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

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

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

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

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

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

NOTES/COMMENTS:

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

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

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

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

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

NOTES/COMMENTS*:*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CATEGORY #1: Training on Policy and Advocacy

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

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

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

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

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

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

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

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

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

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

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

Number of long-term trainees who are Asian _____

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

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

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

Notes/Comments:

Training 07 PERFORMANCE MEASURE **Goal: MCH LEAP Program** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB LEAP Program graduates who have been engaged in work focused on MCH populations.
GOAL	To increase the percent of graduates of MCH Leadership, Education and Advancement in Undergraduate Pathways (LEAP) Programs who have been/are engaged in work focused on MCH populations.
MEASURE	The percent of MCHB LEAP Program graduates who have been engaged in work focused on MCH populations since graduating from the MCH LEAP Training Program.
DEFINITION	**Numerator**: Number of LEAP graduates reporting they have been engaged in work focused on MCH populations since graduating from the MCH LEAP Training Program. **Denominator**: The total number of trainees responding to the survey **Units:** 100 **Text:** Percent MCH LEAP trainees are defined as undergraduate students from underserved or underrepresented backgrounds, including trainees from racially and ethnically underrepresented groups who receive education, mentoring, and guidance to increase their interest and entry into MCH public health and related health professions. **MCH Populations**: Includes women, infants and children, adolescents, young adults, and their families including fathers, and children and youth with special health care needs
BENCHMARK DATA SOURCES	Related to Healthy People 2030: AHS-R01: Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it. AHS-R02: Increase the use to telehealth to improve access to health services. PHI-R02: Expand public health pipeline programs that include service or experiential learning. PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development
GRANTEE DATA SOURCES	A LEAP program follow-up survey will be used to collect these data. Data Sources Related to Training and Work Settings/Populations: Rittenhouse Diane R, George E. Fryer, Robert L. Pillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps Participation. *Ann Fam Med* 2008;6:397-405. DOI: 10.1370/afm.885. Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career

Training 07 PERFORMANCE MEASURE **Goal: MCH LEAP Program** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCHB LEAP Program graduates who have been engaged in work focused on MCH populations.
	Choices Regarding Internal Medicine *JAMA*. 2008;300(10):1154-1164 (doi:10.1001/jama.300.10.1154)
SIGNIFICANCE	HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce for MCH.

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

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

NOTE: Each LEAP trainee should be counted once.

2 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

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

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

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

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

5 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

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

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

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

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

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

Training 08 PERFORMANCE MEASURE **Goal: MCH LEAP Program** **Level: Grantee** **Domain: MCH Workforce Development**	The percent of MCH LEAP Program graduates who have been engaged in work with populations that are underserved or have been marginalized.
	Service Corps Participation. *Ann Fam Med* 2008;6:397-405. DOI: 10.1370/afm.885. Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career Choices Regarding Internal Medicine *JAMA*. 2008;300(10):1154-1164 (doi:10.1001/jama.300.10.1154)
SIGNIFICANCE	HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. This national performance measure relates directly to MCHB Strategic Plan Goal 3: Strengthen public health capacity and workforce for MCH.

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

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

NOTE: Each LEAP trainee should be counted once.

2 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

_____

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

_____

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

_____

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

_____

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

_____

5 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

_____

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

_____

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

_____

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

_____

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

_____

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

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

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

2 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

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

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

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

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

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

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

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

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

5 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

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

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

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

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

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

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

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

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

SECTION A: 2 YEAR FOLLOW-UP

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

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

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

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

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

C. Number of respondents (A-B) _____

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

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

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

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

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

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

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

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

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

SECTION B: 5 YEAR FOLLOW-UP

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

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

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

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

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

H. Number of respondents (A-B) _____

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

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

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

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

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

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

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

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

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

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

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

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

NOTES/COMMENTS:

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

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

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

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

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

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

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

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

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

A. 2 YEAR FOLLOW-UP

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

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

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

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

Number of respondents (Denominator) _____

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

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

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

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

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

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

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

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

Collaborated with various disciplines across agencies/entities? _____%

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

B. 5 YEAR FOLLOW-UP

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

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

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

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

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

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

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

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

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

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

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

Collaborated with various disciplines across agencies/entities? _____%

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

C. 10 YEAR FOLLOW-UP

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

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

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

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

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

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

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

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

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

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

Collaborated with various disciplines across agencies/entities? _____%

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

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

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

Level I Medium-Term Trainees - Knowledge

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

Level II Medium-Term Trainees – Knowledge:

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

Level II Medium-Term Trainees - Skills :

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

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

Training 15 Data Collection Form

A. Provider Consultation and Training

1. Consultation:

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

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

[1] Enrolled provider: a provider who has formally registered with the program to facilitate use of consultation (teleconsultation or in-person) or care coordination support services, at the time of reporting. An enrolled provider is currently enrolled with the program even if initial enrollment occurred prior to current reporting period. An enrolled provider may or may not be a participating provider.

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

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

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

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

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

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

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

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

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

- ☐ Anxiety disorders
  - Number of contacts for this reason _____
- ☐ Depressive disorders (excluding postpartum depression)
  - Number of contacts for this reason _____
- ☐ Postpartum depression
  - Number of contacts for this reason _____
- ☐ Bipolar and related disorders
  - Number of contacts for this reason _____
- ☐ Attention-Deficit/ Hyperactivity Disorder (ADHD)
  - Number of contacts for this reason _____
- ☐ Autism Spectrum Disorder
  - Number of contacts for this reason _____
- ☐ Disruptive, impulse-control, and conduct disorders

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

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

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

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

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

2. Training:

i. Number and types of providers trained.

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

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

ii. Total number of trainings held ____

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

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

 Medication-focused trainings
Number of trainings covering topic _____

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

 Treatment modality-focused trainings
Number of trainings covering topic _____

 Trauma focused trainings
Number of trainings covering topic _____

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

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

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

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

b. Training mechanisms used. Select all that apply:

 In-person
Number of trainings using this mechanism _____

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

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

 Web-based
Number of trainings using this mechanism _____

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

B. Individuals Served

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

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

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

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

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

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

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

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

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

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