINITION	<p>Numerator: number of Healthy Start (HS) women and child participants that have a usual source of primary care as of their last HS contact.</p> <p>Denominator: Total number of women and child HS participants.</p> <p>A participant is considered to have a usual source of care and included in the numerator if the participant identifies a regular place where she or her child 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.</p>
BENCHMARK DATA SOURCES	Kaiser Family Foundation 2011(Children with a Medical Home 54.4%, 2011), Kaiser Family Foundation 2013 (Adults without a Personal Doctor 23.7%, 2013), National Survey of Children’s Health (Children with Medical Home 54.4%, 2011-2012)
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	A medical home reduces overall costs to patients, employers, and health plans by reducing emergency department visits, hospital readmissions, and inpatient visits. The medical home is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. As medical home implementation increases, overall health costs are decreasing and quality of health care is increasing. ²

² <https://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home>

HS 03 PERFORMANCE MEASURE

The percent of Healthy Start women participants who conceive within 18 months of a previous birth.

Goal: Interconception Planning

Level: Grantee

Domain: Healthy Start

GOAL

To reduce the proportion of Healthy Start women participants who conceive within 18 months of a previous birth to 30%.

MEASURE

The percent of Healthy Start women participants who conceive within 18 months of a previous birth.

DEFINITION

Numerator: Number of Healthy Start (HS) women participants whose current pregnancy was conceived within 18 months of the previous birth.

Denominator: Total number of HS women participants enrolled before the current pregnancy who had a prior pregnancy.

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. 18 month spacing of pregnancies applies to both live births.

BENCHMARK DATA SOURCES

CDC National Survey of Family Growth, Healthy People 2020 Family Planning Goal 5.

Numerator, denominator, and definition match the CDC NSFG which also aligns with HP 2020 Family Planning Goal 5.

GRANTEE DATA SOURCES

Grantee data systems

SIGNIFICANCE

Family planning is important to ensure spacing pregnancies at least 18 months apart to reduce health risks for both mother and baby. Pregnancy within 18 months of giving birth is associated with increased risk for the baby including low birth weight, small size for gestational age, and preterm birth. Additionally, the mother needs time to fully recovering from the previous birth.³

³ <http://www.mayoclinic.org/healthy-lifestyle/getting-pregnant/in-depth/family-planning/art-20044072>

HS 04 PERFORMANCE MEASURE

The percent of Healthy Start women participants with elective delivery before 39 weeks.

Goal: Early Elective Delivery

Level: Grantee

Domain: Healthy Start

GOAL

To reduce the proportion of Healthy Start women participants with elective delivery before 39 weeks to 10%.

MEASURE

The percent of Healthy Start women participants with elective delivery before 39 weeks.

DEFINITION

Numerator: Number of Healthy Start (HS) prenatal participants with elective delivery (i.e., exclude medically necessary delivery) before 39 weeks.

Denominator: Total number of HS prenatal participants enrolled prenatally who gave birth.

A participant is included in the denominator if she is enrolled in the program prior to delivering. Exclude women who are enrolled at delivery from the denominator.

An elective delivery is performed for a nonmedical reason. Some reasons include wanting to schedule the birth of the baby on a specific date or living far away from the hospital. Some women request delivery because they are uncomfortable in their last weeks of pregnancy or request a cesarean delivery because they may fear vaginal birth.

Medically indicated delivery is done for medical reasons. These reasons may include the woman's medical condition or problems with fetal development. Labor may be induced or a cesarean delivery may be performed.⁴

BENCHMARK DATA SOURCES

GRANTEE DATA SOURCES

Grantee data systems

SIGNIFICANCE

Babies who are born before 39 weeks may not be as developed as those who are born at a full term of 40 weeks. Because the baby may be underdeveloped, they may have an increased risk of short-term and long-term health problems.⁵

⁴ <http://www.acog.org/Patients/FAQs/Elective-Delivery-Before-39-Weeks>

⁵ <http://www.acog.org/Patients/FAQs/Elective-Delivery-Before-39-Weeks>

HS 05 PERFORMANCE MEASURE

The percent of HS women participants who receive intimate partner violence screening.

Goal: Intimate Partner Violence Screening

Level: Grantee

Domain: Healthy Start

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.

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.⁶

BENCHMARK DATA SOURCES

US DHHS ASPE, ACOG

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.⁷

⁶ <http://mchb.hrsa.gov/whusa09/hstat/hi/pages/226ipv.html>

⁷ <http://aspe.hhs.gov/report/screening-domestic-violence-health-care-settings/prevalence-screening>

HS 06 PERFORMANCE MEASURE	The percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy.
Goal: Father/ Partner Involvement during pregnancy	
Level: Grantee	
Domain: Healthy Start	
GOAL	To increase proportion of Healthy Start women participants that demonstrate father and/or partner involvement (e.g., attend appointments, classes, etc.) to 90%.
MEASURE	The percent of Healthy Start women participants that demonstrate father and/or partner involvement during pregnancy.
DEFINITION	<p>Numerator: Number of Healthy Start (HS) prenatal participants who report supportive father and/or partner involvement (e.g., attend appointments, classes, etc.) as of last HS contact.</p> <p>Denominator: Total number HS prenatal participants.</p> <p>A participant is considered to have support and included in the numerator if she self- reports a partner who has a significant and positive role in the participant’s pregnancy.</p> <p>Involvement during pregnancy may include, but is not limited to:</p> <ul style="list-style-type: none">• Attending prenatal appointments• Attending prenatal classes• Assisting in preparing the home for the baby e.g., putting together a crib• Providing economic support
BENCHMARK DATA SOURCES	Child Trend Research Brief, CDC National Health Statistics Report
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Research suggests that paternal involvement has been recognized to have an impact on both pregnancy and infant outcomes. Father involvement during pregnancy has shown to reduce negative maternal health behaviors, risk of preterm birth, low birth weight, and fetal growth restrictions.

HS 07 PERFORMANCE MEASURE

The percent of Healthy Start participants with father and/or partner involvement with child 0-24 months.

Goal: Father and/or Partner Involvement with child 0-24 Months

Level: Grantee

Domain: Healthy Start

GOAL

To increase the proportion of HS grantees that demonstrate father and/or partner involvement (e.g., attend appointments, classes, infant/child care) with child 0-24 months to 80%.

MEASURE

The percent of Healthy Start participants with father and/or partner involvement with child 0-24 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.) as of the last HS contact.

Denominator: Total number child participants aged 0 to 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:⁸

- 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

BENCHMARK DATA SOURCES

GRANTEE DATA SOURCES

Grantee data systems

SIGNIFICANCE

Father and/or partner involvement should consider participation in areas of medical appointments for infants, children and/or mother, attending HS sponsored classes, prenatal care, care for infant or child, etc.

