

Health Resources and Services Administration Maternal and Child Health Bureau

Discretionary Grants Information System

OMB No. 0915-0298
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Attachment C: Program Specific Forms

OMB Clearance Package

Public Burden Statement: *The purpose of this information collection is to obtain performance data for the following: HRSA program participants, program operations and surveys. In addition, these data will facilitate the ability to demonstrate alignment between MCHB discretionary programs and the Discretionary Grants Information System (DGIS). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0915-0298 and it is valid until 12/31/2026. Public reporting burden for this collection of information is estimated 1.90 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.*

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Training Form 02

Training 02 PERFORMANCE MEASURE	The percent of MCHB training and Healthy Tomorrows programs that have incorporated cultural and linguistic responsiveness elements into their policies, guidelines, and training.
Goal: MCH Training Program and Healthy Tomorrows Cultural Responsiveness	
Level: Grantee	
Domain: MCH Workforce Development	

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, including elements that have been integrated from broader organizational initiatives.

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 that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

'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)

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. (T. Goode and W. Jones, 2004. National Center for Cultural Competence)

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

Training 02 PERFORMANCE MEASURE Goal: MCH Training Program and Healthy Tomorrows Cultural Responsiveness 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.
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responsiveness policies and practices; cultural and 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.

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

BENCHMARK DATA SOURCES

Related to the following Healthy People 2030 Objectives:

- 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 and

Training 02 PERFORMANCE MEASURE

**Goal: MCH Training Program and Healthy
Tomorrows Cultural Responsiveness**

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.

culturally responsive MCH workforce, including professionals, community-based workers, and families.

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

Please indicate if your MCH Training or Healthy Tomorrows program has incorporated the following cultural/linguistic responsiveness elements into your policies, guidelines, and training, including elements that have been integrated from broader organizational initiatives.

Please use the space provided beneath each element to provide additional details or justification. If you selected “No – 0,” please specify any technical assistance needed on the element (500 character limit). If you selected “Yes – 1”, you may provide details on how your program met this element.

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.).		
Additional details:		
2. Training Cultural and linguistic responsiveness knowledge and skills building are included in training aspects of your program.		
Additional details:		
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.		
Additional details:		
4. Staff/faculty cultural and linguistic diversity MCH Training Program or Healthy Tomorrows staff and faculty reflect cultural and linguistic diversity of the populations served (e.g., program has diverse faculty who work with trainees, program has efforts to recruit cultural and linguistically diverse staff and faculty).		
Additional details:		
5. Professional development MCH Training Program or Healthy Tomorrows staff and faculty participate in professional development activities to promote their cultural and linguistic responsiveness.		
Additional details:		

6. 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.		
Additional details:		

Comments:

Training Form 03

Training 03 PERFORMANCE MEASURE	The degree to which the Healthy Tomorrows Partnership for Children program collaborates with State Title V agencies, other MCH or MCH-related programs.
Goal: Healthy Tomorrows Title V Collaboration	
Level: Grantee	
Domain: MCH Workforce Development	
GOAL	To assure that the Healthy Tomorrows program has collaborative interactions related to professional development, policy development and product development and dissemination with relevant national, state and local MCH programs, agencies and organizations.
MEASURE	The degree to which a Healthy Tomorrows program collaborates with State Title V agencies, and other MCH or MCH-related programs.
DEFINITION	<p>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). Selecting “0” (or “no”) indicates that a Healthy Tomorrows program does not collaborate on an element. Selecting “1” (or “yes”) indicates that a Healthy Tomorrows program does collaborate on an element. 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.’</p> <p>Activity: An activity is a collaborative interaction related to professional development, policy development and product development and dissemination with relevant national, state and local MCH programs, agencies and organizations.</p> <p>An ongoing collaborative activity should be counted as one (1) activity. For example, if you are working with a Title V partner on an ongoing research project on maternal health that includes multiple interactions or meetings, you will count that as one (1) collaborative activity with Title V.</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	<p>Related to the following Healthy People 2030 Objectives:</p> <p>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.</p>

Training 03 PERFORMANCE MEASURE Goal: Healthy Tomorrows Title V Collaboration 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.
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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 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 Title V
 Collaboration

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 or other MCH program to develop 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 in a collaborative with MCH partners to develop materials						
6. Dissemination Examples might include: distributing information on Healthy Tomorrows program-specific development, implementation, and impact to local, state, and/or national MCH partners						
7. Sustainability Examples might include: working with state and local MCH representatives to develop and implement plans to increase impact and longevity of programs						
Total						

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

²Other MCH-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 health 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

Comments:

Training Form 04

Training 04 PERFORMANCE MEASURE	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs.
Goal: MCH Training Program Title V Collaboration	
Level: Grantee	
Domain: MCH Workforce Development	
GOAL	To assure that a training program has collaborative interactions related to training, technical assistance, continuing education, and other capacity-building services with relevant national, state and local programs, agencies and organizations.
MEASURE	The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs and other professional organizations.
DEFINITION	<p>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. Selecting “0” (or “no”) indicates that a training program does not collaborate on an element. Selecting “1” (or “yes”) indicates that a training program does collaborate on an element. 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.”</p> <p>Activity: An activity is a collaborative interaction related to service, training, continuing education, technical assistance, research, and product development with relevant national, state and local MCH programs, agencies and organizations.</p> <p>An ongoing collaborative activity should be counted as one (1) activity across all categories. For example, if you are working with a Title V partner on an ongoing research project on maternal health that includes multiple interactions or meetings, you will count that as one (1) collaborative activity with Title V.</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	<p>Related to the following Healthy People 2030 Objectives:</p> <p>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.</p>

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

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

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 – MCH Training Program Title V Collaboration

Indicate the degree to which your training program collaborates with national, state, local and community-based partners, including State Title V (MCH Block Grant) agencies and other MCH-related programs,² by entering the following values:

0= Does not collaborate on this element 1= Does collaborate on this element.

If your program does collaborate on an element, provide the total number of activities for that element. An ongoing collaborative activity should be counted as one (1) activity. For example, if you are working with a Title V partner on an ongoing research project on maternal health that includes multiple interactions or meetings, you will count that as one (1) activity.

An activity that involves both Title V and other MCH-related Programs can be counted in both categories.

Element	State Title V programs ¹			Other MCH-related programs ²		
	0	1	Total number of activities	0	1	Total number of activities
Clinical Service³ Examples might include: Clinics run by the training program and/or in collaboration with other agencies.						
Community Outreach Examples might include: Health education or workshops for community partners.						
Continuing Education Examples might include: Webinars, conferences, or other educational events that serve to enhance the knowledge of and/or maintain credentials of practicing MCH professionals. Activities may lead to CE credit, but do not have to. Do not include formal classes or seminars for trainees.						
Technical Assistance⁴ Examples might include: Conducting or assisting with needs assessments with State programs, policy development, identifying best practices, organizational capacity building for Title V or other partners, and leading collaborative groups.						
Research⁵ Examples might include: Collaborative writing and submission of grants, research teams that include Title V or other MCH-program staff and the training program’s trainees or faculty.						
Product Development⁶ Examples might include: Collaborative development of journal articles, training or informational videos, fact sheets, or policy briefs.						
Total						

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

²Other MCH-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 health centers
- City and County Health Departments
- Health care organizations
- Behavioral health disorder support and advocacy organizations
- College/University programs
- Faith-based programs
- Other national, state, local and community-based programs working with MCH populations

Comments:

³Ongoing 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.)

⁴Any products that are developed as part of technical assistance should be counted in this section.

⁵Any products that are developed as part of research collaborations should be counted in this section.

⁶Do not count any products that are developed as part of technical assistance or research collaborations.

