Leveraging CAHMI’s Data, Measurement, Engagement and Flourishing “In Action” for you Title V Needs Assessment and Implementation

Title V Maternal & Child Health Federal-State Partnership Meeting
November 7, 2023

Christina Bethell, PhD, MBA, MPH
Professor, Johns Hopkins University
Director, Child and Adolescent Health Measurement Initiative
What is the CAHMI?

Our 27 years to promote early and lifelong health using family centered research, data and tools.
CAHMI’s 27-year journey to support and optimize the impact of Title V Needs Assessment and Action

Guiding principles for the development of the MCH Block Grant application/annual reporting for all states:

- “data-driven programming and performance accountability”
- “partnerships with individuals/families/family-led organizations to ensure systems and services that support the interests of all MCH populations.”

Title V Maternal and Child Health Services Block Grant to States Program. Guidance and Forms for the Title V Application/Annual Report.
Data Resource Center and Other CAHMI Resources Are Relevant for Each Step on the Title V Needs Assessment Journey

**Step 1: Engage Stakeholders**
- Identify needs
- Collect/Interpret data
- Sort priorities
- Build consensus
- Select solutions

**Step 2: Assess Needs Identify Outcomes**
Identify community/system needs using evidence from:
- Population-based data
- Surveillance systems
- Program data
- Public forums

**Step 3: Examine Strengths and Capacity**
- Report performance data within 6 MCH populations
- Assess service capacity of 3 MCH service levels

**Step 4: Select Priorities**
Select 7 to 10 priority areas for targeted improvement

**Step 5: Set Performance Objectives**
- National Outcome Measures (NOMs)
- National Performance Measures (NPMs)
- Evidence –based or –informed Strategy Measures (ESMs)
- State Performance Measures (SPMs)

**Step 6: Develop an Action Plan**
Create 5-Year State Plan Action Table
- Priority need
- Key strategies
- Measures for each of the MCH health domains

**Step 7: Seek and Allocate Resources**
Align action plan with:
- Current budgets
- Political priorities
- Input from partnerships

**Step 8: Monitor Progress**
Use qualitative and quantitative information to examine evidence of improvement along the selected performance objectives

**Step 9: Report Back to Stakeholders**
- Provide transparency and accountability
- Disseminate findings
- Provide recommendations for action
Big-4 Approach to Needs Assessment From Our Morning Plenary—Amy Zapata (Louisiana)

**go-to strategy “Big 4” and Title V**

**What are the external trends and pressures?**

- **Data**
  - What’s going up? Down?
  - What has had no attention?
- **Wisdom**
  - How do we know what is important?
  - Who have we asked?
  - Who haven’t we asked?

- What changes are happening or coming?
  - Health system
  - Legislative
- Resources/assets
  - Maternal health blueprint
  - Sickle cell strategic plan
  - CYSHCN roadmap
  - Medicaid innovations
QUICK LINKS TO RESOURCES FOR TITLE V NEEDS ASSESSMENT

The resource links included in this document provide a high-level summary of resources to help you leverage the Data Resource Center (www.childhealthdata.org) and Related Child and Adolescent Health Measurement Initiative (CAHMI) resources to support each step of the needs assessment process.

TA Priority
Topics are organized by steps along the Title V Needs Assessment process and MCH resource category.

RESOURCES
Resources include videos, documents, research and reports, related models and tools and data and measurement resources.

QUICK LINKS
Links are provided throughout. Look out for hyperlinked text to access resources. Simple language is used.

November 2023

Citation: Child and Adolescent Health Measurement Initiative (2023). “Starting Point Quick Links – Title V Needs Assessment.” Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
Quick Glance Overview of CAHMI Resources for Your Title V Needs Assessment

**Data Resource Center**
- Interactive Data Query
- Hot Spotting Tables
- U.S. Maps
- Crosswalk of NSCH Survey Items
- Content Maps

**Measurement in Action: Steps 2,3,4,5,6,9**
- MCH Measures Compendium
- Measurement Research Network
- National Strategic Measurement Agenda

**Engagement in Action: Steps 1,6,7**
- Engagement in Action (EnAct!) Framework
- Cycle of Engagement Well Visit Planner Approach to Care
- Shared Care Planning for CSHCN
A. National Data Resource Center for Child and Adolescent Health (www.childhealthdata.org)

The DRC is a project of the CAHMI project supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) providing point-and-click access to national, state, and regional findings from the National Survey of Children’s Health (NSCH)

- Use the Data Resource Center for Child & Adolescent Health (DRC) to develop quick glance summaries of key issues relevant to each stakeholder and how their partnership is critical to identifying and advancing improvements. Let stakeholders frame their own stories about what matters by helping them use the DRC too!
- DRC Health Equity Brief - Maximizing the Power of the National Survey of Children’s Health to Promote Social Justice Among the Nation’s Children and engage stakeholders to understand disparities and drive positive health equity.
- DRC Introductory Video
- Interactive Data Query - point-and-click access to NSCH Title V Maternal and Child Health Service Block Grant Measures and over 300 Child and Family Health Measures analyzable by child and family demographic and other subgroups for all states
- Video Tour of the Interactive Data Query
- Hot Spotting Tables - compare prevalence rates of multiple National Performance and National Outcome Measures across states in one visual table
- U.S Maps - visually compare state-to-national performance on National Performance Measures and National Outcome Measures for states
- Changes to the Title V National Performance Measures and National Outcome Measures, 2016-2022
- Downloadable DRC datasets with accompanying codebooks - includes all of the DRC measures and indicators which appear in the DRC Interactive Data Query
- Data Driven Early Childhood Systems Transformation - a video lecture sharing tips for leveraging existing data to jump start and inform an integrated early childhood health system
Apply research and frameworks specifically focused on Title V Block Grant goals

1. Promote integrated systems and family and community engaged collaborations
2. Understand and address social and relational determinants of health in actionable ways across partners
3. Access resources to promote improvements in clinical care

B. Actionable Research and Frameworks to Inform, Inspire and Shape Equity Focused Partnerships In Your State

C. Measurement In Action Resources to Advance Shared Goals and Measures and Drive Systems Improvement

- Review an array of measurement resources addressing the MCH population across the lifespan
- Access the Data Resource Center “Learn About the NSCH” to get quick guides to topics and questions asked, survey instruments and measurement changes and data alerts to consider as you use the NSCH measures for action!
- CAHMI’s Measurement in Action - a strategic measurement approach to create positive lasting change by putting children, youth, and families at the center of quality measurement and improvement
  - MCH Measures Compendium - an interactive guide to identify, characterize, and compare measures in use across key MCH programs and initiatives
  - National Strategic Measurement Agenda - a systematic process for creating a strategic agenda for measurement and research priorities and gaps related to maternal, child, and family health
- Understanding the CSHCN Screener and options for scoring and use across strategic elements of action
- Learn about validated, family engaged Online Promoting Healthy Development Survey to assess the quality of preventive and developmental services for young children in your state. With use nationally, across 14 states and now for front line clinical use, check out the Cycle of Engagement Model powered by the Online Promoting Healthy Development Survey to focus action to assess and track progress with the automated aggregate report in real time!
- Learn about the CAHMI’s validated Young Adult Health Care Survey to engage youth in assessing the quality of primary care preventive services they receive. Read this example of use as an online survey.
- Learn more about measuring Adverse Childhood Experiences and Positive Childhood Experiences. Learn about the Prioritizing Possibilities National Agenda and the Engagement In Action (EnAct!) Framework to leverage measurement to take broad action to prevent adversity and promote healing and child and youth well-being.

D. Resources to partner with families directly to focus services on whole child and family priorities and needs

- Leverage the CARE PATH for Kids to partner with families to anchor care plans for children with special health care needs to the goals, priorities, context and needs of families and each child
- Ensure comprehensive well child care services are provided using the Cycle of Engagement Well Visit Planner approach in partnership with pediatric primary care, community health centers, home visiting, early intervention, child welfare, WIC, early care and education, community resources brokers and more! See a short video here.
Optimizing Health and Health Care Systems for Children with Special Health Care Needs Using the Life Course Perspective

Christina D. Bethell, Paul W. Newacheck, Amy Fine, Bonnie B. Strickland, Richard C. Antonelli, Cambria L. Wilhelm, Lynda E. Honberg & Nora Wells

Maternal and Child Health Journal 18, 467–477 (2014) | Cite this article

Taking Stock of the CSHCN Screener: A Review of Common Questions and Current Reflections

Christina D. Bethell, PhD, MBA, MPH1 [Director, Professor], Stephen J. Blumberg, PhD2 [Associate Director for Science], Ruth E. K. Stein, MD3 [Professor], Bonnie Strickland, PhD4 [Director], Julie Robertson, MPH, MSW5 [Former Research Associate], and Paul W. Newacheck, DrPH6 [Professor]

1Child and Adolescent Health Measurement Initiative, Department of Population, Family and Reproductive Health, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD
2National Center for Health Stat Hyattsville, MD
3Abert Einstein College of Med
4Maternal and Child Health Bur Rockville, MD
5Philip R. Lee Institute for Healt

Abstract

Since 2000, the Children with widely used nationally, by six

Using existing population-based data sets to measure the American Academy of Pediatrics definition of medical home for all children and children with special health care needs

Christina D Bethell 1, Debra Read, Krista Brockwood: American Academy of Pediatrics

Affiliations expand
PMID: 15121922

Abstract

Objective: National health goals include ensuring that all children have a medical home. Historically, medical home has been determined by the presence of a usual or primary source of care, such as a

Longstanding work on CYSHCN, Medical Home and Family Voices and Engagement

Scaling Family Voices and Engagement to Measure and Improve Systems Performance and Whole Child Health: Progress and Lessons from the Child and Adolescent Health Measurement Initiative

Historical Notes | Open access | Published: 25 August 2023 | (2013)

Download PDF You have full access to this open access article

Christina D. Bethell, Nora Wells, David Bergman, Colleen Reuland, Scott P. Stumbo, Narangore
Gomboj & Lisa A. Simpson

Use our pre-served manuscripts AVOID COMMON ERROR...
Prevalence of Children With Special Health Care Needs, Mental Health Problems and Mothers in Very Good/Excellent Health by Adverse Childhood Experiences Levels

- **No ACEs**
  - Children With Special Health Care Needs: 76.2%
  - Experienced One or More Risks on the Integrated Child Risk Index: 54.8%
  - Children With Mothers in Excellent/Very Good Health: 48.3%

- **1 ACE**
  - Children With Special Health Care Needs: 34.2%
  - Experienced One or More Risks on the Integrated Child Risk Index: 22.0%

- **2 ACEs**
  - Children With Special Health Care Needs: 14.0%
  - Experienced One or More Risks on the Integrated Child Risk Index: 4.5%
Results:

Prevalence of **school engagement** among US children age 6-17 years, by Child Flourishing Index (CFI) individual items

- **Stays calm and in control when faced with a challenge**
  - Somewhat true or not true: 51.4%
  - Definitely True: 82.8%
  - Adjusted odds ratio (AOR): 3.98

- **Works to finish the tasks he/she starts**
  - Somewhat true or not true: 34.9%
  - Definitely True: 84.9%
  - Adjusted odds ratio (AOR): 9.02

- **Shows interest and curiosity in learning new things**
  - Somewhat true or not true: 28.7%
  - Definitely True: 75.0%
  - Adjusted odds ratio (AOR): 5.98

**Note:** Adjusted odds ratios (AOR) are adjusted for age, sex, race/ethnicity, income, CSHCN status and ACEs. *AOR is statistically significant.*
From Trauma As the Problem to Relational Health As The Solution

No ACEs | 1 ACE | 2-3 ACEs | 4+ ACEs
---|---|---|---
20.1% | 16.8% | 11.9% | 21.6%
44.3% | 36.6% | 30.6% | 40.8%
57.6% | 48.4% | 40.8% | 30.5%

26.8% had this score

Connection key even for children without adversity!