⁸ <http://www.cdc.gov/nchs/data/nhsr/nhsr071.pdf>

HS 08 PERFORMANCE MEASURE

The percent of Healthy Start child participants aged 0-24 months who are read to 5 or more times per week, on average.

Goal: Daily Reading
Level: Grantee
Domain: Healthy Start

GOAL

To increase the proportion of Healthy Start child participants aged 0-24 months who are read to 5 or more times per week to 50%

MEASURE

The percent of Healthy Start child participants aged 0-24 months who are read to 5 or more times per week, on average.

DEFINITION

Numerator: Number of Healthy Start (HS) child participants who were read to 5 or more times a week, on average.⁹

Denominator: Total number of HS child participants age 0 to 24 months.

BENCHMARK DATA SOURCES

National Survey of Children's Health (2011-2012)

GRANTEE DATA SOURCES

Grantee data systems

SIGNIFICANCE

Reading to a child teaches them about communication, introduces concepts such as numbers, letters, colors, and shapes, builds listening, memory, and vocabulary skills, and gives them information about the world around them.¹⁰ 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.¹¹

⁹ <http://www.childhealthdata.org/browse/survey/results?q=2284&r=1&g=458>. Note: Children's Health Survey separates the measure by # of days read.

¹⁰ http://kidshealth.org/parent/positive/all_reading/reading_babies.html

¹¹ <http://pediatrics.aappublications.org/content/pediatrics/134/2/404.full.pdf>

HS 09 PERFORMANCE MEASURE	The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN).
Goal: CAN implementation	
Level: Grantee	
Domain: Healthy Start	

GOAL	To increase the proportion of HS grantees with a fully implemented Community Action Network (CAN) to 100%.
MEASURE	The percent of Healthy Start grantees with a fully implemented Community Action Network (CAN).

DEFINITION **Two benchmarks are calculated to capture Community Action Network (CAN) implementation and progress towards achieving collective impact:**

Numerator: Number of related CAN measure components implemented by the CAN in which the Healthy Start grantee participates.

Denominator: 3 (representing total of CAN components)

This is a scaled measure which reports progress towards full implementation of a CAN. A “yes” answer is scored 1 point; a “no” answer receives no point. To meet the standard of “fully implemented” for this measure, the HS grantee must answer “yes” to all three core elements listed below:

1. Does your CAN have regularly scheduled meetings? (Regular scheduled is minimally defined as every quarter during the reporting period). This can be documented by using sign in sheets. Yes = 1 No = 0
2. Does your CAN have members from three or more community sectors? (e.g., individuals with lived experience, Healthy Start consumer, faith based, hospital, school setting, community based organizations, government, business, medical provider(s), child care provider(s)). Yes = 1 No = 0
3. Does your CAN have a twelve month work plan? This work plan should outline the CAN’s goals, objectives, activities, entities responsible for completing, and timelines. Yes = 1 No = 0

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

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

This is a scaled measure which reports progress towards full implementation of Collective Impact. A “yes” answer is scored 2 points; “in process” 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 five core elements listed below:

HS 09 PERFORMANCE MEASURE

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

Goal: CAN implementation
Level: Grantee
Domain: Healthy Start

1. Does your CAN have a common agenda developed? All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions. This can be documented by using a theory of change, logic model, work plan template that captures this information, and/or a charter.

Yes = 2 In Process = 1 Not started = 0

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

Yes = 2 In Process = 1 Not started = 0

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

Yes = 2 In Process = 1 Not started = 0

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

Yes = 2 In Process = 1 Not started = 0

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

Yes = 2 In Process = 1 Not started = 0

BENCHMARK DATA SOURCES

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 10 PERFORMANCE MEASURE	The percent of Healthy Start grantees with at least 25% community members and Healthy Start program participants serving as members of their CAN.
Goal: CAN participation Level: Grantee Domain: Healthy Start	
GOAL	To increase the proportion of Healthy Start grantees with at least 25% community members and Healthy Start program participants serving as members of their CAN to 100%.
MEASURE	The percent of Healthy Start grantees with at least 25% community members and Healthy Start program participants serving as members of their CAN.
DEFINITION	<p>Numerator: Number of community members and Healthy Start (HS) program participants serving as members of the CAN.</p> <p>Denominator: Total number of individual members serving on the CAN.</p> <p>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.</p> <p>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.</p> <p>A Community Action Network, or CAN, is an existing, formally organized partnership of organizations and individuals. The CAN represents consumers and appropriate agencies which unite in an effort to collectively apply their resources to the implementation of one or more common strategies to achieve a common goal within that project area.</p>
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.

DIVISION OF CHILDREN WITH SPECIAL HEALTH NEEDS

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

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

F2F 1 Performance Measure

Goal: Provide National Leadership for families with children with special health needs
Level: Grantee
Category: Family Participation

The percent of families with Children with Special Health Care Needs (CSHCN) that have been provided information, education, and/or training by Family-to-Family Health Information Centers.

GOAL

To increase the number of families with CSHCN receiving needed health and related information, training, and/or education opportunities in order to partner in decision making and be satisfied with services that they receive.

MEASURE

The percent of families with CSHCN that have been provided information, education and/or training by Family-to-Family Health Information Centers.

DEFINITION

Numerator:

The total number of families with CSHCN in the State that have been provided information, education, and/or training from Family-To-Family Health Information Centers.

Denominator:

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

Units: 100

Text: Percent

BENCHMARK DATA SOURCES

Related to Objective MICH-31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, coordinated systems

GRANTEE DATA SOURCES

Progress reports from Family-To-Family Health Care Information and Education Centers, National Survey for Children's Health (NSCH), Title V Information System

SIGNIFICANCE

The last decade has emphasized the central role of families as informed consumers of services and participants in policy-making activities. Research has indicated that families need information they can understand and information from other parents who have experiences similar to theirs and who have navigated services systems.

