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

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

CH 1 PERFORMANCE MEASURE **Goal: Well Child Visit** **Level: Grantee** **Domain: Child Health**	The percent of programs promoting and/ or facilitating well-child visits.
	provider for preventive care at each of the following ages: by 1 month, 2 months, 4 months, 6 months, 9 months, 1 year, 15 months, 18 months, 24 months/ 2 years, 30 months, 3 years, and then annually thereafter.[2] % of children enrolled in Medicaid/ CHIP with at least one well care visit in the past year **Numerator**: Medicaid/ CHIP-enrolled child program participants who received a well-child visit in the reporting year. **Denominator:** Total number of Medicaid/ CHIP-enrolled child program participants in the reporting year.
BENCHMARK DATA SOURCES	National Survey of Children's Health K4Q20
GRANTEE DATA SOURCES	Title V National Performance Measure #10,
SIGNIFICANCE	Routine pediatrician visits are important to (1) prevent illness and injury through immunizations and anticipatory guidance, (2) track growth and development and refer for interventions as needed, (3) address parent concerns (e.g., behavior, sleep, eating, milestones), and (4) build trusting parent-provider relationships to support optimal physical, mental, and social health of a child.[3]

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

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

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

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

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

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

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

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

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

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

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

Data Collection Form for Detail Sheet # CH 4

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

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