- Talk together about what to do when the family faces problems
- Work together to solve the problem
- Know they have strengths to draw on
- Stay hopeful even in difficult times
- Share ideas and talk about things that really matter

Number of Family Resilience and Connection Experiences

From Trauma As the Problem to Relational Health As The Solution

“Through Any Door” moment by moment positive childhood experiences are highly protective, even amid high adversity.

We Are the Medicine—Building Our Caring Capacity is Imperative ....everyone is a leader!

(1) “Through Any Door”  (2) “In Every Encounter”  (3) “No Broken Link”

Simple rules for a complex system!
Relational health refers to the experience of and capacity to develop and sustain safe, stable, nurturing relationships (SSNRs), which in turn prevent the extreme or prolonged activation of the body’s stress response systems.

<table>
<thead>
<tr>
<th>Moving Beyond Toxic Stress ... Towards Relational Health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary (2013):</strong></td>
</tr>
<tr>
<td><strong>Toxic stress defines the problem.</strong></td>
</tr>
<tr>
<td>Toxic stress explains how many of our society’s most intractable problems (disparities in health, education and economic stability) are rooted in our shared biology but divergent experiences and opportunities.</td>
</tr>
</tbody>
</table>

| **Summary (2020):** |
| **Relational health defines the solution.** |
| Relational health explains how the individual, family and community capacities that support the development and maintenance of safe, stable and nurturing relationships also buffer adversity and build resilience across the life-course. |
Over half of all US children experience complex social and relational health risks – this is 2/3 of those with a mental health condition.

Social Health Risks:
Poverty, food insecurity, exposure to community violence, racism, etc.

Relational Health Risks:
Adverse childhood experiences (ACEs), low parental mental health, low parent emotional support, etc.

60% of children with relational health risks did not have social health risks.

Source: Child and Adolescent Health Measurement Initiative Analysis of National Survey of Children’s Health

Bethell, C. 2023
WHOLE CHILD AND FAIILY INTEGRATED SYSTEMs TRANSFORMATION REQUIRED!
EXAMPLE: Prevalence of Mental, Emotional and/or Behavioral Health Problems
By Children’s Exposure to Social and Relational Health Risks

<table>
<thead>
<tr>
<th>Social Health Risks</th>
<th>0 Relational Health Risks</th>
<th>1 Relational Health Risk</th>
<th>2-4 Relational Health Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>15.3%</td>
<td>18.5%</td>
<td>44.4%</td>
</tr>
<tr>
<td>1</td>
<td>21.2%</td>
<td>30.3%</td>
<td>50.5%</td>
</tr>
<tr>
<td>2-4</td>
<td>31%</td>
<td>34%</td>
<td>61%</td>
</tr>
</tbody>
</table>

Intentional collaboration across system partners to support families and children based on their agenda is possible with the Well Visit Planner interoperable tool.
The Cycle of Engagement Tools

“If you want to effectively engage families, efficiently provide comprehensive care, and meet standards you need the Well Visit Planner.”

- Pediatric Provider
National Data Resource Center for Child and Adolescent Health (DRC)

The DRC is a national center assisting in the design, development, documentation and public dissemination of user friendly information about, data findings on and datasets and codebooks for the National Survey of Children’s Health (NSCH).

childhealthdata.org

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U59MC27866, National Maternal and Child Health Data Resource Initiative, $4.5M. This information or content and conclusions are those of the author and should not be construed as the official position of or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
Welcome to the Data Resource Center for Child and Adolescent Health. Making data accessible to all. It's your data...your story!

For Title V

The DRC focuses on data and resources for Title V programs and partners. For over 25 years, the HRSA Maternal and Child Health Bureau (MCHB) has funded the Title V program to ensure the health of the nation's mothers, women, children and youth.

- Link to Ways to Compare Data Across States on the DRC Website
- Link to HRSA MCHB Title V Information System
- Link to Get Help

How to Use the DRC Website

The DRC advances the use of the National Survey of Children's Health, led by HRSA MCHB. Find more resources here:

- About the DRC
- DRC Video Overview
- DRC Frequently Asked Questions
- Data available in the online data query
- Request NSCH datasets
- Download NSCH codebooks

National Survey of Children's Health Interactive Data Query

Video Tour of the Interactive Data Query

2018-2019 (two years combined) or Nationwide

Note: For the most reliable estimates, use the two-year combined data (e.g., 2018-2019).

Learn More
## Child and Family Health Data for Title V Needs Assessment

**Background**

Title V Maternal and Child Health legislation requires states to prepare a statewide needs assessment every five years consistent with national health objectives and health status goals. The next five-year Needs Assessment will be submitted by July 15th, 2023. Each state’s assessment will identify need for the following services and priority populations:

- Preventive and primary care services for pregnant women, mothers and infants up to age one;
- Preventive and primary care services for children; and
- Services for children with special health care needs (CSHCN).

**Online resource for child health care quality data**

The Data Resource Center for Child and Adolescent Health (DRC) website offers standardized national- and state-level child health data from the National Survey of Children’s Health (NSCH). The site’s interactive data query feature allows users to search and compare state, national and regional results for an array of child health indicators including National Performance and Outcome Measures. In addition, users can stratify and compare findings for children by age, household income, race/ethnicity, family structure, special health care needs status, adverse childhood experiences and more. DRC staff are also available to provide expert technical assistance.

<table>
<thead>
<tr>
<th>Title V Needs Assessment Process</th>
<th>How the Data Resource Center Can Help</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assess Needs and Identify Priorities</strong></td>
<td>Immediate access to over 350 state-specific indicators of child health and well-being for children overall and children with special health care needs (CSHCN) provides information to help frame and choose critical questions.</td>
</tr>
<tr>
<td><strong>Examine Strengths and Capacity</strong></td>
<td>“Point and click” menus allow users to explore disparities and gaps in access to care and services for various subgroups of children and CSHCN.</td>
</tr>
<tr>
<td><strong>Select Priorities</strong></td>
<td>User-generated tables and bar charts supply prevalence and count estimates to help guide selection of priority needs.</td>
</tr>
<tr>
<td><strong>Set Performance Objectives</strong></td>
<td>“All States” ranking maps and tables provide benchmark data to assist in identifying state-negotiated performance measure targets.</td>
</tr>
<tr>
<td><strong>Develop an Action Plan</strong></td>
<td>Information on national, within and across state variation using standardized indicators encourages dialogue and helps stimulate collaborative efforts within the MCHB, Department of Health, and other state organizations.</td>
</tr>
<tr>
<td><strong>Monitor Progress</strong></td>
<td>Centralized resource for population-based survey questions to use in collecting standardized child health data, helping to inform local and program-level evaluation efforts.</td>
</tr>
</tbody>
</table>
Go to [www.childhealthdata.org](http://www.childhealthdata.org) to interactively Explore and Access Information and Resources on the Majority of State Priorities for Improving MCH Outcomes and System Performance.

<table>
<thead>
<tr>
<th>Priority Need</th>
<th>Priority Topic</th>
<th>Frequency</th>
<th>Population Groups with State Level Information Available on the Data Resource Center (DRC) Website</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2020 State Count</td>
<td>2020 State %</td>
</tr>
<tr>
<td>Transition Care</td>
<td>Access to Quality Care</td>
<td>27</td>
<td>45.0%</td>
</tr>
<tr>
<td>Reducing Disparities</td>
<td>Health Equity</td>
<td>25</td>
<td>41.7%</td>
</tr>
<tr>
<td>Developmental Screening</td>
<td>Access to Quality Care</td>
<td>24</td>
<td>40.0%</td>
</tr>
<tr>
<td>Access to Preventive Care</td>
<td>Access to Quality Care</td>
<td>23</td>
<td>38.3%</td>
</tr>
<tr>
<td>Systems of Care for CYSHCN</td>
<td>Access to Quality Care</td>
<td>23</td>
<td>38.3%</td>
</tr>
<tr>
<td>Medical Home</td>
<td>Access to Quality Care</td>
<td>20</td>
<td>33.3%</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Access to Quality Care</td>
<td>20</td>
<td>33.3%</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Healthy Behaviors</td>
<td>19</td>
<td>31.7%</td>
</tr>
<tr>
<td>Oral Health Services</td>
<td>Access to Quality Care</td>
<td>17</td>
<td>28.3%</td>
</tr>
<tr>
<td>Reducing Disparities</td>
<td>Social Determinants of Health</td>
<td>16</td>
<td>26.7%</td>
</tr>
<tr>
<td>Protective Factors</td>
<td>Access to Quality Care</td>
<td>15</td>
<td>25.0%</td>
</tr>
<tr>
<td>Reducing Disparities</td>
<td>Access to Quality Care</td>
<td>15</td>
<td>25.0%</td>
</tr>
<tr>
<td>Tobacco</td>
<td>Healthy Behaviors</td>
<td>14</td>
<td>23.3%</td>
</tr>
<tr>
<td>Social Emotional Health</td>
<td>Access to Quality Care</td>
<td>13</td>
<td>21.7%</td>
</tr>
<tr>
<td>Obesity</td>
<td>Health Status</td>
<td>13</td>
<td>21.7%</td>
</tr>
<tr>
<td>Low Birth Weight/Very Low Birth Weight/Prematurity</td>
<td>Health Status</td>
<td>13</td>
<td>21.7%</td>
</tr>
<tr>
<td>Economic Stability</td>
<td>Social Determinants of Health</td>
<td>12</td>
<td>20.0%</td>
</tr>
<tr>
<td>Specialized Care</td>
<td>Access to Quality Care</td>
<td>11</td>
<td>18.3%</td>
</tr>
<tr>
<td>Protective Factors</td>
<td>Healthy Behaviors</td>
<td>11</td>
<td>18.3%</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Access to Quality Care</td>
<td>9</td>
<td>15.0%</td>
</tr>
<tr>
<td>Health Insurance Coverage</td>
<td>Access to Quality Care</td>
<td>9</td>
<td>15.0%</td>
</tr>
<tr>
<td>Bullying/Harassment</td>
<td>Healthy Behaviors</td>
<td>0</td>
<td>15.0%</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Healthy Behaviors</td>
<td>8</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

1Alatan (2021). State Priorities and Performance Measures Trends Between 2013 and 2020. “Priority needs identified in the FY2021-FY2023 needs assessment cycle are referred to as ‘2020 priority needs’.”
Go to [www.childhealthdata.org](http://www.childhealthdata.org) to interactively Explore and Access Information and Resources on 18 NOMs and NPMs based on NSCH data.

Updated NOMs and NPMs coming soon!
What are the external trends and pressures?

Data
- What’s going up? Down?
- What has had no attention?
- ... (other points)

“Wisdom”
- How do we know what is important?
- Who have we asked?
- Who haven’t we asked?