DATA COLLECTION FORM FOR DETAIL SHEET #F2F 1

A. PROVIDING INFORMATION, EDUCATION, AND/OR TRAINING

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

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

a. Total number of families served/trained: _____

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

1. Hispanic
2. Non-Hispanic

Race

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

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

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

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

e. Of the total number of families served/trained, how many instances of service related to the following issues:

1. Partnering/decision making with providers
Number of families served/trained _____
2. Accessing a medical home
Number of families served/trained _____
3. Financing for needed health services
Number of families served/trained _____
4. Early and continuous screening
Number of families served/trained _____
5. Navigating systems/accessing community services easily
Number of families served/trained _____
6. Adolescent transition issues
Number of families served/trained _____
7. Other (Specify): _____
Number of families served/trained _____

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

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

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

c. Of the total number of professionals/providers served/trained, how many instances of service were used to provide health care information/education related to the following issues:

1. Partnering/decision making with families
Number of professionals/providers served/trained: _____
2. Accessing/providing a medical home
Number of professionals/providers served/trained: _____
3. Financing for needed services
Number of professionals/providers served/trained: _____
4. Early and continuous screening
Number of professionals/providers served/trained: _____
5. Navigating systems/accessing community services easily
Number of professionals/providers served/trained: _____
6. Adolescent transition issues
Number of professionals/providers served/trained: _____
7. Other (Specify): _____
Number of professionals/providers served/trained: _____

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

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

- Electronic newsletters and listservs
- Hardcopy
- Public television/radio
- Social media (Specify platform): _____
- Text messaging

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

a. Types of State agencies/programs - Total: _____

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

- a. State level Commissions, Task Forces, etc.
- b. MCH/CSHCN
- c. Genetics/newborn screening
- d. Early Hearing Detection and Intervention/Newborn Hearing screening
- e. Emergency Medical Services for Children
- f. LEND Programs
- g. Oral Health
- h. NICHQ Learning Collaboratives
- i. Developmental Disabilities
- j. Medicaid (CMS),SCHIP
- k. Private Insurers
- l. Case Managers
- m. SAMHSA/Mental & Behavioral Health
- n. Federation of Families for Children's Mental Health
- o. HUD/housing
- p. Early Intervention/Head Start
- q. Education
- r. Child Care
- s. Juvenile Justice/Judicial System
- t. Foster Care/Adoption agencies

- u. Other (Specify): _____
- v. None

B. MODELS OF FAMILY ENGAGEMENT COLLABORATION

1. Our organization served/worked with community-based organizations to assist them with providing services to their populations and/or to obtain their information to better serve our families.

a. Types of community-based organizations - Total: _____

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

- Other family organizations, groups
- Medical homes, providers, clinics
- Children's hospitals
- American Academy of Pediatrics Chapter
- Hospitals - Residents, hospital staff training
- Hospitals - Other: _____
- Universities - Schools of Public Health
- Universities - Schools of Nursing
- Universities - Schools of Social Work
- Community Colleges
- Schools
- Interagency groups
- Faith-based organizations, places of worship
- Non-Profits, such as United Cerebral Palsy, March of Dimes, etc)
- Ethnic/racial specific organizations
- Community Teams
- Other (Specify): _____
- None

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

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

b. Indicate the type of partnership agreements that were in place during the reporting period:

- Subcontract
- Memorandum of Understanding/Agreement
- Letter of Invitation/Acceptance/Support
- Informal/Verbal Arrangement
- Other (Specify): _____

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

a. Number of Family-to-Family FTE _____

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

Health Resources and Services
Administration
Maternal and Child Health Bureau

Discretionary Grant Performance Measures

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

Attachment B-1
Crosswalk of Proposed to Prior
Performance Measures
OMB Clearance Package

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

DGIS Performance Measure Crosswalk to prior DGIS OMB Package				
Performance Measure	Measure Status	Prior PM # (if applicable)	Topic	Data Source
Core 1	New in 2016 Package	N/A	Grant Impact	Prepopulated from NOA; Grantee self-report
Core 2	New in 2016 Package	N/A	Quality Improvement	Grantee self-report
Core 3	New in 2016 Package	N/A	Health Equity – MCH Outcomes	Grantee self-report
CB 1	New in 2016 Package	N/A	State Capacity for Advancing the Health of MCH Populations	Grantee self-report
CB 2	New in 2016 Package	N/A	Technical Assistance	Prepopulated from Domain Measures
CB 3	New in 2016 Package	N/A	Impact Measurement	Grantee self-report
CB 4	Revised in 2016, included in prior OMB approved package	5	Sustainability	Grantee self-report
CB 5	Revised in 2016, included in prior OMB approved package	3, 4	Scientific Publications	Prepopulated from Domain Measures
CB 6	New in 2016 Package	N/A	Products	Prepopulated from Domain Measures
Program Satisfaction	Removed since prior OMB approved package	1	The percent of MCHB supported programs that are satisfied with the leadership of and services received from MCHB.	N/A
Client Satisfaction	Removed since prior OMB approved package	2	The percent of MCHB customers (clients) of MCHB programs that are satisfied with services received from MCHB supported programs.	N/A
Cultural Competence	Removed since prior OMB approved package	10	The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts and training.	N/A
Dental	Removed since prior OMB approved package	12	The percent of children under age 21 enrolled in Medicaid for at least 6 months continuously during the year who receive any preventive or treatment dental service.	N/A
Data Evaluation	Removed since prior OMB approved package	13	The percent of States that have MCH staff who perform specific epidemiological activities and other MCH evaluations and analyses.	N/A
Data Evaluation	Removed since prior OMB approved package	14	The percent of States that have MCH staff who perform specific epidemiological activities and other MCH evaluations and analyses.	N/A

DGIS Performance Measure Crosswalk to prior DGIS OMB Package				
Performance Measure	Measure Status	Prior PM # (if applicable)	Topic	Data Source
Infrastructure	Removed since prior OMB approved package	24	The degree to which MCHB-funded initiatives contribute to infrastructure development through core public health assessment, policy development and assurance functions.	N/A
Data Evaluation	Removed since prior OMB approved package	25	The degree to which States electronically link vital statistics data sets, Medicaid, and other health information systems data sets.	N/A
Infrastructure	Removed since prior OMB approved package	27	The degree to which grantees have mechanisms in place to ensure quality in the design, development, and dissemination of new information resources that they produce each year.	N/A
Infrastructure	Removed since prior OMB approved package	33	The degree to which MCHB-funded initiatives work to promote sustainability of their programs or initiatives beyond the life of MCHB funding.	N/A
WMH 1	New in 2016 Package	N/A	Prenatal Care	Grantee self-report or HS Data Collection
WMH 2	New in 2016 Package	N/A	Perinatal/ Postpartum Care	Grantee self-report or HS Data Collection
WMH 3	New in 2016 Package	N/A	Well Woman Visit/ Preventive Health Care	Grantee self-report or HS Data Collection
WMH 4	New in 2016 Package	N/A	Depression Screening	Grantee self-report or HS Data Collection
WH	Removed since prior OMB approved package	21	The percentage of women participating in MCHB- funded programs who have a completed referral, among those women who receive a referral.	N/A
WH	Removed since prior OMB approved package	22	The degree to which MCHB-funded programs facilitate health providers' screening of women participants for risk factors.	N/A
WH	Removed since prior OMB approved package	35	The degree to which States and communities have implemented comprehensive systems for women's health services.	N/A
WH	Removed since prior OMB approved package	36	The percentage of pregnant participants in MCHB-funded programs receiving prenatal care beginning in the first trimester.	N/A
WH	Removed since prior OMB approved package	38	The percentage of completed referrals among women in MCHB-funded programs.	N/A