Training Form 07

Training 07 PERFORMANCE MEASURE	The percent of MCHB LEAP Program graduates who have been engaged in work focused on MCH populations.
Goal: MCH LEAP Program	
Level: Grantee	
Domain: MCH Workforce Development	
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	<p>Numerator: Number of LEAP graduates reporting they have been engaged in work focused on MCH populations since graduating from the MCH LEAP Training Program.</p> <p>Denominator: The total number of trainees responding to the survey</p> <p>Units: 100</p> <p>Text: Percent</p> <p>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.</p> <p>Former LEAP trainees should complete a follow-up survey 2-years and 5-years after graduating to provide information on post-graduation activities.</p> <p>Trainees should be tracked based on when they graduate from the undergraduate institution. For example, if a LEAP trainee graduates in 2020, 2-year follow-up should be collected and reported to MCHB in 2022 and 5-year follow-up should be collected and reported in 2025.</p> <p>MCH Populations: Includes women, infants and children, adolescents, young adults, and their families including fathers, and children and youth with special health care needs</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	Related to the following Healthy People 2030 Objectives: AHS-R01: Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it.

Training 07 PERFORMANCE MEASURE

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

Goal: MCH LEAP Program

Level: Grantee

Domain: MCH Workforce Development

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

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

SIGNIFICANCE

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

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

NOTE: Each LEAP trainee should be counted once.

2 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

- A. The total number of LEAP Trainees that graduated 2 years ago _____
- B. The total number of graduates lost to follow-up _____
- C. The total number of respondents (A-B) = denominator _____
- D. Number of respondents who report working with MCH populations since graduating from the MCH LEAP Training Program _____
- E. Percent of respondents who report working with MCH populations since graduating from the MCH LEAP Training Program _____

5 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

- A. The total number of LEAP Trainees that graduated 5 years ago _____
- B. The total number of graduates lost to follow-up _____
- C. The total number of respondents (A-B) = denominator _____
- D. Number of respondents who report working with MCH populations since graduating from the MCH LEAP Training Program _____
- E. Percent of respondents who report working with MCH populations since graduating from the MCH LEAP Training Program _____

Comments:

Proposed Survey Questions

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

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

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

Yes

No

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

Medicine (e.g., Pediatric, Ob/Gyn, Primary Care)

Public health

Nutrition

Social work

Nursing

Pediatric dentistry

Psychology

Pediatric occupational/physical therapy

Speech language pathology

Other MCH-related health profession (specify): _____

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

Yes

No

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

Yes

No

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

Yes

No

3. Have you worked with populations that have been historically underserved and/or marginalized since graduating from the MCH LEAP Training Program?

Yes

No

Training Form 08

Training 08 PERFORMANCE MEASURE

The percent of MCH LEAP Program graduates who have been engaged in work with populations that are underserved or have been marginalized.

Goal: MCH LEAP Program

Level: Grantee

Domain: MCH Workforce Development

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.

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

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

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.

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

BENCHMARK DATA SOURCES

Related to the following Healthy People 2030 Objectives:

Training 08 PERFORMANCE MEASURE

The percent of MCH LEAP Program graduates who have been engaged in work with populations that are underserved or have been marginalized.

Goal: MCH LEAP Program

Level: Grantee

Domain: MCH Workforce Development

AHS-R01: Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it.

AHS-R02: Increase the use of telehealth to improve access to health services.

PHI-R02: Expand public health pipeline programs that include service or experiential learning.

PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development.

GRANTEE DATA SOURCES

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

SIGNIFICANCE

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

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

NOTE: Each LEAP trainee should be counted once.

2 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

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

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

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

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

5 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

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

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

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

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

Comments:

Proposed Survey Questions

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

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

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

- Yes
- No

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

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

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

- Yes
- No

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

- Yes
- No

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

- Yes
- No

6. Have you worked with populations that have been historically underserved and/or marginalized since graduating from the MCH LEAP Training Program?

" Yes

" No

Training Form 09

Training 09 PERFORMANCE MEASURE	The percent of LEAP graduates that enter graduate programs preparing them to work with the MCH population.
Goal: MCH LEAP Program	
Level: Grantee	
Domain: MCH Workforce Development	
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	<p>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.</p> <p>Denominator: Total number of MCH LEAP Trainees who graduated from the MCH LEAP program 2 or 5 years previously.</p> <p>Former LEAP trainees should complete a follow-up survey 2-years and 5-years after graduating to provide information on post-graduation activities.</p> <p>Trainees should be tracked based on when they graduate from the undergraduate institution. For example, if a LEAP trainee graduates in 2020, 2-year follow-up should be collected and reported to MCHB in 2022 and 5-year follow-up should be collected and reported in 2025.</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	<p>Related to the following Healthy People 2030 Objectives:</p> <p>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.</p>

Training 09 PERFORMANCE MEASURE

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

Goal: MCH LEAP Program

Level: Grantee

Domain: MCH Workforce Development

PHI-R03: Increase use of core and discipline-specific competencies to drive workforce development.

PHI-06: Increase the proportion of state public health agencies that use core competencies in continuing education.

PHI-07: Increase the proportion of local public health agencies that use core competencies in continuing education.

PHI-DO1: Increase the proportion of tribal public health agencies that use core competencies in continuing education

GRANTEE DATA SOURCES

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

SIGNIFICANCE

MCHB training programs assist in developing a public health workforce that addresses key MCH issues and fosters field leadership in the MCH arena. 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 09 – Graduate Program
Enrollment**

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

NOTE: Each LEAP trainee should be counted once.

2 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

- A. The total number of LEAP Trainees that graduated 2 years ago _____
- B. The total number of graduates lost to follow-up _____
- C. The total number of respondents (A-B) = denominator _____
- D. Total number of respondents that are enrolled in or have completed graduate programs preparing them to work with the MCH population _____

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

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

- E. Percent of respondents that are enrolled in or have completed graduate programs preparing them to work with the MCH population _____
- F. Number of LEAP trainees who indicate MCH LEAP Training Program helped in admission to a graduate program _____
- G. Percent of LEAP trainees who indicate MCH LEAP Training Program helped in admission to a graduate program _____
- H. Number of LEAP trainees who indicate MCH LEAP Training Program helped in being successful in a graduate program _____
- I. Percent of LEAP trainees who indicate MCH LEAP Training Program helped in being successful in a graduate program _____

5 YEARS AFTER GRADUATING FROM MCH LEAP PROGRAM

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

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

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

D. 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 a graduate program _____

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

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

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

Comments:

Proposed Survey Questions

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

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

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

“ Yes

“ No

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

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

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

- Yes**
- No**

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

- Yes**
- No**

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

- Yes**
- No**

9. Have you worked with populations that have been historically underserved and/or marginalized since graduating from the MCH LEAP Training Program?

- Yes**
- No**

Training Form 14

Training 14 PERFORMANCE MEASURE	The percentage of Level I medium-term trainees who report an increase in knowledge and the percentage of Level II medium-term trainees who report an increase in knowledge or skills related to MCH core competencies .
Goal: Medium-Term Trainees Skill and Knowledge Level: Grantee Domain: MCH Workforce Development	
GOAL	To increase the percentage of medium-term trainees (MTT) who report increased knowledge or skills related to MCH core competencies.
MEASURE	The percentage of Level I medium-term trainees who report an increase in knowledge and the percentage of Level II medium-term trainees who report an increase in knowledge or skills related to MCH core competencies.
DEFINITION	<p>Numerator: The number of Level I medium-term trainees who report an increase in knowledge and Level II medium-term trainees who report an increase in knowledge or skills related to MCH core competencies.</p> <p>Denominator: The total number of medium-term trainees responding to the survey.</p> <p><u>Medium Term trainees:</u> Level I MTT complete 40-149 hours of training. Level II MTT complete 150–299 hours of training.</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	<p>Related to the following Healthy People 2030 Objectives:</p> <p>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.</p>

Training 14 PERFORMANCE MEASURE	The percentage of Level I medium-term trainees who report an increase in knowledge and the percentage of Level II medium-term trainees who report an increase in knowledge or skills related to MCH core competencies .
Goal: Medium-Term Trainees Skill and Knowledge	
Level: Grantee	
Domain: MCH Workforce Development	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 _____

Comments:

Training Form 15

Training 15 PERFORMANCE MEASURE

Goal: Consultation and Training for Mental and Behavioral Health

Level: Grantee

Domain: MCH Workforce Development

GOAL	Increase the availability and accessibility of consultation services to providers caring for individuals with behavioral or mental health conditions.
MEASURE	Number of providers participating in consultation and care coordination support services.
DEFINITION	Total number of providers participating in consultation (teleconsultation and in-person) and care coordination support services provided by the Pediatric Mental Health Care Access (PMHCA) program and the Screening and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD) program.
BENCHMARK DATA SOURCES	None
GRANTEE DATA SOURCES	PMHCA and MMHSUD awardees report using the data collection form.
SIGNIFICANCE	Mental and behavioral health issues are prevalent among children and adolescents, and pregnant and postpartum persons 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 persons, especially those living in rural and other underserved areas.