What changes are happening or coming?
- Health system
- Legislative
- ... (other points)

Resources/assets
- Maternal health blueprint
- Sickle cell strategic plan
- CYSHCN roadmap
- Medicaid innovations
Access Your NSCH Data on the DRC

https://www.childhealthdata.org/
User Friendly Resources to Learn About and Use the NSCH

The Data Resource Center for Child & Adolescent Health (DRC) offers resources to learn about and use the National Survey of Children’s Health (NSCH). The DRC is a project of the Child & Adolescent Health Measurement Initiative (CAHMI), which focuses on children and adolescent health data.

### National Survey of Children's Health Interactive Data Query

- **Video Tour of the Interactive Data Query**

  - 2022
  - Nationwide

  Note: For the most reliable estimates, use the two-year combined data (e.g., 2020-2021).

- **Archived Data Query for NSCH and NS-CSHCM (prior to 2016)**

- **Learn More**

### How to Use the DRC Website

- The DRC advances the use of the National Survey of Children’s Health, led by HRSA MCHB. Find more resources here:
  - About the DRC
  - DRC Video Overview
  - DRC Frequently Asked Questions
  - Data available in the online data query
  - Request NSCH datasets
  - Download NSCH codebooks

### For Title V

- The DRC focuses on data and resources for Title V programs and partners. For over 75 years, the HRSA Maternal and Child Health Bureau (MCHB) has funded the Title V program to ensure the health of the nation’s mothers, women, children, and youth.
  - Ways to Compare Data Across States on the DRC
  - HRSA MCHB Title V Information System
  - Issue Brief: Health Disparities and Health Equity
  - Tell us what TA would be most useful to you!
Changes to NSCH Derived NOMs and NPMs Across Years

Title V National Performance Measure (NPM) and National Outcome Measure (NOM) Changes in the National Survey of Children’s Health (NSCH)

This document summarizes changes in the Title V National Performance and Outcome measures across survey years. The 2016 NSCH data serves as a baseline. Data collected prior to 2016 cannot be compared due to significant changes in the survey design and operation, including the shift from telephone interviews to a self-administered address-based survey completed by web or paper and pencil. View a crosswalk of survey items from 2016 through 2022 for additional information on item-level changes.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Comparable across survey years?</th>
<th>Summary of key changes in measure since 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day</td>
<td>2016, 2017, 2018, 2019, 2020, 2021, 2022</td>
<td>No changes</td>
</tr>
<tr>
<td>NPM 8.2: Percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day</td>
<td>2016, 2017, 2018, 2019, 2020, 2021, 2022</td>
<td>Major content change in 2018; data from 2018 and beyond cannot be compared to 2016 or 2017.</td>
</tr>
<tr>
<td>NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others</td>
<td>2016, 2017, 2018, 2019, 2020, 2021, 2022</td>
<td>Major content change in 2018; data from 2018 and beyond cannot be compared to 2016 or 2017. In 2018, the survey questions and timeframe changed to ask about frequency of occurrence during the past 12 months of how often did the child “bully others, pick on them, or exclude them” and the child “was bullied, picked on, or excluded by other children”. Response options were revised</td>
</tr>
</tbody>
</table>

How do I access data on the DRC?

Interactive Data Query

National Survey of Children’s Health
(2016 - present)

To begin your interactive data search:
1. Select a survey year and geographic level.
2. Select your desired topic/starting point (at-a-glance content maps are available to view/download at this step).
3. Select your measure.

These steps will direct you to a results page where you can compare across states, regions by numerous subgroups.

Note: For the most reliable estimates, use the two-year combined data (e.g. 2020-2021).

Watch a Video Tour of the Interactive Data Query

1. Select a Survey Year and Geographic Area
   - Select Date Range: 2020-2021 (two years combined)
   - Select Data Region: Nationwide

2. Select a Starting Point/Topic
   - Child and Family Health Measures
   - Title V Maternal and Child Health Services Block Grant Measures

Data Source:
National Survey of Children’s Health, Health Resources and Services Administration, Maternal and Child Health Bureau.
https://www.hrsa.gov/data/national-surveys

Grant:
Child and Adolescent Health Measurement Initiative. [Title of the document] [insert name and year of survey]. Data Resource Center for Title V Maternal and Child Health funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
Retrieved from [www.childhealthdata.org]
Currently Available NOMs and NPMs Derived from NSCH

Title V Maternal and Child Health Services Block Grant Measures
Available from the 2020-2021 National Survey of Children’s Health (two years combined)

National Performance Measures (NPM)
- NPM-6: Developmental screening, 9-35 months
- NPM-8.2: Physical activity, 6-11 years
- NPM-9: Bullied, 12-17 years
- NPM-10: Preventive medical visit, 12-17 years
- NPM-11: Medical home, children with special health care needs
- NPM-12: Transition to adult health care, children with special health care needs, 12-17 years
- NPM-13.2: Preventive dental visit, 1-17 years
- NPM-14.3: Someone living in the household smokes
- NPM-15: Adequate and continuous insurance

National Outcome Measures (NOM)
- NOM-14: Tooth decay/caries, 1-17 years
- NOM-17.1: Children with special health care needs
- NOM-17.2: Systems of care, children with special health care needs
- NOM-17.3: Autism/ASD, 3-17 years
- NOM-17.4: AOD/AAD/HIV, 3-17 years
- NOM-18: Mental health treatment or counseling, 3-17 years with a mental/behavioral condition
- NOM-19: Overall health status
- NOM-20: Obesity, 10-17 years
- NOM-25: Forgone health care

Note: The definition of all measures can be found in the 2020-2021 NSCH codebook and through the information icon on the data query at childhealthguide.org. For more information about NPMs and NOMs visit the HHS MCHB website: https://mchb.hrsa.gov

Currently Available NOMs and NPMs
- Age in 3 groups
- Sex of child
- Race/ethnicity of child
- Race/ethnicity of child – 7 categories
- Parental nativity
- Primary language in household
- Primary household language for Hispanic children
- Family structure – 4 categories
- Household income level
- Household income level (SCHIP)
- Highest education of adult in household
- Military status of adult(s) in household
- Family resilience
- Adverse Childhood Experiences – 8 items
- Adverse Childhood Experiences – 9 items
- Special health care needs status
- Complexity of health care needs
- Emotional, behavioral, or developmental issues for which treatment or counseling is needed
- Family resilience
- Medical home
- Current insurance status
- Adequate and consistency of health insurance
- Consistency of health insurance coverage
- Type of health insurance
- Well-functioning system of care

+C+ Over 300 Child and Family Health Measures
The DRC’s Interactive Data Query

3. Select a Survey Question (click the ☰ for more information on the question)

- NPM 6: Developmental screening, age 9-35 months
- NPM 8.1: Physical activity, age 6-11 years
- NPM 8.2: Physical activity, age 12-17 years
- NPM 9: Bullied others, age 12-17 years
- NPM 9: Bullied, age 12-17 years
- NPM 10: Preventive medical visit, age 12-17 years
- **NPM 11:** Medical home, children with special health care needs (CSHCN)
  - NPM 11: Medical home, children without special health care needs (Non-CSHCN)
- NPM 12: Transition to adult health care, CSHCN age 12-17 years
- NPM 12: Transition to adult health care, Non-CSHCN age 12-17 years
- NPM 13.2: Preventive dental visit, age 1-17 years
- NPM 14.2: Someone living in the household smokes
- NPM 15: Adequate and continuous insurance

Title V Maternal and Child Health Services Block Grant Measures (Content Map)
National Performance Measure 11: Percent of children with special health care needs, ages 0 through 17, who have a medical home

<table>
<thead>
<tr>
<th>Care meets medical home criteria</th>
<th>Care does not meet medical home criteria</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td></td>
<td>42.0</td>
</tr>
<tr>
<td>C.I.</td>
<td></td>
<td>40.5 - 43.4</td>
</tr>
<tr>
<td>Sample Count</td>
<td></td>
<td>9,832</td>
</tr>
<tr>
<td>Pop. Est.</td>
<td></td>
<td>5,940,544</td>
</tr>
</tbody>
</table>

C.I. = 95% Confidence Interval.

Percentages and population estimates (Pop. Est.) are weighted to represent child population in U.S.

View Findings in Tabular & Graphic Format

Survey Items:
- Survey Instrument: Item number for children 0-5 years: C1, C8, C9, D1, D4, D7-D12; for children 6-17 years: C1, C8, C9, D1, D4, D7-D12
- Denominator: Children with special health care needs ages 0-17 years

Numerator: Care meets medical home criteria; Care does not meet medical home criteria

Revisions and Changes:
- Though there were changes to a few items which are used to score this measure since 2016, the overall concept of medical home and how this is measured in the survey did not change. For more information about the changes, click here.

Additional Notes:
- The American Academy of Pediatrics specifies seven qualities essential to medical home care: accessible, family-centered, compassionate, comprehensive, coordinated, comprehensive, and culturally effective care. Ideally, medical home care is delivered within the context of a trusting and collaborative relationship between the child's family and a competent health professional who is familiar with the child and family and the child's health history. The presence of a medical home was measured by a composite measure based on five components constructed from a total of 16 survey items. These components include:
  1. Personal doctor or nurse (indicator: 4.12b; PersonCare_2022)
  2. Usual source for sick care (indicator: 4.13a; UsualCare_2022)
  3. Family-centered care (indicator: 4.12c; FamCentCare_2022)
  4. Problems getting needed referrals (indicator: 4.15b; ReferralPro_2022)
  5. Effective Care Coordination when needed (indicator: 4.12e; CoordCare_2022)

Data Source:
- To qualify as having a medical home, children must meet the criteria for adequate care on the first three components: personal doctor or nurse, usual source for care, and family-centered care. Additionally, an individual child's needs or care coordination must also meet criteria for those components in order to qualify as having a medical home. Children with a valid, positive response to at least one component and the remainder of the components were missing or illegitimately skipped were categorized as having a medical home. Further information about the medical home concept and measurement is available in the medical home manual developed by the CAHMI in 2021. The item S4001 asked respondents to include health care visits done by video or phone.

Treatment of Unknown Values:
- Missing values are due to non-response (i.e., a skipped item) or a “don’t know” response. The way these items are handled can vary by measure. For NHM and NDM, having missing values for all items in an indicator will lead to the case being given a missing value on the overall measure. For some other measures, if there is a missing value on one of the items, the case will be set to missing. If missing values are handled differently, the column “N” is listed and is combined with the population estimates (Pop. Est.) given in the model.
- To learn more about the impact of the missing values on the population count estimates, click here.

History and Development:
The Title V Maternal and Child Health Block Grant Program is a federal-state partnership to improve the health and well-being of mothers, children (including children with special health care needs) and their families in all 50 states and jurisdictions. The Title V Block Grant Program includes provisions for the establishment of a Medicaid and Children's Health Insurance Program (CHIP) program, a state license of the Medicaid and CHIP Block Grant Program, and a state license of the Medicaid and CHIP Block Grant Program. The Medicaid and Children's Health Insurance Program (CHIP) program includes provisions for the establishment of a Medicaid and CHIP Block Grant Program, and a state license of the Medicaid and CHIP Block Grant Program.