DGIS Performance Measure Crosswalk to prior DGIS OMB Package				
Performance Measure	Measure Status	Prior PM # (if applicable)	Topic	Data Source
PIH 1	New in 2016 Package	N/A	Safe Sleep	Grantee self-report or HS Data Collection
PIH 2	New in 2016 Package	N/A	Breast Feeding	Grantee self-report or HS Data Collection
PIH 3	New in 2016 Package	N/A	Newborn Screening	Grantee self-report or HS Data Collection
CH 1	New in 2016 Package	N/A	Well Child Visit	Grantee self-report or HS Data Collection
CH 2	New in 2016 Package	N/A	Quality of Well Child Visit	Grantee self-report
CH 3	New in 2016 Package	N/A	Developmental Screening	Grantee self-report or HS Data Collection
CH 4	New in 2016 Package	N/A	Injury Prevention	Grantee self-report
CH	Removed since prior OMB approved package	50	Percent of very low birth weight live births	N/A
CH	Removed since prior OMB approved package	51	Percent of live singleton births weighing less than 2,500 grams	N/A
CH	Removed since prior OMB approved package	52	The infant mortality rate per 1,000 live births	N/A
CH	Removed since prior OMB approved package	53	The neonatal mortality rate per 1,000 live births	N/A
CH	Removed since prior OMB approved package	54	The post-neonatal mortality rate per 1,000 live births	N/A
CH	Removed since prior OMB approved package	55	The perinatal mortality rate per 1,000 live births plus fetal deaths	N/A
CSHN/ Medical Home	Removed since prior OMB approved package	18	The percent of children with special health care needs age 0 through 18 who receive coordinated, ongoing, comprehensive care within a medical home.	N/A
CH/Medical Home	Removed since prior OMB approved	42	The percentage of all children age 0 to 2 participating in MCHB-funded programs who receive coordinated, ongoing,	N/A

DGIS Performance Measure Crosswalk to prior DGIS OMB Package				
Performance Measure	Measure Status	Prior PM # (if applicable)	Topic	Data Source
	package		comprehensive care within a medical home.	
CSHCN 1	Revised in 2016, included in prior OMB approved package	7	Family Engagement	Grantee self-report
CSHCN 2	Revised in 2016, included in prior OMB approved package	40/41	Access to and Use of Medical Home	Grantee self-report
CSHCN 3	New in 2016 Package	N/A	Transition to Adult Health Care	Grantee self-report
CSHN/ Health Insurance	Removed since prior OMB approved package	15	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.	N/A
CSHN/Health Insurance	Removed since prior OMB approved package	16	The degree to which grantees have assisted in increasing the percentage of pregnant women and percentage of children whose families have continuous and adequate private and/or public insurance, or other financing to pay for needed services.	N/A
CSHN/ Infrastructure	Removed since prior OMB approved package	31	The degree to which grantees have assisted States and communities in planning and implementing comprehensive, coordinated care for MCH populations.	N/A
CSHN/ Youth	Removed since prior OMB approved package	37	The degree to which grantees have worked to increase the percentage of youth who have received services necessary to transition to all aspects of adult life, including adult health care, work, and independence.	N/A
Medical Home	Removed since prior OMB approved package	40	The degree to which grantees have facilitated access to medical homes for MCH populations.	N/A
Medical Home	Removed since prior OMB approved package	41	The degree to which grantees have assisted in developing, supporting, and promoting medical homes for MCH populations.	N/A
AH 1	New in 2016 Package	N/A	Adolescent Well Visit	Grantee self-report
AH 2	New in 2016 Package	N/A	Injury Prevention	Grantee self-report
AH 3	New in 2016 Package	N/A	Screening for Major Depressive Disorder	Grantee self-report
LC 1	New in 2016 Package	N/A	Adequate Health Insurance Coverage	Grantee self-report or HS Data Collection
LC 2	Revised in 2016, included in prior	39	Tobacco and eCigarette Cessation	Grantee self-report or HS

DGIS Performance Measure Crosswalk to prior DGIS OMB Package				
Performance Measure	Measure Status	Prior PM # (if applicable)	Topic	Data Source
	OMB approved package			Data Collection
LC 3	New in 2016 Package	N/A	Oral Health	Grantee self-report
Training 01	New in 2016 Package	N/A	MCH Training Program and Healthy Tomorrows Family Member/ Youth/ Community Member participation	Grantee self-report
Training 02	New in 2016 Package	N/A	MCH Training Program and Healthy Tomorrows Cultural Competence	Grantee self-report
Training 03	New in 2016 Package	N/A	Healthy Tomorrows Title V Collaboration	Grantee self-report
Training 04	Revised in 2016, included in prior OMB approved package	59	Title V Collaboration	Grantee self-report
Training 05	Revised in 2016, included in prior OMB approved package	85	Policy	Grantee self-report
Training 06	Revised in 2016, included in prior OMB approved package	09	Diversity of Long-Term Trainees	Grantee self-report
Training 07	New in 2016 Package	N/A	MCH Pipeline Program – Work with MCH populations	Grantee self-report
Training 08	New in 2016 Package	N/A	MCH Pipeline Program – Work with underserved or vulnerable populations	Grantee self-report
Training 09	Revised in 2016, included in prior OMB approved package	83	MCH Pipeline - Graduate Program Enrollment	Grantee self-report
Training 10	Revised in 2016, included in prior OMB approved package	08	Leadership	Grantee self-report
Training 11	Revised in 2016, included in prior OMB approved package	84	Work with MCH Populations	Grantee self-report
Training 12	Revised in 2016, included in prior OMB approved package	60	Interdisciplinary Practice	Grantee self-report
Training 13	Included in 2016, no changes from prior OMB approved package	64	Diverse Adolescent Involvement (LEAH-specific)	Grantee self-report
Training 14	Revised in 2016, included in prior	86	Medium-Term Trainees Skill and Knowledge (PPC-Specific)	Grantee self-report