Training 15 Data Collection Form

Instructions
<p>Tab A. Provider Consultation and Training: Select your program (PMHCA or MMHSUD).</p> <p>A.1.i: Select Yes or No to indicate if your program had any enrolled providers during the reporting period.</p> <ul style="list-style-type: none">• If select Yes, enter provider counts for “Number enrolled”, as well as “Number participating” and “Number enrolled AND participating” if applicable, by provider type. If there are no providers for a field, enter zero.<ul style="list-style-type: none">○ Provider counts may be duplicated across columns (Number enrolled, Number participating, Number enrolled and participating), but not within cells. For example, if a provider is enrolled AND participating during the reporting period, they should be counted in all three columns; the provider would be counted three times across the cells/row, but only once in each column. The "Number of enrolled AND participating" should be less than or equal to both the “Number enrolled” and the “Number participating” in each row.• If select No, enter provider counts for “Number participating”, by provider type. If there are no providers for a field, enter zero.• If a provider contacts the program more than once during the reporting period, they should only be counted once in each applicable column.• If a provider is acting in multiple roles/provider types, categorize them by their primary role as it relates to the encounter. For example, if a family visitor, doula, or social worker is filling the role of a care coordinator/patient navigator, they should be reported as a “Care Coordinator/Patient Navigator”. If a social worker is filling the role of behavioral health clinician and acting as a therapist or counselor, they would be reported in the “Behavioral Health Clinician” category.• Medical Residents should be included in the category for which they are completing their residency. For example, a family medicine resident should be included in “Primary Care Providers (non-specialty), Family Medicine”.• Parents and caregivers are not included in reporting. <p>A.1.ii.a: Enter the number of provider contacts during the reporting period for each type of contact. Enter an unduplicated count of provider contacts across contact types; if a provider is seeking both consultation and care coordination support, count the provider only under “Both”. Count each provider contact regardless of whether it is about the same patient or if it is the same provider calling in multiple times. If no providers contacted the program, enter zero (0) in the cell.</p> <p>If a provider contacted the consultation line about a patient, and then called a separate time and received either consultation and/or care coordination support for the same patient, they would be counted as two separate provider contacts. If a provider contacts the consultation line and receives consultation and/or care coordination support about multiple patients, this would be counted as one provider contact.</p> <ul style="list-style-type: none">• For PMHCA programs only, consultation can be provided by any member of the PMHCA team and not just the child and adolescent psychiatrist. <p>A.1.ii.b: Enter the number of consultations and/or referrals provided by the team during the reporting period. Report consultations by consultation type (telehealth vs. in-person). Enter an unduplicated count of consultations provided via telehealth or in person; a consultation should only fall into one of those categories. For referrals, count the total number of referrals given during the reporting period. If there were no consultations and/or referrals, enter zero (0) into the cell.</p> <p>A.1.ii.c: Select the condition(s) about which providers received consultation (teleconsultation or in-person) or care coordination support services from the program during the reporting period. Select all conditions that apply.</p> <ul style="list-style-type: none">• For each selected condition, enter the number of consultation (teleconsultation or in-person) or care coordination contacts for each. Each contact can involve more than one condition.• If the patient has a diagnosed condition, but the provider received consultation about another condition, a different presenting concern, or another reason, count the reason(s) for which the provider received consultation. If the patient does not have a diagnosis, the reason for contact can be a suspected diagnosis, diagnostic impression, presenting concerns/symptoms, suspected concern, or another reason. The condition or conditions selected should be the reason(s) the provider received consultation

(teleconsultation or in-person) or care coordination support services. Each contact with the consultation team member can involve more than one condition, however, the conditions should be limited to the primary reasons the provider received consultation and/or care coordination support from the consultation program.

- If the condition is not listed, select “Other” and list the condition(s) or reason(s) in “Other- Description”; multiple conditions can be entered, separated by commas. In the “Other” row, indicate the total number of contacts for all combined “Other” conditions that are listed in the “Other-Description”,
- Categorize encounters regarding delusions and disorganized thoughts related to postpartum psychosis in “Other” and share more details with HRSA in the non-competing continuation progress report narratives or contacts with the program. Categorize encounters regarding perinatal mood and anxiety disorders in the anxiety category.

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

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

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

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

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

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

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

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

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

Tab B. Individuals Served PMHCA will complete data entry for Children 0-11, Adolescents 12-21, and/or Children and Adolescents – age unknown. MMHSUD will complete data entry for Pregnant or postpartum persons.

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

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

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

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

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

- HRSA strongly encourages programs to report these data if programs are collecting screening data from electronic medical records (EMRs) or electronic health records (EHRs). If programs can't get EMR or EHR data, programs would add these data by provider report or not report since this measure is optional.
- PMHCA
 - Numerator: Number of children and adolescents, 0-21 years of age, for whom a provider contacted the mental health team for consultation or referral, who received at least one screening for a behavioral health condition using a standardized validated tool.
 - Denominator: Number of children and adolescents, 0-21 years of age, for whom a provider contacted the mental health team for consultation or referral.
- MMHSUD
 - Numerator: Number of pregnant or postpartum persons, for whom a provider contacted the program for consultation or care coordination support, who received at least one screening for a behavioral health condition (depressions, anxiety, or substance use, separately) using a standardized validated tool.
 - Denominator: Number of pregnant or postpartum persons, for whom a provider contacted the program for consultation or care coordination support.
- Do not report data when there is only an assumption about whether the patient was screened. If programs cannot ask the provider whether a screening has occurred, then do not report.
- Include screens conducted by the provider or practice that is calling for the consultation or referral. A paraprofessional may not be conducting screens but can validate that a screening occurred and report that to the consult line.
- Report on screens conducted within the previous 12 months at the time of the consultation/referral call.
- HRSA Project Officers will provide examples of validated screening tools.

Definitions:

Enrolled Provider: A provider who has formally registered with the program to facilitate use of consultation (teleconsultation or in-person) or care coordination support services, at the time of reporting. An enrolled

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

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

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

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

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

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

Example 1: The PMHCA/MMHSUD program recommends Jonathan Smith, PhD, clinical psychologist specializing in childhood anxiety disorders, address xxx Main Street, Springfield, TX, phone number xxx-xxx-xxxx, email address xx@xx.com. This counts as one referral.

Example 2: The PMHCA/MMHSUD program refers the provider or family to a specific mental health counselor or therapist for psychotherapy AND provides a referral for a specific addiction counselor or specific practice. The consultation team member provided 2 referrals.

Example 3: A provider calls into the consultation line regarding a patient experiencing depression. The patient’s family is experiencing housing insecurity, and the provider shares that information for assistance. The consultation team member provides a referral to a behavioral health therapist and to a social worker who specializes in subsidized housing. This counts as 2 referrals.