About NSCH:
The National Survey of Children's Health (NSCH), funded and directed by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB), is a program that collects national and state-level information on the health and well-being of children ages 0-17 years in the United States. The survey is conducted as a part of the National Health Interview Survey (NHIS) - the key metrics of health behavior and health care access and quality - National Performance Measures (NPM) - that influence NDM. For more information on NSCH and NDM content changes, click here. More information about the Title V Medicaid Block Grant and performance measurement system can be obtained at the MCHB website.
View Findings by Subgroups

Subgroups
- Age in 3 groups
- Sex of child
- Race/ethnicity of child
- Race/ethnicity of child – 7 categories
- Parental nativity
- Primary language in household
- Primary household language for Hispanic children
- Family structure
- Household income level
- Household income level (SCHIP)
- Highest education of adult in household
- Military status of adult(s) in household
- Family resilience
- Adverse Childhood Experiences
- Special health care needs status
- Complexity of health care needs
- Emotional, behavioral, or developmental issues for which treatment or counseling is needed
- Family resilience
- Medical home
- Current insurance status
- Adequate and consistency of health insurance
- Consistency of health insurance coverage
- Type of health insurance
- Well-functioning system of care
Compare Data Across States

Ways to Compare Data Across States on the DRC

There are three primary ways to compare data across states using the DRC website. Your options include:

- View findings on single indicators (and by subgroup) for all states using our Across-States Interactive Data Query (see below for steps)
- Compare states on all NSCH derived Title V National Outcome and Performance Measures using our Across-State Comparison Tables
- View US maps shaded to indicate how each state’s finding differs from the nation on Title V National Outcome and Performance Measures using our Across-State Comparison US Maps

Steps for Using the DRC Across-State Interactive Data Query:
1. Go to the DRC Across-State Interactive Data Query
2. Select "All States" in the drop-down menu where you select the state or region you wish to see results for
3. Select your indicator of interest
4. Select any subgroups you wish to view the indicator by
5. View findings for all states and sort by the response option you are interested in by clicking on the response option at the top of the data table
6. If you selected a subgroup, select the specific indicator response option you wish to view across-state findings for by your subgroup
7. If you want to return to the interactive query just for your state (or with one other geographic area), just click on the state and it will return you to the state by state (and two areas at a time) data query option

Steps for Using the Across-State Comparison Tables
1. Go to the Across-State Comparison Tables
2. Select to view National Outcome or Performance Measures
3. The color-coding in the table represents a state's comparison with national estimates
4. To sort a measure by state prevalence, click the arrows at the top of the column
5. To see the full measure description, hover over the measure title
6. To compare national and state level data and to access subgroup level data in the data query, click on any prevalence estimate in the table

Steps for Using the Across-State Comparison US Maps
1. Go to the Across-State Comparison US Maps
2. Select the National Outcome or Performance Measure you wish to view
3. The color-coding in the map represents a state's comparison with national estimates
4. To compare national and state level data, click on any state
View Findings By States or Regions or Across All States or Regions At the Same Time

Current Search Criteria
Survey: 2020-2021 National Survey of Children's Health
Starting Point: Title V Maternal and Child Health Services Block Grant Measures
State/Region: Nationwide vs. Maryland (quick edit)
Topic: National Performance Measures
Question: NPM 11: Medical home, children with special health care needs (CSHCN)

National Performance Measure 11: Percent of children with special health care needs, ages 0 through 17, who have a medical home

<table>
<thead>
<tr>
<th>State</th>
<th>Care meets medical home criteria %</th>
<th>Care does not meet medical home criteria %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>44.1</td>
<td>55.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Arizona</td>
<td>38.6</td>
<td>61.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Arkansas</td>
<td>40.0</td>
<td>59.9</td>
<td>100.0</td>
</tr>
<tr>
<td>California</td>
<td>35.6</td>
<td>64.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Colorado</td>
<td>48.0</td>
<td>52.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Connecticut</td>
<td>44.0</td>
<td>56.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Delaware</td>
<td>36.0</td>
<td>64.0</td>
<td>100.0</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>38.0</td>
<td>62.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Florida</td>
<td>32.6</td>
<td>67.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Georgia</td>
<td>43.5</td>
<td>56.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Hawaii</td>
<td>43.7</td>
<td>56.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Idaho</td>
<td>45.4</td>
<td>54.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Illinois</td>
<td>42.4</td>
<td>57.6</td>
<td>100.0</td>
</tr>
<tr>
<td>Indiana</td>
<td>41.5</td>
<td>58.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Iowa</td>
<td>52.5</td>
<td>47.5</td>
<td>100.0</td>
</tr>
<tr>
<td>Kansas</td>
<td>51.6</td>
<td>48.4</td>
<td>100.0</td>
</tr>
<tr>
<td>Kentucky</td>
<td>42.1</td>
<td>57.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Louisiana</td>
<td>39.7</td>
<td>60.3</td>
<td>100.0</td>
</tr>
<tr>
<td>Maine</td>
<td>47.4</td>
<td>52.6</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Notes: Click on the Column Header to sort the results by ascending or descending order. To get a detailed explanation of the data hover over the text in the table.
### Across-State Comparison Tables

**Title V National Performance Measures (NPMs)**

Across State Comparison Table, 2020-2021 NSCH

<table>
<thead>
<tr>
<th>State</th>
<th>NPM10</th>
<th>NPM11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationwide</td>
<td>69.7</td>
<td>42.0</td>
</tr>
<tr>
<td>Alabama</td>
<td>72.0</td>
<td>23.2</td>
</tr>
<tr>
<td>Alaska</td>
<td>65.0</td>
<td>20.4</td>
</tr>
<tr>
<td>Arizona</td>
<td>64.3</td>
<td>19.1</td>
</tr>
<tr>
<td>Arkansas</td>
<td>61.3</td>
<td>18.4</td>
</tr>
<tr>
<td>California</td>
<td>60.1</td>
<td>13.4</td>
</tr>
<tr>
<td>Colorado</td>
<td>57.2</td>
<td>13.2</td>
</tr>
<tr>
<td>Connecticut</td>
<td>55.4</td>
<td>12.6</td>
</tr>
<tr>
<td>Delaware</td>
<td>54.0</td>
<td>11.9</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>41.4</td>
<td>9.8</td>
</tr>
<tr>
<td>Florida</td>
<td>71.4</td>
<td>21.3</td>
</tr>
<tr>
<td>Georgia</td>
<td>72.6</td>
<td>23.1</td>
</tr>
<tr>
<td>Hawaii</td>
<td>71.3</td>
<td>22.0</td>
</tr>
<tr>
<td>Idaho</td>
<td>66.2</td>
<td>19.9</td>
</tr>
<tr>
<td>Illinois</td>
<td>59.0</td>
<td>15.7</td>
</tr>
<tr>
<td>Indiana</td>
<td>56.0</td>
<td>14.3</td>
</tr>
<tr>
<td>Iowa</td>
<td>55.3</td>
<td>13.7</td>
</tr>
<tr>
<td>Kansas</td>
<td>54.9</td>
<td>13.3</td>
</tr>
<tr>
<td>Kentucky</td>
<td>54.5</td>
<td>13.0</td>
</tr>
<tr>
<td>Louisiana</td>
<td>52.6</td>
<td>11.9</td>
</tr>
<tr>
<td>Maine</td>
<td>51.7</td>
<td>11.5</td>
</tr>
<tr>
<td>Maryland</td>
<td>50.2</td>
<td>11.1</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>58.8</td>
<td>16.3</td>
</tr>
<tr>
<td>Michigan</td>
<td>59.0</td>
<td>15.7</td>
</tr>
<tr>
<td>Minnesota</td>
<td>57.0</td>
<td>14.9</td>
</tr>
<tr>
<td>Mississippi</td>
<td>56.0</td>
<td>14.3</td>
</tr>
<tr>
<td>Missouri</td>
<td>55.8</td>
<td>14.1</td>
</tr>
<tr>
<td>Montana</td>
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<td>13.6</td>
</tr>
<tr>
<td>Nebraska</td>
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<td>13.3</td>
</tr>
<tr>
<td>Nevada</td>
<td>53.8</td>
<td>13.4</td>
</tr>
<tr>
<td>New Hampshire</td>
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<tr>
<td>New Jersey</td>
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<td>11.3</td>
</tr>
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<td>New Mexico</td>
<td>52.1</td>
<td>11.5</td>
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<td>New York</td>
<td>50.7</td>
<td>11.1</td>
</tr>
<tr>
<td>North Carolina</td>
<td>50.1</td>
<td>10.7</td>
</tr>
<tr>
<td>North Dakota</td>
<td>49.3</td>
<td>10.3</td>
</tr>
<tr>
<td>Ohio</td>
<td>57.0</td>
<td>15.7</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>56.0</td>
<td>15.3</td>
</tr>
<tr>
<td>Oregon</td>
<td>54.5</td>
<td>14.0</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>55.0</td>
<td>14.3</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>52.9</td>
<td>11.9</td>
</tr>
<tr>
<td>South Carolina</td>
<td>50.2</td>
<td>11.5</td>
</tr>
<tr>
<td>South Dakota</td>
<td>49.3</td>
<td>10.7</td>
</tr>
<tr>
<td>Tennessee</td>
<td>51.7</td>
<td>11.5</td>
</tr>
<tr>
<td>Texas</td>
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<td>11.9</td>
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<tr>
<td>Utah</td>
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<td>11.3</td>
</tr>
<tr>
<td>Vermont</td>
<td>51.2</td>
<td>11.1</td>
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<tr>
<td>Virginia</td>
<td>50.7</td>
<td>11.1</td>
</tr>
<tr>
<td>Washington</td>
<td>50.1</td>
<td>10.7</td>
</tr>
<tr>
<td>West Virginia</td>
<td>49.3</td>
<td>10.3</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>51.7</td>
<td>11.5</td>
</tr>
<tr>
<td>Wyoming</td>
<td>52.9</td>
<td>11.9</td>
</tr>
</tbody>
</table>

**Color Key of State Level Data When Compared to National Level Data**

- **Light Green**: State had Significantly Lower Performance
- **Moderate Green**: State had Lower Performance, but not statistically significant
- **Dark Green**: State had Higher Performance, but not statistically significant
- **Red**: State had Significantly Higher Performance

**Legend**

- **NPM10**: Preventive Medical Visit (CCHN)
- **NPM11**: Medical Home Visit (%)
Click on measure and state to access the interactive query and continue exploring!

### National Performance Measure 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

#### 2020-2021 National Survey of Children’s Health (NSCH) (two years combined)

<table>
<thead>
<tr>
<th>State</th>
<th>1 or more preventive medical visits</th>
<th>No preventive medical visit</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>District of Columbia</strong></td>
<td><strong>70.5</strong></td>
<td><strong>30.4</strong></td>
<td><strong>100.0</strong></td>
</tr>
<tr>
<td><strong>Nationwide</strong></td>
<td><strong>69.6</strong></td>
<td><strong>30.4</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

#### Current Search Criteria
Survey: 2020-2021 National Survey of Children’s Health
Starting Point: Title V Maternal and Child Health Services
Block Grant Measures
State/Region: Nationwide vs. District of Columbia

#### Question: National Performance Measures
NPM 10: Preventive medical visit, age 12-17 years

- **District of Columbia**
- **Nationwide**

<table>
<thead>
<tr>
<th>%</th>
<th>69.6</th>
<th>60.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.I.</td>
<td>(60.3 - 70.8)</td>
<td>(60.3 - 70.8)</td>
</tr>
</tbody>
</table>

C.I. = 95% Confidence Interval.
Percentages and population estimates (Pop.Est.) are weighted to represent child population in US.
Compare States Using Single-Measure Maps

Title V National Outcome Measure #17.1: Percent of children with special health care needs (CSHCN), ages 0 through 17

2020-2021 National Survey of Children's Health (2 years combined)

<table>
<thead>
<tr>
<th>State</th>
<th>Pennsylvania</th>
<th>Nationwide</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA</td>
<td>22.7</td>
<td>19.3</td>
</tr>
<tr>
<td>CI (95% CI)</td>
<td>(19.3 - 25.7)</td>
<td>(18.0 - 20.2)</td>
</tr>
</tbody>
</table>
Guidelines to Optimize Data for Local Areas Using Synthetic Estimate

www.childhealthdata.org

Your State Data... Your Local Story

Local Uses of National and State Data
And how to construct a synthetic estimate

Do you always need local data?
No! In fact, national and state data can often be applied locally and have many local uses:
- Reforms needed at the state level are likely also needed at the local level – this isn’t likely to change with slight prevalence differences
- Combined with what is already known about your local area, state level data can be very powerful in informing change and measuring benchmarks
- Data collection is expensive – consider what you can do with the data and information already available
- Local data make up state estimates. If demographic distributions between a local area and the state are similar, state and local estimates likely are too. However, large within-state demographic variation may mean that local areas actually differ markedly from the state as a whole. In these cases, a synthetic estimate can help provide a more accurate local picture.