DGIS Performance Measure Crosswalk to prior DGIS OMB Package				
Performance Measure	Measure Status	Prior PM # (if applicable)	Topic	Data Source
	OMB approved package			
Training	Removed since prior OMB approved package	26	The extent of training and technical assistance (TA) provided and the degrees to which grantees have mechanisms in place to ensure quality in their training and TA activities.	N/A
Training	Removed since prior OMB approved package	58	The percentage of MCH training faculty who demonstrate field leadership in the areas of academic, clinical, public health/policy and advocacy.	N/A
Training	Removed since prior OMB approved package	63	The degree to which LEND programs incorporate medical home concepts into their curricula/training.	N/A
Training	Removed since prior OMB approved package	61	The degree to which MCH long term interdisciplinary trainees report valuing their interdisciplinary training at 1, and 5 years.	N/A
Training	Removed since prior OMB approved package	65	The percent of individuals who participated in long-term nutrition training that are practicing in a Maternal and Child Health (MCH) related field within 5 years after receiving training.	N/A
Training	Removed since prior OMB approved package	82	The degree to which MCH training programs use principles of adult learning, scholarly and scientific research, and effective education models that utilize available technology.	N/A
EMSC 01	New in 2016 Package	N/A	Using NEMSIS Data to Identify Pediatric Patient Care Needs.	Grantee self-report
EMSC 02	New in 2016 Package	N/A	Pediatric Emergency Care Coordination	Grantee self-report
EMSC 03	New in 2016 Package	N/A	Use of pediatric-specific equipment	Grantee self-report
EMSC 04	Included in 2016, no changes from prior OMB approved package	74	Pediatric medical emergencies	Grantee self-report
EMSC 05	Included in 2016, no changes from prior OMB approved package	75	Pediatric traumatic emergencies	Grantee self-report
EMSC 06	Included in 2016, no changes from prior OMB approved package	76	Written inter-facility transfer guidelines that contain all the components as per the implementation manual.	Grantee self-report

DGIS Performance Measure Crosswalk to prior DGIS OMB Package				
Performance Measure	Measure Status	Prior PM # (if applicable)	Topic	Data Source
EMSC 07	Included in 2016, no changes from prior OMB approved package	77	Written inter-facility transfer agreements that covers pediatric patients.	Grantee self-report
EMSC 08	Included in 2016, no changes from prior OMB approved package	79	Established permanence of EMSC	Grantee self-report
EMSC 09	Included in 2016, no changes from prior OMB approved package	80	Established permanence of EMSC by integrating EMSC priorities into statutes/regulations.	Grantee self-report
EMSC	Removed since prior OMB approved package	66	The degree to which the State/Territory has ensured the operational capacity to provide pediatric emergency care.	N/A
EMSC	Removed since prior OMB approved package	67	The adoption of requirements by the State/Territory for pediatric emergency education for the recertification of paramedics.	N/A
EMSC	Removed since prior OMB approved package	68	The degree to which the State/Territory has established permanence of EMSC in the State/Territory EMS system.	N/A
EMSC	Removed since prior OMB approved package	73	The percent of patient care units in the State/Territory that have essential pediatric equipment and supplies.	N/A
EMSC	Removed since prior OMB approved package	78	The adoption of requirements by the State/Territory for pediatric emergency education for the license/certification renewal of basic life support (BLS) and advanced life support (ALS) providers.	N/A
EMSC	Removed since prior OMB approved package	81	The percent of program participant mothers who breastfeed their infants at 6 months of age.	N/A
EMSC	Removed since prior OMB approved package	69	The percent of States and jurisdictions with pediatric guidelines for acute care to provide emergency and critical care.	N/A
EMSC	Removed since prior OMB approved package	71	The percent of pre-hospital provider agencies in the State/Territory that have on-line pediatric medical direction.	N/A

DGIS Performance Measure Crosswalk to prior DGIS OMB Package				
Performance Measure	Measure Status	Prior PM # (if applicable)	Topic	Data Source
EMSC	Removed since prior OMB approved package	72	The percent of pre-hospital provider agencies in the State/Territory that have off-line pediatric medical direction.	N/A
HS 01	New in 2016 Package	N/A	Reproductive Life Plan	Grantee self-report or HS Data Collection
HS 02	Revised in 2016, included in prior OMB approved package	17, 20	Usual Source of Care	Grantee self-report or HS Data Collection
HS 03	New in 2016 Package	N/A	Interconception Planning	Grantee self-report or HS Data Collection
HS 04	New in 2016 Package	N/A	Early Elective Delivery	Grantee self-report or HS Data Collection
HS 05	New in 2016 Package	N/A	Intimate Partner Violence Screening	Grantee self-report or HS Data Collection
HS 06	New in 2016 Package	N/A	Father/ Partner Involvement during Pregnancy	Grantee self-report or HS Data Collection
HS 07	New in 2016 Package	N/A	Father and/or Partner Involvement with Child 0-24 Months	Grantee self-report or HS Data Collection
HS 08	New	N/A	Daily Reading	Grantee self-report or HS Data Collection
HS 09	New	N/A	CAN implementation	Grantee self-report or HS Data Collection
HS 10	New	N/A	CAN Participation	Grantee self-report or HS Data Collection
F2F 1	Revised in 2016, included in prior OMB approved package	70	Provide National Leadership for families with children with special health needs	Grantee self-report
Form 1	Included in 2016, no changes from prior OMB approved package	N/A	MCHB Project Budget Details For FY_____	Grantee self-report
Form 2	Included in 2016, no changes from prior OMB approved package	N/A	Project Funding Profile	Grantee self-report
Form 3	Revised in 2016,	N/A	Budget Details by Types of Individuals	Grantee self-

DGIS Performance Measure Crosswalk to prior DGIS OMB Package				
Performance Measure	Measure Status	Prior PM # (if applicable)	Topic	Data Source
	included in prior OMB approved package		Served	report
Form 4	Revised in 2016, included in prior OMB approved package	N/A	Project Budget and Expenditures - revisions combine Population-Based Services and Infrastructure Building Services into Public Health Services and Systems	Grantee self-report
Form 5	Included in 2016, no changes from prior OMB approved package	N/A	Number of Individuals Served (unduplicated)	Grantee self-report
Form 6	Included in 2016, no changes from prior OMB approved package	N/A	Maternal & Child Health Discretionary Grant Project Abstract for FY _____	Grantee self-report
Form 7	Included in 2016, no changes from prior OMB approved package	N/A	Discretionary Grant Project Summary Data and Demographics	Grantee self-report
Form 8	Included in 2016, no changes from prior OMB approved package	N/A	MCH Discretionary Grant Project Abstract for FY (For Research Projects ONLY)	Grantee self-report
Technical Assistance/ Collaboration Form	Included in 2016, no changes from prior OMB approved package	N/A	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.	Based on information reported in Domain measures.
Continuing Education Form	Removed since prior OMB approved package	N/A	Continuing Education programs or trainings that serve to enhance the knowledge and/or maintain the credentials and licensure of professional providers.	N/A
Products, Publications and Submissions Data Collection Form	Included in 2016, no changes from prior OMB approved package	N/A	List 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.	Based on information reported in Domain measures.
MCH Training Program Data Forms	New in 2016 Package	N/A	List of all personnel (faculty, staff, and others) contributing to MCH training project	