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

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

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

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

Rural/Underserved: HRSA defines rural areas as all counties that are not designated as parts of metropolitan areas (MAs) by the Office of Management and Budget. In addition, HRSA uses Rural Urban Commuting Area Codes to designate rural areas within MAs. This rural definition can be accessed at: <https://www.hrsa.gov/rural-health/about-us/what-is-rural>. If the county is not entirely rural or urban, follow the link for “Rural Health Grants Eligibility Analyzer” to determine if a specific site qualifies as rural based on its specific census tract within an otherwise urban county. 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>

A. Provider Consultation and Training

Select Program: PMHCA MMHSUD

1. Consultation:

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

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

Provider Type		Number enrolled	Number participating	Number enrolled AND participating
Primary Care Providers (non-specialty)	Pediatrician			
	Family Medicine			
	OB/GYN			
	Internal Medicine			
	Advanced Practice Nurse/Nurse Practitioner			
	Certified Nurse Midwife			
	Physician Assistant			
Others	Psychiatrist			

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

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

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

- Anxiety disorders
 - o Number of contacts for this reason _____
- Depressive disorders (excluding postpartum depression)
 - o Number of contacts for this reason _____
- Postpartum depression

- Number of contacts for this reason _____
- Bipolar and related disorders
 - Number of contacts for this reason _____
- Attention-Deficit/ Hyperactivity Disorder (ADHD)
 - Number of contacts for this reason _____
- Autism Spectrum Disorder
 - Number of contacts for this reason _____
- Disruptive, impulse-control, and conduct disorders
 - Number of contacts for this reason _____
- Neurodevelopmental disorders (including developmental delay and intellectual disabilities)
 - Number of contacts for this reason _____
- Feeding and eating disorders
 - Number of contacts for this reason _____
- Obsessive-compulsive and related disorders
 - Number of contacts for this reason _____
- Trauma and stressor-related disorders
 - Number of contacts for this reason _____
- Schizophrenia spectrum and other psychotic disorders
 - Number of contacts for this reason _____
- Substance-related disorders
 - Number of contacts for alcohol _____
 - Number of contacts for marijuana _____
 - Number of contacts for nicotine _____
 - Number of contacts for opioids _____
 - Number of contacts for other substance-related disorders _____
- Suicidality or self-harm
 - Number of contacts for this reason _____
- Social and environmental concerns (including violence, unstable housing, language barriers, isolation/lack of social support, food insecurity, transportation, etc.)
 - Number of contacts for this reason _____
- Other (please specify) _____
 - Number of contacts for this reason _____

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

Member of mental health team	Number of consultations provided	Number of referrals provided
Psychiatrist		
Psychologist		
Social Worker		
Counselor		
Care Coordinator		
Other behavioral clinicians		

Other (specify type):		
Total (will auto-populate)		

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

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

Number of trainings covering topic _____

Medication-focused trainings

Number of trainings covering topic _____

Screening and assessment/testing-focused trainings

Number of trainings covering topic _____

Treatment modality-focused trainings

Number of trainings covering topic _____

- Trauma focused trainings
 Number of trainings covering topic _____
- Parent and family-focused trainings
 Number of trainings covering topic _____
- Practice Improvement/Systems Change/Quality Improvement
 (e.g., practice workflows, integrating protocols into the EHR,
 integrating behavioral health into primary care, expanding
 community referrals, 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 _____
- Hybrid (combination of in-person and virtual)
 Number of trainings using this mechanism _____
- Other (please specify) _____
 Number of trainings using this mechanism _____

B. Individuals Served

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

	Total	Rural/underserved
Children 0-11		
Adolescents 12-21		
Children and Adolescents – age unknown		
Pregnant or postpartum persons		

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			
Children and Adolescents – age unknown			
Pregnant or postpartum persons			

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

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

Comments:

EMSC 04

EMSC 04 PERFORMANCE MEASURE

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

Goal: Emergency Department Readiness

Level: Grantee

Domain: Emergency Medical Services for Children

GOAL

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

MEASURE

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

DEFINITION

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

Denominator: Total number of hospitals with an ED in the state/territory.

Units: 100

Text: Percent

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

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

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

EMSC STRATEGIC OBJECTIVE

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

EMSC 04 PERFORMANCE MEASURE

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

Goal: Emergency Department Readiness

Level: Grantee

Domain: Emergency Medical Services for Children

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

GRANTEE DATA SOURCES

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

SIGNIFICANCE

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

This measure helps to ensure essential resources and protocols are available in facilities where children receive care for emergencies. A standardized program can also facilitate EMS transfer of children to appropriate levels of resources.

Additionally, a standardized program that includes a verification process to identify facilities meeting specific criteria, has been shown to increase the degree to which EDs are compliant with published guidelines and improve hospital pediatric readiness statewide.

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

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 04

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

Numerator:	
Denominator	
Percent	

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

Denominator: Total number of hospitals with an ED in the state/territory. For the purposes of data collection, exclude Military and Indian Health Service hospitals.

Further Disaggregation of Data for Geographic Distribution

Numerator: Number of hospitals with an ED located in a rural ¹ area that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies.	
Denominator: Number of hospitals with an ED that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies	
Percent	

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

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

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

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

¹ Rural and urban area classifications use the Office of Management and Budget definition. Rural: counties classified as a micro area (urban core of 10,000-49,999 people) or counties outside of metro and micro areas. Urban: counties with a core population of 50,000 or more. <https://www.ers.usda.gov/data-products/urban-influence-codes/>

- 1= Research has been conducted on the effectiveness of a standardized program (i.e., improved pediatric outcomes)
And/or
Developing a standardized program has been discussed by the EMSC Advisory Committee and members are working on the issue.
- 2= Criteria that facilities must meet in order to receive recognition as being able to stabilize and/or manage pediatric emergencies have been developed.
- 3= An implementation process/plan for the standardized program has been developed.
- 4= The implementation process/plan for the standardized program has been piloted.
- 5= At least one facility has been formally recognized through the standardized program. Supporting documentation will be requested to confirm this selection.

Comments:

EMSC 08

EMSC 08 PERFORMANCE MEASURE

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

Goal: EMSC Permanence

Level: Grantee

Domain: Emergency Medical Service for Children

GOAL

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

MEASURE

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

DEFINITION

The number of elements that are associated with permanence of EMSC in a state/territory EMS system on a scoring system ranging from a possible score of no elements (0) to five elements (5).

Permanence of EMSC in a state/territory EMS system is defined as:

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

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

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

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

EMSC 08 PERFORMANCE MEASURE

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

Goal: EMSC Permanence

Level: Grantee

Domain: Emergency Medical Service for Children

EMSC STRATEGIC OBJECTIVE

- Establish permanence of EMSC in each state/territory EMS system.
- Establish an EMSC Advisory Committee within each state/territory
- Incorporate pediatric representation on the state/territory EMS Board
- Establish one full-time equivalent EMSC manager that is dedicated solely to the EMSC Program.

GRANTEE DATA SOURCES

Attached data collection form to be completed by grantee.

SIGNIFICANCE

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

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 08

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

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

Yes = 1
No = 0

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

Comments:

EMSC 09

EMSC 09 PERFORMANCE MEASURE

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

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

GOAL

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

MEASURE

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

DEFINITION

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

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

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

EMSC 09 PERFORMANCE MEASURE

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

Goal: Integration of EMSC priorities

Level: Grantee

Domain: Emergency Medical Services for Children

- Hospitals in the state/territory have written inter-facility transfer agreements that cover pediatric patients.
- BLS and ALS pre-hospital provider agencies in the state/territory are required to have on-line and off-line pediatric medical direction available.
- BLS and ALS patient care units in the state/territory have the essential pediatric equipment and supplies, as outlined in the nationally recognized and endorsed guidelines.
- Requirements adopted by the state/territory that requires pediatric continuing education prior to the renewal of BLS/ALS licensing/certification.