The graph to the left is an example of how summary measures do not tell the whole story. In Idaho, the state overweight/obesity prevalence is quite similar to that for both privately and publicly insured children within the state. However, in Minnesota that is not the case. While Minnesota has a lower overall prevalence, it has much greater disparities in overweight/obesity by insurance type. We would not have known this had we not stratified by an important subgroup.

Similarly, local areas within a state can vary on factors known or suspected to affect health, health care and the other topics in the NSCH and the NS-CSHCN. Synthetic estimates can

So, let’s calculate a synthetic estimate!
We’ll estimate the percentage of children in Marin County with a medical home.

STEP 1: Determine the prevalence of your variable by selected demographic category at the state level. You can choose any variable for which you have state-level data.

www.childhealthdata.org provides data on numerous measures of child health and well-being and allows stratification by various subgroups. We used data from the 2007 NSCH to find the prevalence of having a medical home in California stratified by race/ethnicity.

STEP 2: Determine the number of children in your county who fall into each category of the demographic characteristic you are using. You can use any demographic variable for which you have county and state-level information.

<table>
<thead>
<tr>
<th>Race/Ethnicity Category</th>
<th>Distribution in Marin County</th>
<th>We got the 2007 race distribution in Marin County directly from KidsData.org (California only).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latino/Hispanic</td>
<td>15,241</td>
<td>Note that we combined the Native American and Asian/Pacific Islander groups from the KidsData website into an “other” category to match categories in the 2007 NSCH. It is important to make sure the groupings in your two data sources match! You can also access county-level information from places such as: <a href="http://www.KidsCount.org">www.KidsCount.org</a>, <a href="http://www.census.gov">www.census.gov</a> and your state department of finance.</td>
</tr>
<tr>
<td>White</td>
<td>31,583</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>1,269</td>
<td></td>
</tr>
<tr>
<td>Multiracial</td>
<td>2,570</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1,988</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>53,631</td>
<td></td>
</tr>
</tbody>
</table>

STEP 3: Calculate the estimate. First, determine the estimated number of children who meet the indicator of interest within each demographic group for your selected county. In this example, it is the number of children with a medical home by race in Marin County (3rd column in the table below).

Then, determine the prevalence of your variable of interest in your county by dividing the total number of children in the county who meet that variable by the total number of children in the county. Here, we divide the total number of children estimated to have a medical home in Marin County by the total number of children living in Marin County in

<table>
<thead>
<tr>
<th>Race/Ethnicity Category</th>
<th>Distribution in Marin County</th>
<th>with medical home by race in CA</th>
<th>with medical home by race in Marin County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latino/Hispanic</td>
<td>16,241</td>
<td>37.6%</td>
<td>16,241*0.376=6,107</td>
</tr>
<tr>
<td>White</td>
<td>31,583</td>
<td>65.7%</td>
<td>20,750</td>
</tr>
<tr>
<td>Black</td>
<td>1,269</td>
<td>42.2%</td>
<td>536</td>
</tr>
<tr>
<td>Multiracial</td>
<td>2,570</td>
<td>71.0%</td>
<td>1,825</td>
</tr>
<tr>
<td>Other</td>
<td>1,988</td>
<td>50.6%</td>
<td>996</td>
</tr>
<tr>
<td>Total</td>
<td>53,631</td>
<td>30,214</td>
<td>30,214</td>
</tr>
</tbody>
</table>

www.childhealthdata.org
Transformational Change and the Creative and Effective Use of Data

Data to Action = Opportunity into Results

Spin the Wheel...

- Shared Vision
- Build Trust
- Committed Leadership
- Incremental Success
- Joint Ownership - Establish Credibility

Avoid the 3C’s: Control, Credit, Competition,
Spotlight on Using the DRC to Drive Health Equity

Example 1 - Subgroup Comparison: Prevalence of children who experienced two or more adverse childhood experiences by their race/ethnicity

How to Use DRC to Address Health Equity (cont.)

This Reports:

Differences in prevalence of children who experienced two or more adverse childhood experiences by their race/ethnicity

**Example Question**: Are non-white children more likely to experience this outcome?

### Subgroup Comparison

**Race/Ethnicity is the Subgroup**

**The main measure**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>No adverse childhood experiences</th>
<th>One adverse childhood experience</th>
<th>Two or more adverse childhood experiences</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hispanic</strong></td>
<td>56.8</td>
<td>24.4</td>
<td>19.8</td>
<td>100.0</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>95% CI</td>
<td>54.6 - 58.8</td>
<td>22.7 - 26.2</td>
<td>17.3 - 20.4</td>
<td></td>
</tr>
<tr>
<td>Sample Count</td>
<td>7,130</td>
<td>2,882</td>
<td>2,449</td>
<td></td>
</tr>
<tr>
<td>Pop. Est.</td>
<td>10,343,445</td>
<td>4,466,176</td>
<td>3,423,137</td>
<td></td>
</tr>
<tr>
<td><strong>White, non-Hispanic</strong></td>
<td>66.1</td>
<td>19.0</td>
<td>14.9</td>
<td>100.0</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>95% CI</td>
<td>63.6 - 68.6</td>
<td>18.4 - 19.6</td>
<td>14.4 - 15.5</td>
<td></td>
</tr>
<tr>
<td>Sample Count</td>
<td>40,921</td>
<td>10,883</td>
<td>9,081</td>
<td></td>
</tr>
<tr>
<td>Pop. Est.</td>
<td>23,601,153</td>
<td>6,782,004</td>
<td>5,327,984</td>
<td></td>
</tr>
<tr>
<td><strong>Black, non-Hispanic</strong></td>
<td>47.3</td>
<td>28.4</td>
<td>24.3</td>
<td>100.0</td>
</tr>
<tr>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>95% CI</td>
<td>45.2 - 49.5</td>
<td>26.5 - 30.4</td>
<td>22.5 - 26.1</td>
<td></td>
</tr>
<tr>
<td>Sample Count</td>
<td>2,812</td>
<td>1,716</td>
<td>1,452</td>
<td></td>
</tr>
<tr>
<td>Pop. Est.</td>
<td>4,386,653</td>
<td>2,634,989</td>
<td>2,232,812</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>65.6</td>
<td>18.9</td>
<td>15.5</td>
<td>100.0</td>
</tr>
</tbody>
</table>
How to Use DRC to Address Health Equity

Subgroup Comparison in Your State

Compare your state with the national average
This Reports:

Does the prevalence of 2+ ACEs across race/ethnicity groups vary across states?

Example Question: Are there states with lower inequities in ACEs than others?
Example 2 - Distribution of children with a specific issue/topic, by race: Proportion of all children who experience Adverse Childhood Experiences that are Hispanic, White-NH, Black-NH, or other race/ethnicities.

Note: This is different from variations in prevalence as shown in Example 1. To view distribution by race for a specific health issue or topic, select “Race and ethnicity distribution of the child population” as the main measure, and select the health issue/topic of interest as the subgroup.
**Example 2 - Distribution of children with a specific issue/topic, by race:** Proportion of all children who experience Adverse Childhood Experiences that are Hispanic, White-NH, Black-NH, or other race/ethnicities.

This reports: The proportion of all children meeting criteria for an indicator that fall into different race/ethnicity groups.

**Example Question:** Is there a disproportionate number of non-white children experiencing this health risk?
DRC “Ready to Use” Datasets

DRC data set includes:
- All variables released in the Census public use file
- All DRC indicators and items shown on the DRC website: coded/constructed Child and Family Health Indicators and demographics
- All constructed NPMs and NOMs

Available Formats:
SAS, SPSS, Stata (some years) and CSV

Labels and Formats:
Variable, value labels and missing values are clearly labeled

A codebook, other survey documents, online resources will also accompany the datasets.

http://childhealthdata.org/help/dataset
The DRC anticipates and provides quick links to resources for common questions from:

- State and national partners (Title V, CDC, HRSA)
- Community and local partners (non-profit, local community organizations)
- Participants and public (students, researchers, media, families, etc.)
- MCH systems professionals (health care, education, social services, wide range)

- Visit our **Ask a Question page with FAQs and links to address common TA questions and responses**. If you’re question cannot be answered, feel free to email us at **info@cahmi.org**. We try to respond within 48 hours.

**Examples of technical assistance area:**
- Data Research and Evaluation
- CSHCN/Medical Home
- CSHCN/Developmental Disabilities
- Adequate Health Insurance Coverage
- CSHCN Family Engagement

**Examples of assistance provided:**
- General NSCH and DRC website
- Understanding NSCH Data
- NSCH Data Analysis
- Specific Measures or Variables in the NSCH
- DRC and NSCH Citation Information
QUICK LINKS TO RESOURCES FOR TITLE V NEEDS ASSESSMENT

The resource links included in this document provide a high-level summary of resources to help you leverage the Data Resource Center (www.childhealthdata.org) and Related Child and Adolescent Health Measurement Initiative (CAHMI) resources to support each step of the needs assessment process.

TA Priority
Topics are organized by steps along the Title V Needs Assessment process and MCH resource category.

RESOURCES
Resources include videos, documents, research and reports, related models and tools and data and measurement resources

QUICK LINKS
Links are provided throughout. Look out for hyperlinked text to access resources. Simple language is used.
DRC Quick Links to get started:

<table>
<thead>
<tr>
<th>Data Resource Center Home Page</th>
<th>Home [childhealthdata.org]</th>
</tr>
</thead>
</table>
| **Data query content maps** – good orientation to NSCH indicators that are available in the query  
*NOTE: Indicator #s match what you find in the query for the given year(s).* | NSCH Content Maps - Data Resource Center for Child and Adolescent Health [childhealthdata.org] |
| **Guide to NSCH topics and questions** – provides an interactive or PDF version of all survey questions and associated variable names for coding. | NSCH Guide to Topics & Questions - Data Resource Center for Child and Adolescent Health [childhealthdata.org] |
| **State comparison maps** – NOMs/NPMs  
*NOTE: Maps may not be available due to data reliability, so there may only be charts of comparisons* | US Maps: Compare NPM/NOMs Across States - Data Resource Center for Child and Adolescent Health [childhealthdata.org] |
| **State comparison tables** – NOMs/NPMs | Comparison Tables - Compare NPM/NOMs Across States [childhealthdata.org] |
| **Data sets** - constructed variables displayed in the data query | Data sets - SAS, SPSS, STATA, CSV [childhealthdata.org] |
| **Codebooks** – a resource to understand how the measures are conceptualized, constructed and interpreted, codes | Codebooks - SAS, SPSS, STATA [childhealthdata.org] |
| **Please Register** with CAHMI/DRC to stay updated. | CAHMI : Sign Up to Stay in Touch [constantcontact.com] |
Thank you!