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

Health Resources and Services Administration
Maternal and Child Health Bureau

Discretionary Grant Performance Measures

OMB No. 0915-0298

Expires: 06/30/2019

Attachment C
Financial and Demographic Data Elements
OMB Clearance Package

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

FORM 1
MCHB PROJECT BUDGET DETAILS FOR FY _____

1.	MCHB GRANT AWARD AMOUNT	\$	
2.	UNOBLIGATED BALANCE	\$	
3.	MATCHING FUNDS	\$	
	(Required: Yes [] No [] If yes, amount)		
	A. Local funds	\$	
	B. State funds	\$	
	C. Program Income	\$	
	D. Applicant/Grantee Funds	\$	
	E. Other funds: _____	\$	
4.	OTHER PROJECT FUNDS (Not included in 3 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)	\$	
5.	TOTAL PROJECT FUNDS (Total lines 1 through 4)		\$
6.	FEDERAL COLLABORATIVE FUNDS		\$
	(Source(s) of additional Federal funds contributing to the project)		
	A. Other MCHB Funds (Do not repeat grant funds from Line 1)		
	1) Special Projects of Regional and National Significance (SPRANS)	\$	
	2) Community Integrated Service Systems (CISS)	\$	
	3) State Systems Development Initiative (SSDI)	\$	
	4) Healthy Start	\$	
	5) Emergency Medical Services for Children (EMSC)	\$	
	6) Combating Autism Act Initiative	\$	
	7) Patient Protection and Affordable Care Act	\$	
	8) Universal Newborn Hearing Screening	\$	
	9) State Title V Block Grant	\$	
	10) Other: _____	\$	
	11) Other: _____	\$	
	12) Other: _____	\$	
	B. Other HRSA Funds		
	1) HIV/AIDS	\$	
	2) Primary Care	\$	
	3) Health Professions	\$	
	4) Other: _____	\$	
	5) Other: _____	\$	
	6) Other: _____	\$	
	C. Other Federal Funds		
	1) Center for Medicare and Medicaid Services (CMS)	\$	
	2) Supplemental Security Income (SSI)	\$	
	3) Agriculture (WIC/other)	\$	
	4) Administration for Children and Families (ACF)	\$	
	5) Centers for Disease Control and Prevention (CDC)	\$	
	6) Substance Abuse and Mental Health Services Administration (SAMHSA)	\$	
	7) National Institutes of Health (NIH)	\$	
	8) Education	\$	
	9) Bioterrorism	\$	
	10) Other: _____	\$	
	11) Other: _____	\$	
	12) Other: _____	\$	
7.	TOTAL COLLABORATIVE 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. Enter the amount of carryover (e.g, unobligated balance) from the previous year's award, if any. New awards do not enter data in this field, since new awards will not have a carryover balance.
- Line 3. If matching funds are required for this grant program list the amounts by source on lines 3A through 3E as appropriate. Where appropriate, include the dollar value of in-kind contributions.
- Line 4. Enter the amount of other funds received for the project, by source on Lines 4A through 4E, specifying amounts from each source. Also include the dollar value of in-kind contributions.
- Line 5. Displays the sum of lines 1 through 4.
- Line 6. Enter the amount of other Federal funds received on the appropriate lines (A.1 through C.12) **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.
- Line 6C.1. Enter only project funds from the Center for Medicare and Medicaid Services. Exclude Medicaid reimbursement, which is considered Program Income and should be included on Line 3C or 4C.
- If lines 6A.8-10, 6B .4-6, or 6C.10-12 are utilized, specify the source(s) of the funds in the order of the amount provided, starting with the source of the most funds. .
- Line 7. Displays the sum of lines in 6A.1 through 6C.12.

FORM 2

PROJECT FUNDING PROFILE

	<u>FY</u>		<u>FY</u>		<u>FY</u>		<u>FY</u>		<u>FY</u>	
	<u>Budgeted</u>	<u>Expended</u>								
1 <u>MCHB Grant</u> <u>Award Amount</u> <i>Line 1, Form 2</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
2 <u>Unobligated</u> <u>Balance</u> <i>Line 2, Form 2</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
3 <u>Matching Funds</u> <u>(If required)</u> <i>Line 3, Form 2</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
4 <u>Other Project</u> <u>Funds</u> <i>Line 4, Form 2</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
5 <u>Total Project</u> <u>Funds</u> <i>Line 5, Form 2</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
6 <u>Total Federal</u> <u>Collaborative</u> <u>Funds</u> <i>Line 7, Form 2</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

INSTRUCTIONS FOR THE COMPLETION OF FORM 2 PROJECT FUNDING PROFILE

Instructions:

Complete all required data cells. If an actual number is not available, use an estimate. Explain all estimates in a note.

The form is intended to provide funding data at a glance on the estimated budgeted amounts and actual expended amounts of an MCH project.

For each fiscal year, the data in the columns labeled Budgeted on this form are to contain the same figures that appear on the Application Face Sheet (for a non-competing continuation) or the Notice of Grant Award (for a performance report). The lines under the columns labeled Expended are to contain the actual amounts expended for each grant year that has been completed.

FORM 3

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

Target Population(s)	FY		FY	
	\$ Budgeted	\$ Expended	\$ Budgeted	\$ Expended
Pregnant Women (All Ages)				
Infants (Age 0 to 1 year)				
Children (Age 1 year to 12 years)				
Adolescents (Age 12 to 18 years)				
CSHCN Infants (Age 0 to 1 year)				
CSHCN Children and Youth (Age 1 year to 25 years)				
Non-pregnant Women (Age 25 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 25.

Enter the budgeted amounts for the appropriate fiscal year, for each targeted population group. Note that the Total for each budgeted column is to be the same as that appearing in the corresponding budgeted column in Form 2, Line 5.

Enter the expended amounts for the appropriate fiscal year that has been completed for each target population group. Note that the Total for the expended column is to be the same as that appearing in the corresponding expended column in Form 2, Line 5.

FORM 4

**PROJECT BUDGET AND EXPENDITURES
 By Types of Services**

<u>TYPES OF SERVICES</u>	FY _____		FY _____	
	<u>Budgeted</u>	<u>Expended</u>	<u>Budgeted</u>	<u>Expended</u>
I. <u>Direct Health Care Services</u> (Basic Health Services and Health Services for CSHCN.)	\$ _____	\$ _____	\$ _____	\$ _____
II. <u>Enabling Services</u> (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC and Education.)	\$ _____	\$ _____	\$ _____	\$ _____
III. <u>Public Health Services and Systems</u> (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information System Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	\$ _____	\$ _____	\$ _____	\$ _____
IV. <i>TOTAL</i>	\$ _____	\$ _____	\$ _____	\$ _____

INSTRUCTIONS FOR THE COMPLETION OF FORM 4 PROJECT BUDGET AND EXPENDITURES BY TYPES OF 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. Administrative dollars should be allocated to the appropriate level(s) of the pyramid on lines I, II, III or IV. If an estimate of administrative funds use is necessary, one method would be to allocate those dollars to Lines I, II, III and IV at the same percentage as program dollars are allocated to Lines I through IV.