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

EMSC STRATEGIC OBJECTIVE

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

GRANTEE DATA SOURCES

Attached data collection form to be completed by grantee.

SIGNIFICANCE

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

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 09

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

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

Yes = 1
 No = 0

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

Comments:

EMSC 10

EMSC 10 PERFORMANCE MEASURE	The percent of prehospital Emergency Medical Services (EMS) agencies recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies.
Goal: Prehospital Emergency Medical Services Readiness	
Level: Grantee	
Domain: Emergency Medical Services for Children	
GOAL	To increase the percent of prehospital EMS agencies that are recognized as part of a statewide, territorial, or regional standardized program that are able to stabilize and/or manage pediatric emergencies.
MEASURE	The percent of prehospital EMS agencies recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies.
DEFINITION	<p>Numerator: Number of prehospital EMS agencies that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies.</p> <p>Denominator: Total number of prehospital EMS agencies in the state/territory.</p> <p>Units: 100 Text: Percent</p> <p>EMS: Emergency Medical Services</p> <p>Prehospital EMS Agency: A prehospital EMS agency is defined as an organization staffed with personnel who render medical care in response to a 911 or similar emergency call. Data will be gathered from both transporting and non-transporting agencies.</p> <p>Standardized program: A program or system of care, also referred to as a pediatric readiness recognition program, that provides a framework for collaboration across agencies, health care organizations/services, families, and youth for the purposes of improving access and expanding coordinated culturally and linguistically competent care for children and youth. The program/system is coordinated, accountable, and recognizes the pediatric emergency care capabilities of prehospital EMS agencies in a state, territory, or region. The program supports the development of a standardized system of care that is responsive to the needs of children, and extends access to specialty resources when needed.</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>

EMSC 10 PERFORMANCE MEASURE

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

Goal: Prehospital Emergency Medical Services Readiness

Level: Grantee

Domain: Emergency Medical Services for Children

EMSC STRATEGIC OBJECTIVE

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

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

GRANTEE DATA SOURCES

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

SIGNIFICANCE

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

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

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

DATA COLLECTION FORM FOR DETAIL SHEET: EMSC 10

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

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

Numerator: number of prehospital EMS agencies located in rural ² areas that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies.	
Denominator: total number of prehospital EMS agencies that are formally recognized through a statewide, territorial or regional standardized program that are able to stabilize and/or manage pediatric emergencies.	
Percent:	

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

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

Check this box if the number reported above is an estimate

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

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

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

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

² Rural and urban area classifications use the Office of Management and Budget definition. Rural: counties classified as a micro area (urban core of 10,000-49,999 people) or counties outside of metro and micro areas. Urban: counties with a core population of 50,000 or more. <https://www.ers.usda.gov/data-products/urban-influence-codes/>

And/or

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

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

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

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

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

Comments:

HS 04

HS 04 PERFORMANCE MEASURE

The percent of HS women participants who receive interpersonal violence screening and referral.³

Goal: Interpersonal Violence Screening and Referral

Level: Grantee

Domain: Healthy Start

GOAL

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

MEASURE

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

DEFINITION

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

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

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

Definition: A participant is considered to have been screened and included in the denominator if a standardized screening tool which is appropriately validated for her circumstances is used. A number of screening tools have been validated for IPV screening.

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

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

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

Definition: A participant is considered to have been referred for follow-up services and included in the numerator if she is referred to a qualified practitioner for further assessment for IPV. Referral can be to either an internal or external provider depending on availability and staffing model.⁴

Interpersonal Violence is a pattern of assaultive behavior and coercive behavior that may include physical injury, psychological abuse, sexual assault,

³ Consistent with Healthy Start Benchmark 13

⁴ <https://www.ahrq.gov/ncepcr/tools/healthier-pregnancy/fact-sheets/partner-violence.html>

progressive isolation, stalking, deprivation, intimidation, and reproductive coercion. These behaviors are committed by someone who is, was, or wishes to be involved in an intimate relationship with the participant.⁵

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

BENCHMARK DATA SOURCES

PRAMS

GRANTEE DATA SOURCES

Grantee data systems

SIGNIFICANCE

Interpersonal Violence is a substantial yet preventable public health problem that affects women across the world. Research shows that interpersonal violence screening differs among health care specialties and is overall relatively low. The U.S. Department of Health and Human Services recommends IPV screening and counseling be a core part of a women's well visit.⁶

⁵ <http://mchb.hrsa.gov/whusa09/hstat/hi/pages/226ipv.html>

⁶ <http://aspe.hhs.gov/report/screening-domestic-violence-health-care-settings/prevalence-screening>

HS 10

HS 10 PERFORMANCE MEASURE	The percent of pregnant HS participants who receive prenatal care beginning in the first trimester.
Goal: Prenatal Care Level: Grantee Domain: Healthy Start	
GOAL	To increase the proportion of pregnant HS participants who receive prenatal care in the first trimester to 80 percent.
MEASURE	The percent of pregnant HS participants who receive prenatal care beginning in the first trimester.
DEFINITION	<p>During the reporting period: Numerator: Number* of pregnant HS participants who began prenatal care in the first trimester of pregnancy.</p> <p>*The number of pregnant participants is unduplicated. Pregnant HS participants should be counted only once during a calendar year unless they have experienced more than one pregnancy in that calendar year. (If pregnant participant is counted more than once in the numerator, they should be counted more than once in the denominator.)</p> <p>During the reporting period: Denominator: Number of pregnant HS participants who had enrolled prenatally, prior to their second trimester of pregnancy.</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective MICH-08: Increase the proportion of pregnant women who receive early and adequate prenatal care. (Baseline: 76.4% in 2018, Target: 80.5%) ⁷
GRANTEE DATA SOURCES	Grantee Data System
SIGNIFICANCE	Early and continuous prenatal care is essential for identification of maternal disease and risks for complications of pregnancy or birth. This can help ensure that women with complex problems, chronic illness, or other risks are seen by specialists. Prenatal care can also provide important education and counseling on modifiable risks in pregnancy, including smoking, drinking, and inadequate or excessive weight gain.

⁷ <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08> (accessed on 5/25/2022)

HS 11

HS 11 PERFORMANCE MEASURE

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

Goal: Perinatal/ Postpartum Care

Level: Grantee

Domain: Healthy Start

GOAL

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

MEASURE

The percent of pregnant/newly postpartum HS participants with a postpartum visit within 12 weeks of delivery.⁸

DEFINITION

During the reporting period:

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

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

During the reporting period:

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

Definition: ACOG recommends that postpartum care would ideally include an initial assessment, either in person or by phone, within the first 3 weeks postpartum to address acute postpartum issues. This initial assessment should be followed up with ongoing care as needed, concluding with a comprehensive well-woman visit no later than 12 weeks after birth.^{9, 10}

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

BENCHMARK DATA SOURCES

PRAMS (postpartum visit: 88%, 2020)

GRANTEE DATA SOURCES

Grantee Data System; Pregnancy Risk Assessment Monitoring System

⁸ Consistent with Healthy Start Benchmark 3: The percent of Healthy Start women participants who receive a postpartum visit.