Contact Us
Email us at: info@cahmi.org
Visit “Ask a Question” page on the DRC
Measurement Meta-Data and Other Measurement Resources
National Maternal & Child Health Measures Compendium:
- Contains 13 measure sets including
  - AMCHP Life Course Indicators
  - MIECHV Performance Measures
  - Title V Performance and Outcome Measures
- 71 measurement topics
- Over 1,000 measures

National Strategic Measurement Agenda:
- Lear about priority areas, gaps, and recommendations
  - Positive and Relational Child and Family Health Protective factors
  - Community and Family Health Assessment and Engagement in Systems and Services
  - Whole Child Care and Early Childhood Development
### National Maternal And Child Health Measures Compendium

Click on an individual measure to view information about each measure, including its title and/or description, numerator and denominator, unit of analysis, specific data source, target population, key words, and reporting requirements.

#### Start searching the MCH Interactive Compendium:

Once you have located a measure or measures of interest, click on the measure title to learn more!

<table>
<thead>
<tr>
<th>Measure Set</th>
<th>Data Source Category</th>
<th>Topic Level 1</th>
<th>Topic Level 2</th>
<th>Topic Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>V</td>
<td>Vital Statistics</td>
<td>Access to and quality of health and related services</td>
<td>Health service utilization</td>
<td>Pregnancy, birth, and sexual health services</td>
</tr>
<tr>
<td>V</td>
<td>State-based Surveys</td>
<td>Health status, well-being, and health conditions across the life course</td>
<td>Health protective and risk behaviors</td>
<td>Pregnancy and perinatal behaviors</td>
</tr>
<tr>
<td>V</td>
<td>Records Analysis</td>
<td>Health status, well-being, and health conditions across the life course</td>
<td>Condition prevalence and health status</td>
<td>Pregnancy, perinatal, birth and sexual health conditions</td>
</tr>
<tr>
<td>V</td>
<td>National Surveys</td>
<td>Health status, well-being, and health conditions across the life course</td>
<td>Condition prevalence and health status</td>
<td>Oral health conditions</td>
</tr>
</tbody>
</table>

#### Measurement In Action

**NOM 1. Percent of pregnant women who receive prenatal care beginning in the first trimester**

- **Numerator:** Number of live births with reported first prenatal visit during the first trimester (before 12 weeks' gestation) in the calendar year
- **Denominator Statement:** Number of live births
- **Measures Set:** Title V
- **Data Source:** National Vital Statistics System (NVSS)
- **Target Population:** Women
- **Categories:** Access to health and related services, health service utilization, Pregnancy, birth, and sexual health services
- **Additional Information:** [Link](https://mchb.cdc.gov/resource/NationalOutcomesMeasures)

**Keywords:** Maternal child health
Shared Accountability Drives Collaboration and Change

Our Goal:
Analyze the performance measures of nine federal/state programs and to identify current focus, overlapping measures, gaps, and future alignment
71 Topical Areas Across 9 MCH Programs By Measurement Domain

A: Access and Utilization
- N=12, 16.9%

B: Quality of Care: Screening, Referral, and Follow Up
- N=17, 23.6%

C: Quality of Care: Care Processes, Education, and Counseling
- N=11, 15.5%

D: Health and Intermediate Outcomes
- N=31, 43.6%

Bethell, C. 4.13.2023
13 Topical Areas Shared Across 3+ MCH Programs
(out of 71 topical areas and 309 measures)

<table>
<thead>
<tr>
<th>A</th>
<th>Prenatal and Postpartum care</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Receipt of Dental Care Services</td>
</tr>
<tr>
<td>A</td>
<td>Well Child Visits</td>
</tr>
<tr>
<td>A</td>
<td>Adolescent Well Visits</td>
</tr>
<tr>
<td>A</td>
<td>Well Woman Visit</td>
</tr>
<tr>
<td>B</td>
<td>Completed Depression Referrals</td>
</tr>
<tr>
<td>B</td>
<td>Depression Screening</td>
</tr>
<tr>
<td>B</td>
<td>Early Childhood Developmental Screening</td>
</tr>
<tr>
<td>B</td>
<td>Tobacco, Alcohol or Other Drug Cessation Referrals/Treatments for Adults and/or Caregivers</td>
</tr>
<tr>
<td>C</td>
<td>Weight Assessment, Counseling for Nutrition, Physical Activity</td>
</tr>
<tr>
<td>C</td>
<td>Child and Adolescent Immunization status</td>
</tr>
<tr>
<td>D</td>
<td>Emergency Department Visits and Injury Hospitalizations</td>
</tr>
<tr>
<td>D</td>
<td>Low Birth Weight</td>
</tr>
</tbody>
</table>

5 agencies involved:
1. CHCs
2. MIECHV
3. HEDIS
4. Medicaid/CHIP
5. Title V

Note: In 2024 Medicaid/CHIP, MIECHV, Title V and CHCs/FQHCs will be required to report on Development Screening rates

Depression Screening and Prenatal/Postpartum Care are aligned across all five
## Visualization of the CAHMI’s Applied Framework for Advancing MCH Measurement

<table>
<thead>
<tr>
<th>Determinants of Health</th>
<th>Measurement Domains</th>
<th>Measurement Purposes</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bio-genetic factors</td>
<td>Health status and conditions</td>
<td>MCH measurement used at the national, state, local, and clinical levels for purposes of:</td>
<td>Positive health and well-being across the life course</td>
</tr>
<tr>
<td>Safe, stable, and nurturing relationships</td>
<td>Access to and quality of health and related services</td>
<td>• Monitoring health and well-being at the population level</td>
<td></td>
</tr>
<tr>
<td>Family, Community, and environmental context</td>
<td>Social determinants of health (SDOH)</td>
<td>• Advancing and adapting measures, tools, and approaches for providers/service settings to use in practice</td>
<td></td>
</tr>
<tr>
<td>Health care systems and services</td>
<td></td>
<td>• Applying measurement to guide the design, performance measurement, and improvement of programs</td>
<td></td>
</tr>
<tr>
<td>Public health and population approaches</td>
<td></td>
<td>• Building actionable and comparable knowledge through research</td>
<td></td>
</tr>
<tr>
<td>Policy and macro-economic factors</td>
<td></td>
<td>• Using measurement to understand, advance, and ensure equity</td>
<td></td>
</tr>
</tbody>
</table>

MCH Measurement Research Network

An applied, sustainable, multidisciplinary approach to improve outcomes and systems performance on behalf of the nation's children, youth, and families by:

- inspiring, supporting and coordinating efforts,
- driving measurement innovation, and
- promoting shared accountability.
Family Engaged, Whole Child, Integrated Early Childhood Health Systems
The Engagement in Action (EnAct!) Framework for a Statewide Integrated Early Childhood Health System
Collaboratively designed with Mississippi Thrive! by the Child and Adolescent Health Measurement Initiative

Framework Purpose: Positive Health Equity
The purpose of the EnAct! framework is to catalyze child health equity and improve child flourishing, school readiness and family resilience.

Framework Goals:
1. All In: Universal provision of comprehensive, personalized, whole child and family preventive and developmental services.
2. Real Engagement: Families are engaged to access and ensure services are personalized to their goals and needs and to shape improvements in practice, policy and systems of care.
3. Seamless System: All early childhood systems intentionally collaborate to optimize early screening, address social and relational health needs, and promote well-being.

Key Elements of the EnAct! Approach
1. “Through any door” family engagement to activate trust and partner in care
2. Universal developmental and comprehensive whole child and family screening and assessments
3. Personalized, Strengths-Based Health Promotion and Supports
4. Coordinated, Warm Links to Quality Services and Interventions
5. Outcomes and Equity-Based Quality Measurement and Improvement

Four “Simple Rules”
- Through any door
- Everyone a leader
- In every encounter
- No broken links
- No hard lines

IMPLEMENTATION ROADMAP
1. Action: Establish a sustainable, cross-system, multi-level state leadership capacity
   - Outcome #1: A cross-sector body has the structure, capacity and influence to sustainably advance state program and policy strategies that promote positive early childhood health equity
   - Outcome #2: State leadership builds an across state agency infrastructure to coordinate strategies, resources, operations and performance measures that promote early childhood development
   - Outcome #3: Local community coordinating bodies lead and link with state leadership to drive effective frontline systems change and improvements

2. Action: Create a culture of engagement among families, professionals, and system partners
   - Outcome #4: Families are supported, included and activated to partner in care.
   - Outcome #5: Families trust and experience authentic power-sharing and respect
   - Outcome #6: Professional competencies and mechanisms for effective family engagement and partnerships are prioritized

3. Action: Catalyze, facilitate, study and spread cross-sector, practice-based implementation
   - Outcome #7: A learning and communications network supports early adopters and spread
   - Outcome #8: Launch and learn demonstrations inform spread and continuous improvement
   - Outcome #9: Implementation resources are built, integrated and accessible
   - Outcome #10: Professionals are trained to implement the science of healthy development and positive and adverse childhood experiences (PACEs) with all children and families

4. Action: Drive enabling and incentivizing policies and financing strategies critical to success
   - Outcome #11: Policies support processes to facilitate coordination of healthcare and community based services and resources across organizations and state agency programs
   - Outcome #12: Health plans, providers and early childhood development professionals are incentivized and financed to enable high quality care and improvement

Source: Child and Adolescent Health Measurement Initiative, Feb. 2023
Our Opportunity!
30.8% of Children Ages 0-5 In the United States Are Reported to Be In Excellent or Very Good Health Status AND to also Consistently Meet Flourishing Criteria

Only 2 in 5 Are ready for school

Source: Child and Adolescent Health Measurement Initiative Analysis of National Survey of Children’s Health
Tremendous opportunities are presented by the large gaps in child flourishing, school readiness and engagement, family resilience, parent-child connection, protective family routines and habits.

**The Well Visit Is:**
- The most accessible and used portal into young families
- An ideal context for building trusting relationships between pediatricians and families to promote relational health
- Essential venue to recognize and address social & relational health risks and link to concrete supports

Why are well visits important?
Well visits are an opportunity for families and health providers to connect and celebrate what's going well, meet family needs, and address child health concerns. These visits allow for age-specific:

- Surveillance & Screening
- Anticipatory Guidance
- Disease prevention
- Health Promotion

**One Big Doable Thing:** Equitable access to high-quality well-child care services for all young children and families. The 60 million encounters recommended; ½ occur; 90% missing core elements of guideline-based care. 15 age-specific visits in the first 6 years of life.

Bright Futures Guidelines recommend 15 well visits in the first six years of life.
Half of... the estimated well child visits that should happen do not occur

Before Children Start School

Source: Child and Adolescent Health Measurement Initiative Analysis of National Survey of Children’s Health
Even today, only 1 in 3 young children receive the appropriate developmental screenings.

Source: Child and Adolescent Health Measurement Initiative Analysis of National Survey of Children’s Health
Range of Screeners, Assessments and Priority Topics Recommended in Bright Futures Guidelines
Vary by age and are NOT translated for provider or family ease of use!
Trust, relationships and coordination across healthcare and community required

What's going well?