Note: Lines I, II and III are for projects providing services. If grant funds are used to build the infrastructure for direct care delivery, enabling or population-based services, these amounts should be reported in Line IV (i.e., building data collection capacity for newborn hearing screening).

Line I 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.

Line II 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.

Line III 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.

Line V Total – Displays the total amounts for each column, budgeted for each year and expended for each year completed.

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

Pregnant Women Served	(a) Number Served	(b) Total Served	(c) Title XIX %	(d) Title XXI %	(e) Private/ Other %	(f) None %	(g) Unknown %
Pregnant Women (All Ages)							
10-14							
15-19							
20-24							
25-34							
35-44							
45 +							

Table 2

Infants, Children and Youth Served	(a) Number Served	(b) Total Served	(c) Title XIX %	(d) Title XXI %	(e) Private/ Other %	(f) None %	(g) Unknown %
Infants <1							
Children and Youth 1 to 25 years							
12-24 months							
25 months-4 years							
5-9							
10-14							
15-19							
20-24							

Table 3

CSHCN Infants, Children and Youth Served	(a) Number Served	(b) Total Served	(c) Title XIX %	(d) Title XXI %	(e) Private/ Other %	(f) None %	(g) Unknown %
Infants <1 yr							
Children and Youth 1 to 25 years							
12-24 months							
25 months- 4 years							
5-9							
10-14							
15-19							
20-24							

Table 4

Women Served	(a) Number Served	(b) Total Served	(c) Title XIX %	(d) Title XXI %	(e) Private/ Other %	(f) None %	Unknown % (g)
Women 25+							
25-29							
30-34							
35-44							
45-54							
55-64							
65+							

Table 5

Other	(a) Number Served	(b) Total Served	(c) Title XIX %	(d) Title XXI %	(e) Private/ Other %	(f) None %	Unknown % (g)
Men 25+							

TOTAL SERVED: _____

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 18, 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. On the other hand, 45+ means age 45 and over.

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 5.
3. In Column (b), the total number of the individuals served is summed from Column (a).
4. 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 (c): Title XIX (includes Medicaid expansion under Title XXI)
 - Column (d): Title XXI
 - Column (e): Private or other coverage
 - Column (f): None
 - Column (g): 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.

REVISED FORM 6
MATERNAL & CHILD HEALTH DISCRETIONARY GRANT
PROJECT ABSTRACT
FOR FY_____

PROJECT: _____

I. PROJECT IDENTIFIER INFORMATION

1. Project Title:
2. Project Number:
3. E-mail address:

II. BUDGET

- | | |
|---|----------|
| 1. MCHB Grant Award
(Line 1, Form 2) | \$ _____ |
| 2. Unobligated Balance
(Line 2, Form 2) | \$ _____ |
| 3. Matching Funds (if applicable)
(Line 3, Form 2) | \$ _____ |
| 4. Other Project Funds
(Line 4, Form 2) | \$ _____ |
| 5. Total Project Funds
(Line 5, Form 2) | \$ _____ |

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

- Direct Services
- Enabling Services
- 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. Aims and Key Activities: (List up to 5 major aims and key related activities for the project. These should reflect the aims from the FOA, also these will be used for Grant Impact measurement at the end of your grant period)

Aim 1:

Related Activity 1:

Related Activity 2:

Aim 2:

Related Activity 1:

Related Activity 2:

Aim 3:

Related Activity 1:

Related Activity 2:

Aim 4:

Related Activity 1:

Related Activity 2:

Aim 5:

Related Activity 1:

Related Activity 2:

3. Specify the primary *Healthy People 2020* 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 FOA.)
6. Quality Improvement Activities

B. Continuing Grants ONLY

1. Experience to Date (For continuing projects ONLY):
2. Website URL and annual number of hits
 - a. _____ Number of web hits
 - b. _____ Number of unique visitors

VI. KEY WORDS

VII. ANNOTATION

REVISED 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 5.

Section III - Types of Services

Indicate which type(s) of services your project provides, checking all that apply.

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. Provide up to 5 aims 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 aims in an information system for comparison, tracking, and reporting purposes; you must list at least 1 and no more than 5 aims. For each goal, list the key related activities. The aims and activities must be specific and time limited (i.e. Aim 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 2020 goal(s) that the project addresses.
4. Describe the programs and activities used to reach aims, 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 aims and implementing activities.

B. For continuing projects ONLY:

1. Provide a brief description of the major activities and accomplishments over the past year (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 aims of the project, the related activities which will be used to meet the aims, 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:

<input type="checkbox"/>	Direct Health Care Services
<input type="checkbox"/>	Enabling Services
<input type="checkbox"/>	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 18-25 years												
CSHCN Infants <1 year												
CSHCN Children and Youth 1 to 25 years												
Women 25+ years												
Men 25+												
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.

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.

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:
4. Principle Investigator(s), Discipline

II. BUDGET

1. MCHB Grant Award \$ _____
(Line 1, Form 2)
2. Unobligated Balance \$ _____
(Line 2, Form 2)
3. Matching Funds (if applicable) \$ _____
(Line 3, Form 2)
4. Other Project Funds \$ _____
(Line 4, Form 2)
5. Total Project Funds \$ _____
(Line 5, Form 2)

III. CARE EMPHASIS

- Interventional
 Non-interventional

IV. POPULATION FOCUS

- | | |
|--|--|
| <input type="checkbox"/> Neonates | <input type="checkbox"/> Pregnant Women |
| <input type="checkbox"/> Infants | <input type="checkbox"/> Postpartum Women |
| <input type="checkbox"/> Toddlers | <input type="checkbox"/> Parents/Mothers/Fathers |
| <input type="checkbox"/> Preschool Children | <input type="checkbox"/> Adolescent Parents |
| <input type="checkbox"/> School-Aged Children | <input type="checkbox"/> Grandparents |
| <input type="checkbox"/> Adolescents | <input type="checkbox"/> Physicians |
| <input type="checkbox"/> Adolescents (Pregnancy Related) | <input type="checkbox"/> Others |
| <input type="checkbox"/> Young Adults (>20) | |

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 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).
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 5 will be transferred from Form 1, Lines 1 through 5.

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 aims of the project, the related activities which will be used to meet the stated aims, and the materials, which will be developed.