⁹ <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care> (accessed 5/25/2022)

¹⁰ <https://www.marchofdimes.org/pregnancy/your-postpartum-checkups.aspx> (accessed 5/25/2022)

SIGNIFICANCE

Since the period immediately following birth is a time of many physical and emotional adjustments, the postpartum visit is important for educating new mothers on what to expect during this period and address any concerns which may arise. Additional issues include any health complications the mother may have and the health benefits of breastfeeding for the mother and baby.¹¹

¹¹ <http://www.aafp.org/afp/2005/1215/p2491.html>

HS 12

HS 12 PERFORMANCE MEASURE	The percent of HS women participants with a well-woman/ preventive visit in the past year. ¹²
Goal: Well Woman Visit/ Preventive Health Care	
Level: Grantee	
Domain: Healthy Start	
GOAL	To increase the proportion of HS women participants that receive a well-woman/ preventive visit in the past year to 80 percent.
MEASURE	The percent of HS women participants with a well-woman/ preventive visit in the past year.
DEFINITION	<p>Numerator: Number of HS women participants within the reporting period who received a well-woman or preventive visit (including prenatal or postpartum visit) in the past 12 months prior to last assessment.</p> <p>Denominator: Total number of HS women participants during the reporting period.</p> <p>Definition: A participant is considered to have a well-woman or preventive visit and included in the numerator if she has a documented health assessment visit where she obtained recommended preventive services that are age and developmentally appropriate within twelve months of her last contact with the Program in the reporting year. For purposes of reporting, a prenatal visit or postpartum visit during the twelve month period would meet the standard.</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	BRFSS (Women 18-44 with a past-year preventive visit: 72%, 2019-2020); PRAMS (early prenatal care: 87%, 2020); PRAMS (postpartum visit: 88%, 2020)
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	An annual well-woman visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. The American College of Obstetrics and Gynecologists (ACOG) recommends an annual well-woman visit beginning in adolescence and continuing across the lifespan with any health care provider offering preventive well-woman care.

¹² Consistent with Healthy Start Benchmark 5: The percent of Healthy Start women participants who have a well-woman visit.

HS 13

HS 13 PERFORMANCE MEASURE

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

Goal: Depression Screening and Referral

Level: Grantee

Domain: Healthy Start

GOAL

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

MEASURE

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

DEFINITION

Percent of women screened for depression using a validated tool¹³

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

Denominator: Number of HS women participants in the reporting period.

Definition: A participant is considered to have been screened and included in the numerator if a standardized screening tool which is appropriately validated for her circumstances is used. Several screening instruments have been validated for use to assist with systematically identifying patients with depression.¹⁴

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

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

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

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

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

¹³ Consistent with Healthy Start Benchmark 12a and 12b: Percent of Healthy Start women participants who receive depression screening and referral.

¹⁴ <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression>

HS 13 PERFORMANCE MEASURE	The percent of HS women participants who receive depression screening and referral.
Goal: Depression Screening and Referral	
Level: Grantee	
Domain: Healthy Start	
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective MICH-D01: (Developmental) Increase the proportion of women who are screened for postpartum depression at their postpartum checkup. PRAMS (depression screening)
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	Postpartum depression (PPD) is common, affecting as many as 1 in 7 mothers. ⁸ Symptoms may include depressed mood, loss of interest or pleasure in activities, sleep disturbance, appetite disturbance, loss of energy, feelings of worthlessness or guilt, diminished concentration, irritability, anxiety, and thoughts of suicide. ¹⁵ PPD is associated with negative maternal physical and psychological health, relationship problems, and risky behaviors. ¹⁶ PPD is also associated with poor maternal and infant bonding and may negatively influence child development. Infant consequences of PPD include less infant weight gain and stunting, problems with sleep, poor social, emotional, behavioral, cognitive, and language development. ¹⁰ Universal screening and treatment for pregnant and postpartum women is recommended by the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), and the U.S. Preventive Services Task Force. ¹⁷

¹⁵ Pearlstein T, Howard M, Salisbury A, Zlotnick C. Postpartum depression. American Journal of Obstetrics & Gynecology. 2009; 200(4): 357-364

¹⁶ Slomian J, Honvo G, Emons P, Reginster JY, Bruyere O. Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. Women's Health. 2019; 15:1-55.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6492376/pdf/10.1177_1745506519844044.pdf

¹⁷ <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression>

HS 14

HS 14 PERFORMANCE MEASURE	Percent of HS infants placed to sleep following safe sleep practices ¹⁸ .
Goal: Safe Sleep	
Level: Grantee	
Domain: Healthy Start	
GOAL	To increase the proportion of HS infants placed to sleep following safe sleep practices to 80%.
MEASURE	The percent of HS infants placed to sleep following safe sleep practices.
DEFINITION	<p>Numerator: Number of HS infant participants aged <12 months whose parent/ caregiver reports that they are always or most often placed to sleep following all three AAP recommended safe sleep practices.¹⁹</p> <p>Denominator: Total number of HS infant participants aged <12 months.</p> <p>A participant is considered to engage in safe sleep practices and included in the numerator if it is reported that the baby is ‘always’ or ‘most often’ 1) placed to sleep on their back, 2) always or often sleeps alone in his or her own crib or bed with no bed sharing, and 3) sleeps on a firm sleep surface (crib, bassinet, pack and play, etc.) with no soft objects or loose bedding.²⁰</p> <p>The requirement is that the baby is placed on their back to sleep. If they roll over onto their stomach after being placed to sleep, the standard is met. Although safe sleep behaviors are self-reported, programs are encouraged to observe safe sleep practices during home visits, as possible.</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective MICH-14: Increase the proportion of infants placed to sleep on their backs (Baseline: 78.7% in 2016; Target: 88.9%); Healthy People 2030 Objective MICH-D03: Increase the proportion of infants who are put to sleep in a safe sleep environment. (Developmental) Pregnancy Risk Assessment Monitoring System (PRAMS) Phase 7, Question 48 (Sleep Position) and F1 (Bed Sharing). ²¹
GRANTEE DATA SOURCES	Grantee Data Systems
SIGNIFICANCE	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after

¹⁸ Consistent with Healthy Start Benchmark 6: Percent of Healthy Start participants who are placed to sleep following safe sleep behaviors.

¹⁹ <https://www.aap.org/en/patient-care/safe-sleep/> (accessed 5/26/2022)

²⁰ Pediatrics (2016) 138 (5): e20162938. <https://doi.org/10.1542/peds.2016-2938>

²¹ http://nccd.cdc.gov/PRAMStat/rdPage.aspx?rdReport=DRH_PRAMS.ExploreByTopic&isClassId=CLA&isTopicId=TOP23&go=GO

HS 14 PERFORMANCE MEASURE

Percent of HS infants placed to sleep following safe sleep practices¹⁸.

Goal: Safe Sleep

Level: Grantee

Domain: Healthy Start

the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding.²²

²² American Academy of Pediatrics (AAP). Task Force on Sudden Infant Death Syndrome. SIDS and other sleep-related infant deaths: Updated 2016 recommendations for a safe infant sleeping environment. *Pediatrics* 2016. 138 (5):e20162938.

HS 15

HS 15 PERFORMANCE MEASURE	The percent of HS infant participants who were ever breastfed or fed pumped breast milk, and/ or were fed breast milk at 6 months of age.
Goal: Breastfeeding Level: Grantee Domain: Healthy Start	
GOAL	To increase the proportion of HS infant participants who were: <ul style="list-style-type: none">• ever breastfed or fed pumped breast milk to 82 percent.• breastfed or fed pumped breast milk at 6 months to 50 percent.
MEASURE	The percent of HS infant participants who were ever breastfed or fed pumped breast milk, and/ or were fed breast milk at 6 months of age.
DEFINITION	<p>Percent of HS infant participants ever breastfed or fed pumped breast milk²³</p> <p>Numerator: Total number of HS infant participants aged <12 months who were ever breastfed or fed pumped breast milk, and whose parent was enrolled prenatally.</p> <p>Denominator: Total number of HS infant participants aged <12 months whose parent was enrolled prenatally.</p> <p>Definition: A participant is considered to have ever breastfed and included in the numerator if the infant received breast milk directly from the breast or that was pumped/expressed; this includes breast milk received at any time in any amount.</p> <p>Percent of HS infant participants breastfed or fed pumped breast milk at 6 months²⁴</p> <p>Numerator: Total number of HS infant participants ages 6 through 11 months who were breastfed or were fed pumped breast milk in any amount at 6 months of age, and whose parent was enrolled prenatally.</p> <p>Denominator: Total number of HS infant participants ages 6 through 11 months whose parent was enrolled prenatally.</p> <p>Definition: A participant is considered to have ever breastfed at 6 months and included in the numerator if the infant received breast milk directly from the breast or That was pumped/expressed; this includes breast milk received in any amount during the sixth month.</p>

²³ Consistent with Healthy Start Benchmark 7: Percent of Healthy Start child participants whose parent reports the child was ever breastfed or fed breastmilk, even for a short period of time.