- Developmental surveillance and screening - SWYC
- Autism screening - M-CHAT-RTM
- Concerns about speaking, vision, hearing
- Caregiver depression - PHQ-2 & EPDS
- Household smoking and substance use

General health information
- e.g. special needs, insurance, family health history, etc.

- Caregiver anticipatory guidance and education priorities
- Parent/caregiver emotional support, coping and self-care
- Other options:
  - Child social and emotional development
  - Family resilience
  - Child flourishing
  - + More

Context and environmental assessments
- (e.g., lead, fluoride, etc.)

Overall goals and concerns
The Engagement in Action (EnAct!) Framework for a Statewide Integrated Early Childhood Health System
Collaboratively designed with Mississippi Thrive! by the Child and Adolescent Health Measurement Initiative

Framework Purpose: Positive Health Equity
The purpose of the EnAct! framework is to catalyze child health equity and improve child flourishing, school readiness and family resilience.

Key Elements of the Framework
1. Through any door—activate trust and
3. Personalized, Strengths-Based Promotion and Support

Outcomes and Equity-Based Quality Measurement and Improvement

Action: Establish a sustainable, cross-system, multi-level state leadership capacity
• Outcome #1: A cross-sector body has the structure, capacity and influence to sustain advance state program and policy strategies to promote positive early childhood health
• Outcome #2: State leadership builds an infrastructure to coordinate strategies, resources, operations and performance measures that promote effective health development
• Outcome #3: Local community coordination bodies lead and link with state leadership to drive effective cross-system change and improvements

"Through any door" family engagement to activate trust and partner in care

Universal developmental and comprehensive whole child and family screening and assessments

Personalized, Strengths-Based Health Promotion and Supports

Coordinated, Warm Links to Quality Services and Interventions

Work—One Thing!
- All early childhood systems collaborate to screening, address health needs, and
- Access

NO BROKEN LINK

IN EVERY ENCOUNTER

Source: Child and Adolescent Health Measurement Initiative, Feb. 2023
The Engagement In Action (EnAct!) Framework for a Statewide Integrated Early Childhood Health System

Positive Health Equity

Framework Purpose: Positive Health Equity

The purpose of the EnAct! framework is to catalyze child health equity and improve child flourishing, school readiness and family resilience.

Framework Goals:

1. All In: Universal provision of comprehensive, personalized, whole child and family preventive and developmental services.
2. Real Engagement: Families are engaged to access and ensure services are personalized to their goals and needs and to shape improvements in practice, policy and systems of care.
3. Seamless System: All early childhood systems intentionally collaborate to optimize early screening, address social and relational health needs, and promote well-being.

EnAct! Framework—ONE Big Doable Thing!
Through Any Door Family and Engagement And Supports

Illustration of the Engagement in Action Framework’s Through Any Door Approach
Towards a Family Engaged, Community Based, Integrated Early Childhood Health System

Through Any Door Family Access Points

FAMILY

Community Based Access Points

Early care and education, home visiting, community resource brokers, faith based, etc.

Everyone leads, through every door, in every encounter to inquire and engage families to provide and/or link to quality whole child and family preventive and developmental services and partner to coordinate supports across systems

Healthcare Access Points

Pediatrics, Family Practice, Perinatal Care, etc.

Use the family driven Well Visit Planner (or similar) to engage families and share standardized data reports using the interoperable data platform to promote comprehensive, personalized, coordinated services.

Source: Child and Adolescent Health Measurement Initiative, Feb. 2023
The Engagement In Action(EnAct!) Framework Implementation Roadmap for a Statewide Integrated Early Childhood Health System

**IMPLEMENTATION ROADMAP**

1. **Action: Establish a sustainable, cross-system, multi-level state leadership capacity**
   - **Outcome #1:** A cross-sector body has the structure, capacity and influence to sustainably advance state program and policy strategies that promote positive early childhood health equity
   - **Outcome #2:** State leadership builds an across state agency infrastructure to coordinate strategies, resources, operations and performance measures that promote early childhood development
   - **Outcome #3:** Local community coordinating bodies lead and link with state leadership to drive effective frontline systems change and improvements

2. **Action: Create a culture of engagement among families, professionals, and system partners**
   - **Outcome #4:** Families are supported, included and activated to partner in care.
   - **Outcome #5:** Families trust and experience authentic power-sharing and respect
   - **Outcome #6:** Professional competencies and mechanisms for effective family engagement and partnerships are prioritized

3. **Action: Catalyze, facilitate, study and spread cross-sector, practice-based implementation**
   - **Outcome #7:** A learning and communications network supports early adopters and spread
   - **Outcome #8:** Launch and learn demonstrations inform spread and continuous improvement
   - **Outcome #9:** Implementation resources are built, integrated and accessible
   - **Outcome #10:** Professionals are trained to implement the science of healthy development and positive and adverse childhood experiences (PACEs) with all children and families

4. **Action: Drive enabling and incentivizing policies and financing strategies critical to success**
   - **Outcome #11:** Policies support processes to facilitate coordination of healthcare and community based services and resources across organizations and state agency programs
   - **Outcome #12:** Health plans, providers and early childhood development professionals are incentivized and financed to enable high quality care and improvement

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This is the road to positive health equity, school readiness, family resilience and child flourishing.

Source: Child and Adolescent Health Measurement Initiative, Feb. 2023
**21 Priority Policy Levers**

**Box 4:** Financial and Non-Financial Levers Medicaid Can Use with Managed Care Health Plans to Advance the Purpose and Goals of the EnAct! framework

**Financial levers Medicaid can include in health plan contracts and with providers**

1. **Adequate baseline payment for expected care:** Ensure per member, per month algorithms Medicaid uses with managed care plans adequately reflect planned payments for utilization of high quality well child care services for all children anchored to Bright Futures Guidelines.

2. **Health plan payment withhold:** Employ a payment holdout using motivating measures and benchmarks sufficient to compel action as specified in the EnAct! Framework materials.

3. **Health plan incentive Payments:** Employ a health plan incentive payment for deploying innovative strategies anchored to the EnAct! Framework goals and approach as outlined in sections 2-4.

4. **Bundled, enhanced billing codes:** Streamline and incentivize provider/practice uptake with bundled and enhanced billing codes for use when EnAct! Framework evidence based approaches are used (e.g., one stop billing if the comprehensive pre-visit screening, planning and data sharing Well Visit Planner is used, billing for Family Specialists, etc.)

5. **Expand sites for service:** Enable the EnAct! Framework “through any door” approach by establishing new service sites that can bill for services when they lead to engage families in comprehensive assessments and provision of health promotion and care coordination (e.g., community and home-based settings for qualified professionals).

**Non-financial levers Medicaid can employ with health plans and providers**

1. **Enable payment innovations:** Create mechanisms to encourage, enable and monitor impact of innovative, value-based payment models with providers to drive improvement in preventive and developmental health promotion services and outcomes for young children and families.

2. **Strengthen provider networks:** Specify requirements for adequacy of the provider network to ensure networks are specified to the needs of young children and families as reflected in the EnAct! Framework. Report network adequacy information to families, provider, community partners.

3. **Standardize coding:** Require uniform coding and payment rates across health plans for specific services to streamline provider and system uptake of EnAct! Framework care approach.

4. **Improve projects:** Require health plan Performance Improvement Projects (PIPs) related to the EnAct! Framework goals, approach and strategies, including transparent reporting on actions/results.

5. **Targeted demonstrations:** Develop Health Services Initiatives pilots (HSIs) with health plans to implement approaches anchored to EnAct! Framework goals and approaches and priority populations.

Source: Child and Adolescent Health Measurement Initiative, Feb. 2023

**Box 5:** Other Cross Agency and Strategic Levers Medicaid Can Use to Help Implement the EnAct! Framework

**Other state levers of critical importance that Medicaid can support**

1. **Coordinate governance:** State leadership requires coordination across state administrative and public-private sector governing bodies related to Medicaid, the Child Care Development Fund required State Early Childhood Advisory Committee, the Individuals with Disabilities Act Part C/F Early Intervention Interagency Coordination Committee, etc.

2. **Leverage Title V:** Encourage optimizing the power of the Title V Block grant, which priorities systems building, coordination of services, family engagement, early childhood development and achievement of MCH outcomes/system performance

3. **Establish postpartum coverage:** Work to secure Medicaid postpartum coverage, dramatic improvements in early intervention and home visiting resources and coordination with healthcare and support family income support policies

4. **Services and income support program eligibility and access:** Monitor and improve processes to streamline eligibility and access to early intervention, home visiting, early care and education and related state health and income support programs essential to the healthy development and wellbeing of young children and families.

Source: Child and Adolescent Health Measurement Initiative, Feb. 2023

**Strategic levers Medicaid can use to promote implementation and improvement**

1. **State plan amendments:** Secure a State Plan Amendment with the federal government to enable innovative payment and service approaches aligned with the EnAct! Framework

2. **State quality strategy:** Strengthen the Medicaid state quality strategy to specifically set measurable goals for the healthy development of children aligned with EnAct! Framework goals and strategies.

3. **Family leadership:** Include and support family leaders to serve as Medicaid Beneficiary Advisory Panel/Medical advisory committee members to shape Medicaid to meet child and family goals.

4. **Quality reporting:** Enrich Medicaid contracts with External Quality Review Organizations (EQROs) to further assess quality for preventive and developmental services that align with the Affordable Care Act, Section 2713 of the Public Health Service Act, EPSDT and the EnAct! Framework

5. **Public reporting:** Ensure public transparency of all health plan PIPs, HSIIs and quality ratings to the public, families, health systems, providers and system partners in improvement.

6. **Cross-agency collaboration:** Further formalize and monitor Division of Medicaid, Title V, Early Intervention and other agency partnerships and resource flows agreements to optimize early access to and quality of early childhood services and using publicly accessible cross-agency agreements, memoranda of understanding that are reviewed for implementation and improved over time.

7. **Administrative improvements:** Identify and publicly report on quality metrics related to administrative processes related to child and family enrollment in Medicaid and access to quality services, as well as clarity about and timeliness of payment for providers.

Source: Child and Adolescent Health Measurement Initiative, Feb. 2023

**STATEWIDE LEADERSHIP:** The Mississippi Thrive! Early Childhood Development Coalition connects, coordinates and drives implementation and systems change with partners, including other state early childhood governing committees.