FORM 9

TRACKING PROJECT PERFORMANCE MEASURES

Annual Objective and Performance Data

	FY__	FY__	FY__	FY__	FY__
<u>PERFORMANCE MEASURE # 1</u>					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
<u>PERFORMANCE MEASURE # 2</u>					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____
<u>PERFORMANCE MEASURE #</u>					
Annual Performance Objective	_____	_____	_____	_____	_____
Annual Performance Indicator	_____	_____	_____	_____	_____
Numerator	_____	_____	_____	_____	_____
Denominator	_____	_____	_____	_____	_____

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 2020 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 nationally required Project Performance Measures and the any 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

2020 Objective: If the measure is related to a *Healthy People 2020* 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 10 exactly as they appear on this Form.

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

Health Resources and Services Administration
Maternal and Child Health Bureau

Discretionary Grant Performance Measures

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

Attachment D
Part 3
Additional Data Elements

OMB Clearance Package

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

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 <i>Select one from list A and all that apply from List B.</i>		Recipient of TA/Collaborator	Intensity of TA	Primary Target Audience
	List A (select one) A. Clinical care related (including medical home) B. Cultural Competence 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	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): _____

REVISED
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
<u>In Press</u> peer-reviewed publications in scholarly journals <i>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.</i>	
<u>Submission(s)</u> 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 sites)	
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 Sites/ Social Media___ 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 Sites/ Social Media___ 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 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 networking 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) contributing¹ 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 or Female)	Discipline	Year Hired in MCH Leadership Training Program	Former MCHB Trainee? (Yes/No)
Faculty						
Staff						
Other						

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.

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

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: Undergraduate Pre-doctoral Post-doctoral

Part-time student Full-time student

Epidemiology training grants ONLY

Length of time receiving support: _____

Research Topic or Title _____

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

Former Trainee Information – REVISED SEPT 2015

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	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 (<i>see pick list below*</i>)	Working in Public Health organization or agency (including Title V)? (Yes/No)	Working in MCH? (Yes/No)	Working with underserved populations or vulnerable groups**? (Yes/No)	Met criteria for Leadership in PM 08? (Yes/No)	Met criteria for interdisciplinary practice in PM 60? (Yes/No)

* Employment pick list

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

** The term “underserved” refers to “Medically Underserved Areas and Medically Underserved Populations with shortages of primary medical care, dental or mental health providers. Populations may be defined by geographic (a county or service area) or demographic (low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services) factors. The term "vulnerable groups," refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life.

Vulnerable Groups refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability

is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. (i.e, Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, etc)
Source: Center for Vulnerable Populations Research. UCLA. <http://www.nursing.ucla.edu/orgs/cvpr/who-are-vulnerable.html>

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 _____ (a pick list will be provided-same as the one provided in the EHB faculty information form)

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.

- Hispanic or Latino**
- Not Hispanic or Latino**
- Unrecorded**

Race: (choose one)

American Indian and Alaskan Native refer to people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment. Tribe: _____

Asian refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g. Asian Indian).

Black or African American refers to people having origins in any of the Black racial groups of Africa.

Native Hawaiian and Other Pacific Islander refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa.

More than One Race includes individuals who identify with more than one racial designation.

Unrecorded 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 EI 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 considered to be underserved or vulnerable² (e.g., immigrant, tribal, migrant, or uninsured populations, individuals who have experienced family violence, homeless, foster care, HIV/AIDS, people with disabilities)

- 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)

² The term "underserved" refers to "Medically Underserved Areas and Medically Underserved Populations with shortages of primary medical care, dental or mental health providers. Populations may be defined by geographic (a county or service area) or demographic (low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services) factors. The term "vulnerable groups," refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life.

___ k. None

6. If you checked any 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)

Confidentiality Statement

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 – REVISED SEPT 2015

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 – REVISED SEPT 2015

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 Male _____ Female _____

(number not percent)

Ethnicity Hispanic or Latino _____ Not Hispanic or Latino _____ Unrecorded _____

(number not percent)

Race American Indian or Alaska Native: _____

(number not percent) Asian: _____

Black or African American: _____

Native Hawaiian or Other Pacific Islander: _____

White: _____

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 - REVISED SEPT 2015

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 – REVISED SEPT 2015

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.

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) | <input type="checkbox"/> Women’s Reproductive/ Perinatal Health |
| B. Diversity or Cultural Competence-Related | <input type="checkbox"/> Early Childhood Health/ Development (birth to school age) |
| C. Data, Research, Evaluation Methods (Knowledge Translation) | <input type="checkbox"/> School Age Children |
| D. Family Involvement | <input type="checkbox"/> Adolescent Health |
| E. Interdisciplinary Teaming | <input type="checkbox"/> CSHCN/Developmental Disabilities |
| F. Healthcare Workforce Leadership | <input type="checkbox"/> Autism |
| G. Policy | <input type="checkbox"/> Emergency Preparedness |
| H. Prevention | <input type="checkbox"/> Health Information Technology |
| I. Systems Development/ Improvement | <input type="checkbox"/> Mental Health |
| | <input type="checkbox"/> Nutrition |
| | <input type="checkbox"/> Oral Health |
| | <input type="checkbox"/> Patient Safety |
| | <input type="checkbox"/> Respiratory Disease |
| | <input type="checkbox"/> Vulnerable Populations* |
| | <input type="checkbox"/> Health Disparities |
| | <input type="checkbox"/> Health care financing |
| | <input type="checkbox"/> Other (specify) _____ |

* “Vulnerable populations” refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. Center for Vulnerable Populations Research. UCLA. <http://www.nursing.ucla.edu/orgs/cvpr/who-are-vulnerable.html>.

MCH PIPELINE PROGRAM GRADUATE FOLLOW-UP QUESTIONS – NEW SURVEY

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

What year did you graduate from the MCH Pipeline 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

NOTE: Graduate programs preparing graduate students to work in the MCH population include:

Medicine (e.g. Pediatric, Ob/Gyn, Primary Care), public health, MCH nutrition, public health social work, MCH nursing, pediatric dentistry, psychology, health education, health administration, pediatric occupational/physical therapy, speech language pathology.

- 2. Have you worked with Maternal and Child Health (MCH) populations since graduating from the MCH Pipeline 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 considered to be underserved or vulnerable³ since graduating from the MCH Pipeline Training program?** (e.g., Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, health disparities, etc)

- Yes
 No

³ The term “underserved” refers to “Medically Underserved Areas and Medically Underserved Populations with shortages of primary medical care, dental or mental health providers. Populations may be defined by geographic (a county or service area) or demographic (low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services) factors. The term “vulnerable groups,” refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life.

Vulnerable Groups refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. (i.e. Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, etc) *Source: Center for Vulnerable Populations Research. UCLA.*
<http://www.nursing.ucla.edu/orgs/cvpr/who-are-vulnerable.html>