²⁴ Consistent with Healthy Start Benchmark 8: Percent of Healthy Start child participants whose parent reports the child was breastfed or fed breastmilk at 6 months.

HS 15 PERFORMANCE MEASURE

Goal: Breastfeeding
Level: Grantee
Domain: Healthy Start

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

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

BENCHMARK DATA SOURCES

Related to Healthy People 2030 Objective MICH-15: Increase the proportion of infants who are breastfed exclusively through 6 months (Baseline: 24.9% in 2015, Target: 42.4%); Related to Healthy People 2030 MICH-16: Increase the proportion of infants who are breastfed at 1 year (Baseline: 35.9% in 2015, Target: 54.1%)

GRANTEE DATA SOURCES

Grantee data systems.

SIGNIFICANCE

The American Academy of Pediatrics (AAP) recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months, followed by continued breastfeeding as complementary foods are introduced for 1 year or longer. Exclusive breastfeeding for six months supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, reduces respiratory infections, gastrointestinal illness, and SIDS, and promotes neurodevelopment. Breastfed children may also be less likely to develop diabetes, childhood obesity, and asthma. Maternal benefits include reduced postpartum blood loss due to oxytocin release and possible protective effects against breast and ovarian cancer, diabetes, hypertension, and heart disease.

HS 16

HS 16 PERFORMANCE MEASURE	The percent of HS child participants who received well-child visits. ²⁵
Goal: Well Child Visit	
Level: Grantee	
Domain: Healthy Start	
GOAL	To increase the proportion of HS child participants who received the last age-appropriate recommended well-child visit based on AAP schedule to 90 percent.
MEASURE	The percent of HS child participants who received recommended well-child visits.
DEFINITION	<p>Numerator: Number of HS child 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.</p> <p>Denominator: Total number of HS child participants in the reporting period.</p> <p>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 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.²⁶</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	National Survey of Children’s Health K4Q20
GRANTEE DATA SOURCES	Grantee data systems
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. ²⁷

²⁵ Consistent with Healthy Start Benchmark 11: The percent of Healthy Start child participants who receive well child visits.

²⁶ https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

²⁷ <https://www.aappublications.org/news/aapnewsmag/2015/12/15/WellChild121515.full.pdf>

HS 17

HS 17 PERFORMANCE MEASURE	The percent of HS women and child participants with health insurance coverage.
Goal: Health Insurance Coverage	
Level: Grantee	
Domain: Healthy Start	
GOAL	To increase the proportion of HS women and child participants with health insurance to 90 percent (reduce uninsured to less than 10 percent).
MEASURE	The percent of HS women and child participants who had health insurance as of the last assessment during the reporting period. ²⁸
DEFINITION	<p>% of HS women participants with health insurance</p> <p>Numerator: Number of HS women participants with health insurance as of the last assessment during the reporting period</p> <p>Denominator: Total number of HS women participants during the reporting period.</p> <p>% of HS child participants with health insurance</p> <p>Numerator: Number of HS child participants with health insurance as of the last assessment during the reporting period</p> <p>Denominator: Total number of HS child participants during the reporting period.</p> <p>Participants are identified as not insured if they report not having any of the following: private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), State-sponsored or other government-sponsored health plan, or military plan at the time of the interview. A participant is also defined as uninsured if he or she reported having only Indian Health Service coverage, or only a private plan that paid for one type of service such as family planning, accidents, or dental care. For more information regarding health insurance questions please refer to Section VII (page 35) of the 2014 National Health Interview Survey (NHIS) Survey Description</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective AHS-01: Increase the proportion of people with health insurance (Baseline: 89.0% of persons under 65 years had medical insurance in 2018; Target: 92.1%); National Survey of Children's Health

²⁸ Consistent with Healthy Start Benchmark 1: The percent of Healthy Start women and child participants with health insurance.

HS 17 PERFORMANCE MEASURE Goal: Health Insurance Coverage Level: Grantee Domain: Healthy Start	The percent of HS women and child participants with health insurance coverage.
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(Children's Average 94.5%, 2011/2012),²⁹ National Health Interview Survey³⁰

GRANTEE DATA SOURCES

Grantee data systems

SIGNIFICANCE

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

²⁹ <http://childhealthdata.org/browse/survey/results?q=2197&r=1>

³⁰ <http://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201406.pdf>

HS 18

HS 18 PERFORMANCE MEASURE	The percent of prenatal HS participants who abstain from smoking cigarettes, or using any tobacco products, in their third trimester.
Goal: Prenatal Tobacco and eCigarette Use	
Level: Grantee	
Domain: Healthy Start	
GOAL	To increase the proportion of pregnant HS participants that abstain from cigarette smoking, or using any tobacco products, to 90 percent.
MEASURE	The percent of prenatal HS participants who abstain from smoking cigarettes, or using any tobacco products, in their third trimester.
DEFINITION	<p>Numerator: Number of prenatal Healthy Start participants who abstained from using any tobacco products during their third trimester (i.e., last 3 months of pregnancy).</p> <p>Denominator: Total number of prenatal Healthy Start participants who were enrolled at least 90 days before delivery.</p> <p>Smoking includes all tobacco products and e-cigarettes.</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective MICH-10: Increase abstinence from cigarette smoking among pregnant women. (Baseline: 93.5% in 2018, Target: 95.7%). Related to HP2030 TU-15: Increase smoking cessation success during pregnancy among females. (Baseline: 20.2% in 2018, Target 24.4%)
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Research shows that smoking in pregnancy is directly linked to problems including premature birth, certain birth defects, sudden infant death syndrome (SIDS), and separation of the placenta from the womb prematurely. Women who smoke may have a harder time getting pregnant and have increased risk of miscarriage.

HS 19

HS 19 PERFORMANCE MEASURE	Percent of low birthweight infants among all singleton live births to Healthy Start participants.
Goal: Low Birthweight	
Level: Grantee	
Domain: Healthy Start	
GOAL	To reduce the proportion of low birthweight infants among all singleton live births to HS participants. ³¹
MEASURE	The percent of low birthweight infants among all live births to Healthy Start participants.
DEFINITION	<p>Numerator: Number of singleton live births with birth weight less than 2,500 grams in the calendar year among HS participants.</p> <p>Denominator: Total number of singleton live births in the calendar year among HS participants.</p> <p>Count only participants who gave birth while enrolled in Healthy Start.</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	CDC, NCHS (2020 data: 8.24%) ³² HS Budget Justification (Targets: 2023=9.6%; 2024=10.3%) ³³
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Low birthweight (LBW) is among the leading causes of infant death in the United States. LBW infants are also more likely to have health problems. After reaching its highest level in four decades, the LBW rate among all births declined from 2006 to 2014, but the trend reversed in 2015 and 2016 when the LBW rate increased, moving further away from the Healthy People 2020 goal of reducing LBW rates to 7.8% of live births. ³⁴ Black infants (14.0%) were about 2 times as likely as white infants (6.9%) to be born low birthweight during 2018-2020 (average). ³⁵

³¹ <https://www.cdc.gov/nchs/products/databriefs/db306.htm>

³² <https://www.cdc.gov/nchs/fastats/birthweight.htm> (accessed on 5/26/2022)

³³ <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2023.pdf>
(FY2024 target included in HRSA's not-yet-published FY2024 Budget Justification)