### Partner Organization / Agency Type
- **Community-Based Resources Organizations**
  - Families as Allies
  - Mississippi Families for Kids/Help Me Grow
  - Faith-Based Organizations

- **Federal/State Funded Agencies and Programs**
  - MS Dept of Health, Healthy Families/MIECHV
  - MS Dept of Health, First Steps/Early Intervention Part C (and Part B)
  - MS Dept of Health, Healthy Moms, Healthy Babies (high risk)
  - Community Health Centers (Federally Qualified Health Centers)

- **Healthcare System and Services**
  - MS Early Childhood Association; MS Early Learning Association, Barksdale Reading Institute
  - Excel by 5; SPARK MS
  - Parent Support/Advocacy: Parent Training Institute; OneVoice; Teen Health MS, etc.; Media
  - Private Foundations, Businesses, MS Children’s Museum, UProot Mississippi and Other Partners

### Potential Leadership Roles
- 1. Maintain Systems Building Structures
- 2. Change and/or Implement Policy
- 3. Build/Fund Implementation Infrastructure
- 4. Build Capacity for Family Engagement
- 5. Direct Service Delivery
- 6. Service Access and Coordination
- 7. Build Workforce

### Relevance to Key Partners
- **A** Statutory Requirements Partner is Accountable for are Advanced by the EnAct! Framework
- **B** Performance Standards Used Are Promoted by the EnAct! Framework
- **C** Key Programs and the Mission of the Partner is Aligned with the EnAct! Framework

Annotations assigned based on analysis and require further partner assessment. Source: Child and Adolescent Health Measurement Initiative, Feb. 2023

Bethell, C. 4.13.2023
The Engagement in Action (EnAct) Framework for a Statewide Integrated Early Childhood Health System
Collaboratively designed with Mississippi Thrive by the Child and Adolescent Health Measurement Initiative

Overview of the Framework In Action (EnAct) Framework Possibility Prototypes: Envisioning relevance and application of the EnAct! Approach Across Key State Integrated Early Childhood Health System Partners (see Attachment D to read each brief prototype)

Division of Medicaid and Coordinated Care Organizations/Health Plans
Activating the power of the payer to accelerate transformations in child and family well-being.
The EnAct approach supports Medicaid’s obligation to ensure quality provision of EPSDT services and health plan requirements under the Affordable Care Act to provide and coordinate health care within Bright Futures Guidelines aligned preventive services. Implementation population health and lower available costs.

Family-Led Organizations
Fueling the capacity of family leaders to engage families as partners in their child’s care.
The EnAct framework provides concrete approaches to directly engage and activate families to partner in their child’s care and build collaboration systems and services that serve children and families. Families As Allies can leverage resources to ensure high-quality family-driven early childhood health services.

State Early Childhood Care and Development Programs and Resource/Referral Centers
Leveraging early childhood resources and services to engage families and promote early childhood development.
The EnAct approach helps 30525 meet goals to promote emotional, social, and emotional development and link them with primary care medical homes. At least 15 of 15 30525 programs are linked directly by the EnAct approach. The 30525 program in Mississippi is essential to educate families about well-child visits and link them in care.

Pediatric Primary Care
Catalyzing a whole child and family approach in pediatrics, family medicine and beyond.
When providers implement the EnAct approach to care, they can better align with high-quality medical home criteria and meet “Bright Futures” goals in connecting children, families, and schools through comprehensive health care and overall population health and performance. Hospitals and specialists are also key partners.

Community-Based Family Resource Brokers
Engaging families to personalize and access connections to services and supports.
The EnAct approach improves the Mississippi Family System for Kids (MFSK), productivity, partner with families to help them identify their needs and receive high-quality services and supports in their local community. Mississippi Family System for Kids benefits from the array of direct services and resources provided by MFSK and its new help Desk (HMD) program. Additionally, their strengthening work with children in foster care supports permanency and safety of children and families during times of transition. As a one-stop shop for families, MFSK/HMD seeks to ensure that all young children in Mississippi receive required developmental screenings and referrals for additional support if needed. MFSK’s direct work with families and children makes them important advocates for local and state policy and program improvements to optimize supports for all children and families in Mississippi. With 229 children served through HMD and 100 developmental screenings completed in the last year (2021-2022), MFSK is building its current partnership with MSH and its operational capacity statewide to support more families given their capacity and drive to assist a wider population.

The Engagement in Action Opportunity
The Engagement in Action approach seeks to set forth critical resources to help MFSK/HMD build upon their existing work of engaging families, conducting developmental screening, and providing referrals to community services. The EnAct approach to care emphasizes family engagement and child and family assessments, which are embedded through the inclusion of Child and Adolescent Health Measurement Initiatives (CAMI). Well Visits/Van (WV/V) family facing digital costs. While the rise of developmental screening improved from 19% to 34% in the Mississippi during the 5-year Mississippi Thrive project, only 19% of children in Mississippi are estimated to receive developmental screening. MATH/MD has used the Ages and Stages Questionnaires (ASQ) for developmental screening and can also access and develop family-oriented, family-driven, online Well Visit Planner (WVP) digital tool that uses the equalized valid Surveys of Well-Born Young Children (LBCI). Along with the range of social and emotional health, local and national health assessments included in “Bright Futures” Guidelines. The WVP also guides families to learn about and pick their priorities for education and support. The automatically generated WVP Well-Born Guide (WBG) and the MATH/MD Survey for Care Coordination can help MFSK/HMD care coordination to quickly identify and provide individualized referrals and personalized supports for children and families. MATH/MD understands the critical importance of engaging families as partners in their child’s healthy development and health care and is piloting the WVP as an evidence-based tool in their program efforts.

From Possibilities to Progress
As part of their piloting of the Engagement Approach to care, MATH/MD created a customized WVP website that care coordinators can use to enhance. Families have about 30 minutes to complete MATH/MD’s WBG tool.

Source: Child and Adolescent Health Measurement Initiative, Feb. 2023

Bethell, C. 4.13.2023

Community-Based Family Resource Brokers
Engaging families to personalize and access connections to services and supports.

What’s Working Now
Open in communities rich in family support resources and services, caregivers struggle to find essential services they can trust to meet the needs of their children and family. Family support and resource brokers, such as Mississippi Family System for Kids (MFSK), partner with families to help them identify their needs and receive high-quality services and supports in their local community. Mississippi Family System for Kids benefits from the array of direct services and resources provided by MFSK and its new help Desk (HMD) program. Additionally, their strengthening work with children in foster care supports permanency and safety of children and families during times of transition. As a one-stop shop for families, MFSK/HMD seeks to ensure that all young children in Mississippi receive required developmental screenings and referrals for additional support if needed. MFSK’s direct work with families and children makes them important advocates for local and state policy and program improvements to optimize supports for all children and families in Mississippi. With 229 children served through HMD and 100 developmental screenings completed in the last year (2021-2022), MFSK is building its current partnership with MSH and its operational capacity statewide to support more families given their capacity and drive to assist a wider population.

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Source: Child and Adolescent Health Measurement Initiative, Feb. 2023

Bethell, C. 4.13.2023
The Cycle of Engagement Well Visit
Planner Approach to Care

Leveraging the Well Child Visit to Optimize Child and Family Wellbeing With Families and Across Systems
The Cycle of Engagement Tools

“"If you want to effectively engage families, efficiently provide comprehensive care, and meet standards you need the Well Visit Planner.”

- Pediatric Provider
“The WVP empowers families so we can support their goals and needs. It gives us the reassurance all screens are done and we meet family priorities. Saves time to connect, build trust and link to supports.” (Pediatrician)

www.cycleofengagement.org
Clinical Summary of Well Visit Planner® Findings: 15 Month Well Visit

Date of Well Visit: No response • Date WVP Completed: 9/7/2022 • Birth Month & Year: 4/2021

Key: □ family response indicated □ family response indicated □ family did not respond; no low risk some risk or concern nonresponse could indicate risk

Screening and Assessments Summary and Topics to Address: Assess & Address

Child Development

Developmental Surveillance and Screening

- Developmental Screening SWYC milestones score=10 (Results from 15 Month SWYC: did not meet age expectations); score may or may not indicate a delay. Clinical review with family needed.

Very Much
- Calls you “mama” or “dada” or similar name
- Looks around when you say things like “Where’s your blanket?” or “Where’s your blanket?”
- Names at least 5 body parts - like nose, hand, or tummy
- Names at least 5 familiar objects - like ball or milk

Somewhat
- Copies sounds that you make
- Walks across a room without help

Not Yet
- Kicks a ball
- Ruts
- Walks up stairs with help

Missing
- Follows directions - like Come here or “Give me the ball”

- Caregiver reports completing standardized developmental, behavioral screening: No
- Caregiver’s overall level of concern about child’s development, learning, behavior: A little
- Hearing concerns: Yes
- Speaking concerns: No
- Lazy or crossed eyes: No
- Bowel movements/urination concerns: No

Health Behaviors

- Smoking: Child exposed to smoking
- Flag for potential alcohol misuse
- Recreational/non-prescription drug use
- Intimate partner violence risk? - Caregiver and partner work out arguments with some difficulty
- Some tension in relationship with partner

Relational Health Risks

- Economic Hardships: Somewhat/Very often hard to cover costs of basic needs, like food or housing
- Impact of COVID-19 on family’s well-being: Somewhat

Social Factors/Determinants

- Lives with both parents: Yes

Caregiver Emotional Health

- Depression risk: PHQ-2 Score: 3
  - Depressed, depressed, or hopeless several days over the past 2 weeks
  - Little interest or pleasure in doing things more than half the days over past 2 weeks

- Caregiver social support

- Caregiver self care/hobbies: Has spent time in last 2 weeks doing things they enjoy
- Caregiver coping: Not Very Well

About This Child

Name: Sara Initials (F: M: I): SM
Special Keyword: dog
WVP completed by: Mother
Gender: No response
Insurance coverage/type: No response
Interested in telemedicine visits: No
Concerns about telemedicine to address: Family’s privacy

General Health and Updates

Child’s Health and Health History

- Child has ongoing health problem requiring above routine services (CSHCN screener)
- New medications
- Currently taking vitamins/herbal supplements:
  - Dentist: Currently no dentist
  - Fluoride: No fluoride in water source

Family History and Updates

- Recent family changes (e.g. move, job change, separation, divorce, death in the family): Move
- New medical problem in family
- Parent/grandparent had stroke or heart problem before age 55
- Parent has elevated blood cholesterol

Strengths to Celebrate! Connect & Celebrate

Caregiver social support: Caregiver has at least one person they trust and can go to with personal difficulties
Caregiver self care/hobbies: Caregiver has spent time in the last 2 weeks doing hobbies, self care, or spare-time activities they enjoy
One thing that is going well for the caregiver as a caregiver: My parents are very supportive and they love my child.
Mathematica Independent Evaluation Across End User Groups

**Equity-focused benefits**
- Brings screening to 100%. Equalizes family knowledge. Aligns health literacy. In Spanish. Families given ways to express concerns about racism. Addresses challenges driven by structural racism.
- Provides families with information about what to expect from a provider and gives tools to communicate during the visit.

**Equity-focused strategies**
- Use aggregate data reports for advocacy, to celebrate strengths, identify priorities, needs, quality.
- Partner with family-serving organizations.
- Let family specialist support families to use WVP.
- Identify and share resources to address family needs that are uncovered through the WVP.

Amplify community voices

Advance health equity

Address structural racism
Potential settings for Well Visit Planner implementation noted by interviewees

- Pediatric practices
- Family medicine practices
- Early childhood programs
- Family support programs
- Faith organizations
- Public health programs
- Child welfare programs
- Other community settings frequented by families
A QUICK OVERVIEW OF THE WELL VISIT PLANNER
How Families Use the Well Visit Planner

1. Set UP
   - Go to provider's WVP website
   - Sign up for a free family account
   - Agree to complete/share results
   - Enter child's information

2. Reflect and Assess
   - Reflect on and share what is going well
   - List your specific goals or concerns
   - Learn, reflect and complete assessments to save time completing forms
   - Get your results right away!

3. Pick your Priorities
   - Learn about topics relevant to you, your child & family's well-being
   - Get age-specific resource sheets
   - Select the priority topics most important to you to discuss with your child's provider

4. Partner in Care
   - Get a Well Visit Guide with personalized resources
   - Providers with accounts get a summary to partner in care
   - Providers bill for screening
   - Well visit is focused on you and your child
Thank you!

Contact Us
Email us at: info@cahmi.org
Visit “Ask a Question” page on the DRC