³⁴ <https://www.cdc.gov/nchs/products/databriefs/db306.htm> (accessed on 5/26/2022)

³⁵ <https://www.marchofdimes.org/peristats/data?reg=99&top=4&stop=45&lev=1&slev=1&obj=1>

HS 20

HS 20 PERFORMANCE MEASURE	Percent of infants born preterm (delivery prior to 37 completed weeks of gestation) among all singleton live births to Healthy Start participants.
Goal: Preterm Birth Level: Grantee Domain: Healthy Start	
GOAL	To reduce the proportion of infants born preterm among all singleton live births to HS participants.
MEASURE	Percent of infants born preterm (delivery prior to 37 completed weeks of gestation) among all singleton live births to Healthy Start participants.
DEFINITION	<p>Numerator: Number of singleton infants born preterm (delivery prior to 37 completed weeks of gestation) in the calendar year among HS participants.</p> <p>Denominator: Total number of singleton live births in the calendar year among HS participants.</p> <p>Count only participants who gave birth while enrolled in Healthy Start.</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	Related to Healthy People 2030 Objective MICH-07: Reduce preterm births (Baseline 10.0%, 2018; Target 9.4%) ³⁶ CDC, NCHS (2019 data: 10.2%) ³⁷ [HS Data for 2020 (singleton): 9.4%]
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	<p>Infants born before 37 weeks of gestation have a higher risk of infections, developmental problems, breathing problems, and even death. Preterm births are more common in some racial/ethnic groups. Strategies to reduce preterm births include promoting adequate birth spacing, helping women quit smoking, and providing high-quality medical care for women during pregnancy.³⁸</p> <p>Following increases from 2014 to 2019, the singleton preterm birth rate declined by less than 1% from 2019 (8.47%) to 2020 (8.42%).³⁹</p>

³⁶ <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-preterm-births-mich-07> (accessed on 5/26/2022)

³⁷ <https://www.cdc.gov/nchs/fastats/birthweight.htm> (accessed on 5/26/2022)

³⁸ <https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/reduce-preterm-births-mich-07> (accessed on 5/26/2022)

³⁹ <https://www.cdc.gov/nchs/data/databriefs/db430.pdf>

HS 21

HS 21 PERFORMANCE MEASURE	The infant mortality rate (per 1,000 live births) of enrolled Healthy Start (HS) infants.
Goal: Infant Mortality Level: Grantee Domain: Healthy Start	
GOAL	To reduce infant death among enrolled Healthy Start participants.
MEASURE	The infant mortality rate (per 1,000 live births) of enrolled Healthy Start (HS) infants.
DEFINITION	<p>Numerator: Number of deaths of enrolled HS infants (from birth through 364 days of age to HS participants in the calendar year).</p> <p>Definition: Count deaths that occurred in both infants “born into the program” to enrolled participants (regardless of infant enrollment status) AND infants enrolled at some point after their birth and before their first birthday (less than one year in age/through 364 days of age).</p> <p>“Born into the program” refers to infants born to participants who were enrolled prenatally.⁴⁰</p> <p>Denominator: Total number of live births in the calendar year among HS participants.</p> <p>Note: This form utilizes DGIS Form 10.A for annual performance objective and data reporting.</p>
BENCHMARK DATA SOURCES	<p>Note: All IMR data below reported in the format of “number of infant deaths per 1,000 live births.”</p> <p>Related to Healthy People 2030 Objective MICH-02: Reduce the rate of infant deaths (Baseline 5.8, 2017; Target 5.0)⁴¹, CDC, NCHS (2020 data: 5.42)⁴²</p> <p>[HS IMR Data: 2020: 7.04, 2019: 8.05, 2018: 6.26]</p>
GRANTEE DATA SOURCES	Grantee data systems
SIGNIFICANCE	Every year in the United States, thousands of infants die from causes like preterm birth, low birth weight, and sudden infant death syndrome. Although the rate of infant deaths has fallen over the past decade, there are disparities by race/ethnicity, income, and geographic location. Equitable, high-quality care for moms and babies and community-based interventions can help reduce the rate of infant deaths.

⁴⁰ Healthy Start Aggregate Template User Guide and Data Dictionary (2021):

<https://www.healthystartepic.org/healthy-start-implementation/monitoring-data-and-evaluation/>

⁴¹ <https://health.gov/healthypeople/objectives-and-data/browse-objectives/infants/reduce-rate-infant-deaths-mich-02> (accessed on 5/26/2022)

⁴² US DHHS, CDC, NCHS, Division of Vital Statistics, Natality public-use data 2016-2020, on CDC WONDER Online Database, October 2021.

F2F 1

F2F 1 Performance Measure

Goal: Provide National Leadership for families with children with special health needs

Level: Grantee

Category: Family Participation

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

GOAL

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

MEASURE

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

DEFINITION

Numerator: The total number of families of CYSHCN receiving one-to-one services and training from Family-To-Family Health Information Centers.

Denominator: The estimated number of families with CYSHCN in the state.

Units: 100

Text: Percent

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

BENCHMARK DATA SOURCES

Related to Healthy People 2030 Objective MICH-20: Increase the proportion of children and adolescents with special health care needs who have a system of care.

GRANTEE DATA SOURCES

Progress reports from Family-To-Family Health Information Centers, National Survey for Children's Health (NSCH), Title V Information System

SIGNIFICANCE

The last decade has emphasized the central role of families as informed consumers of services and participants in policy-making activities. Research has indicated that families need information they can understand and information from other parents who have experiences similar to theirs and who have navigated services systems.

DATA COLLECTION FORM FOR DETAIL SHEET #F2F 1

Instructions

Complete the data collection table below.

For the purpose of this form:

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

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

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

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

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

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

A. PROVIDING INFORMATION, EDUCATION, AND/OR TRAINING

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

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

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

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

Ethnicity

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

Race

1. White _____
2. Black or African American _____
3. Asian _____

4. Native Hawaiian or Other Pacific Islander _____
5. American Indian or Alaska Native _____
6. Some other Race _____
7. More than one race _____
8. Unknown _____

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

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

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

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

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

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

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

- a. Select the modes of how print/media information and resources are disseminated. (Select all that apply).
 - Electronic newsletters
 - Listservs
 - Hardcopy/print
 - Public television/radio
 - Social media platform description: _____
 - Text messaging
 - Other (specify): _____

B. MODELS OF FAMILY ENGAGEMENT COLLABORATION

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

- a. Total number of State agencies/programs with which your organization has worked: _____

b. Indicate the types of State agencies/programs with which your organization has worked: _____

	Check the box if you worked with this type of organization
Title V MCH/CSYHCN Program	
Newborn Screening Program	
Early Hearing Detection and Intervention/Newborn Hearing Screening	
Emergency Medical Services for Children	
Home Visiting	
State Medicaid	
State CHIP	
State Mental and/or Behavioral Health	
Government Housing Program	
Early Intervention/Part C	
Head Start Collaboration Office	
Other (Specify):	
None	

2. Our organization served/worked with community-based organizations to assist them with providing services to their populations and/or to obtain their information to better serve our families.

a. Total number of community-based organizations: _____

b. Indicate the types of community-based organizations with which your organization has worked:

	Check the box if you worked with this type of organization
Medical homes, providers, clinics, hospitals	
Provider organizations (for example, American Academy of Pediatric chapter)	
Provider training programs (for example, residency programs; schools of medicine, nursing, public health, LEND programs, social work, etc.)	
Schools (K-12, pre-school)	
Faith-based organizations, places of worship	
Condition-specific organizations (for example, United Cerebral Palsy, March of Dimes, etc.)	
Child care programs	
Local Head start	
Other community organization (Specify):	
None	

c. Of those community-based organizations, indicate if any were dedicated to specific racial and/or ethnic populations

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

3. Number of staff who work on Family-to-Family HIC activities _____
4. Number of F2F staff who are family/have a disability _____

Comments: