Data Resource Center for Child & Adolescent Health

A project of the Child and Adolescent Health Measurement Initiative

CAHMI

The Child & Adolescent Health Measurement Initiative

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

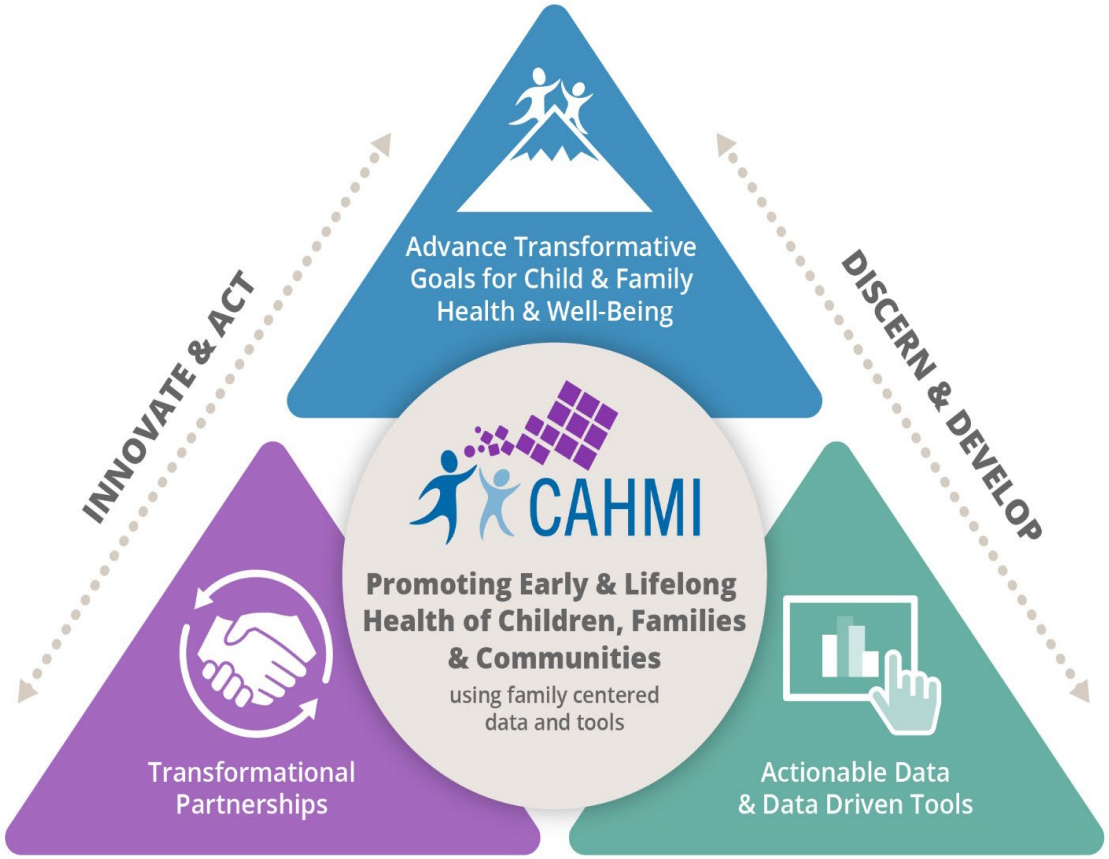
Christina Bethell, PhD, MBA, MPH

Professor, Johns Hopkins University

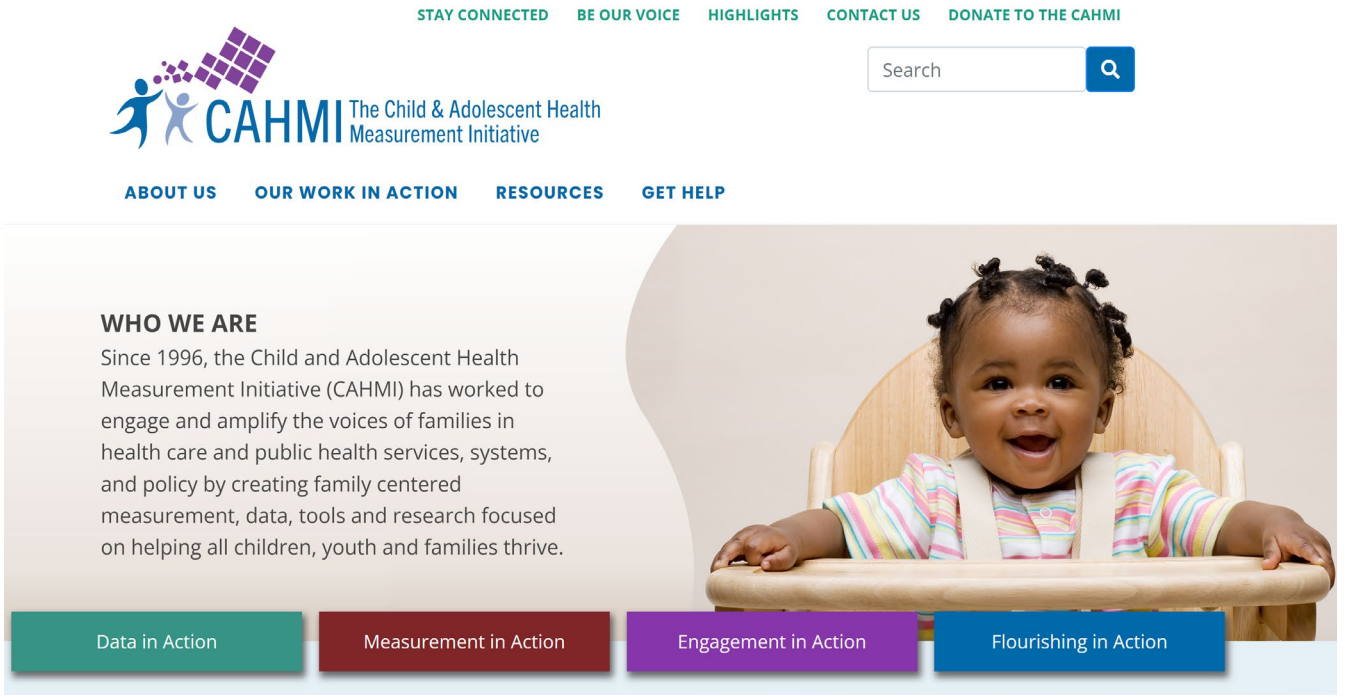
Director, Child and Adolescent Health Measurement Initiative

What is the CAHMI?

Theory of Change



Our 27 years to promote early and lifelong health using family centered research, data and tools



CAHMI

CAHMI's 27-year journey to support and optimize the impact of Title V Needs Assessment and Action

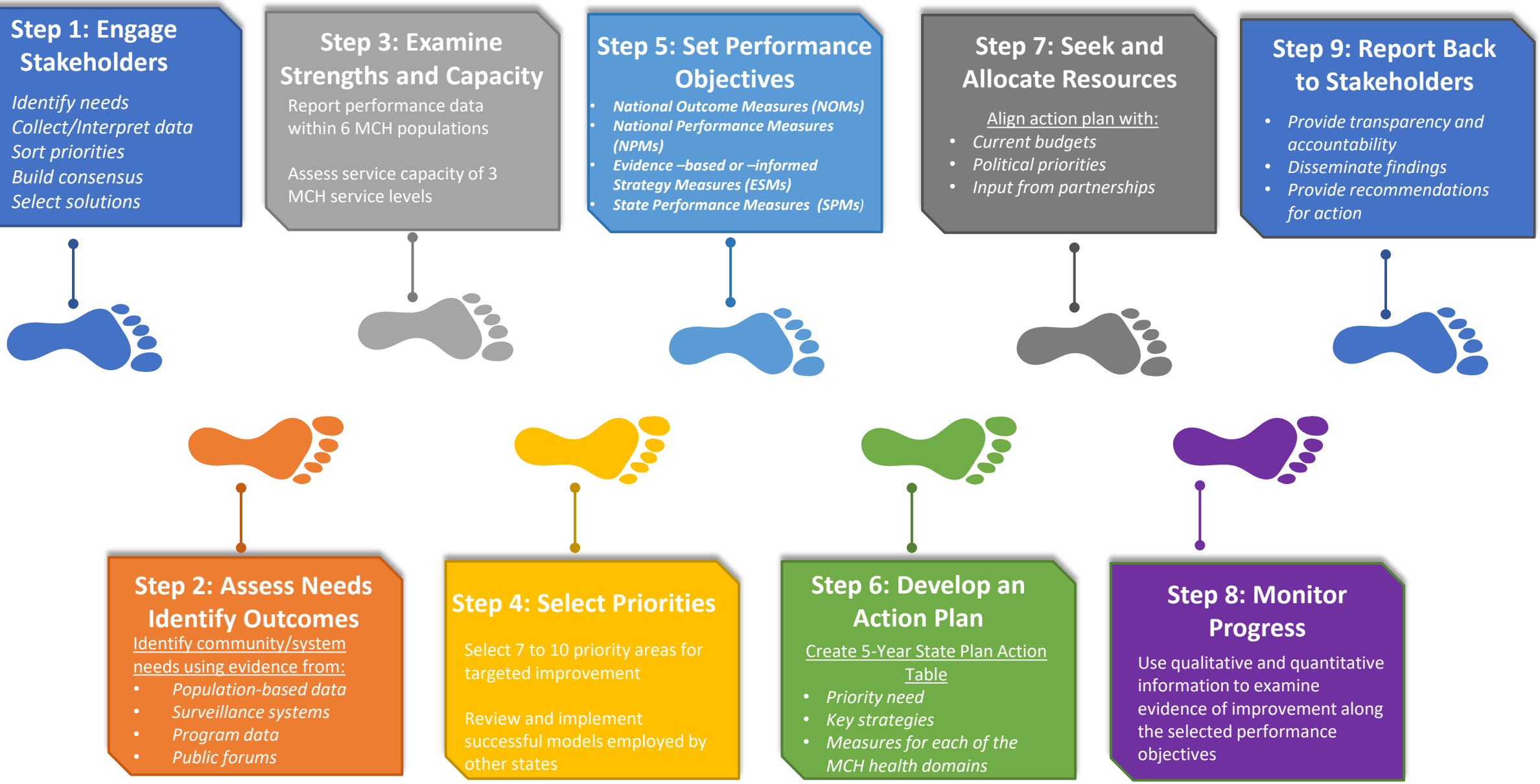
Guiding principles for the development of the MCH Block Grant application/annual reporting for all states:

- ❑ ……"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."

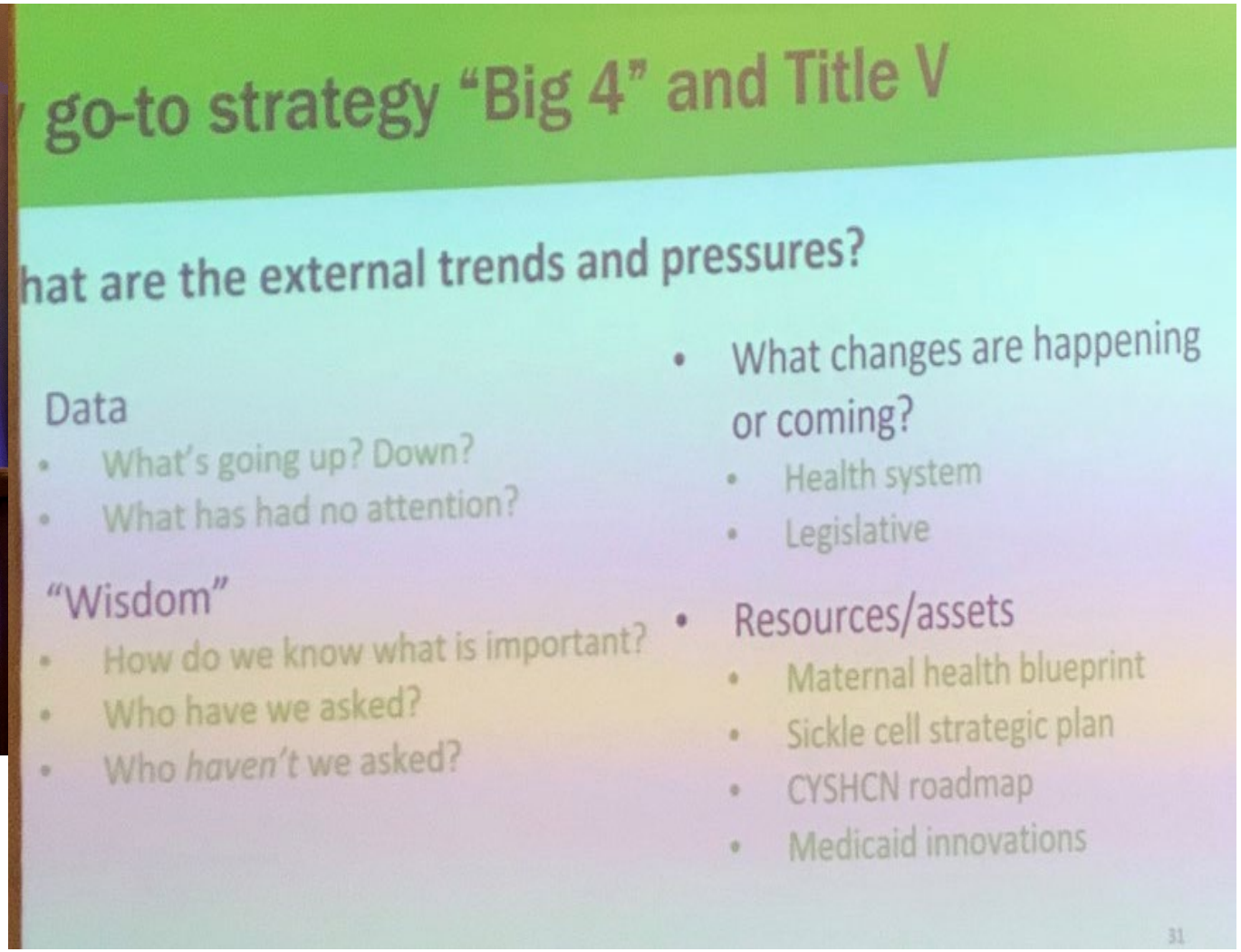
Title V Maternal and Child Health Services Block Grant to States Program. Guidance and Forms for the Title V Application/Annual Report.

CAHMI

Data Resource Center and Other CAHMI Resources Are Relevant for Each Step on the Title V Needs Assessment Journey



Big-4 Approach to Needs Assessment From Our Morning Plenary—Amy Zapata (Louisiana)



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The Child & Adolescent Health Measurement Initiative

SCAN ME

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

SCAN ME

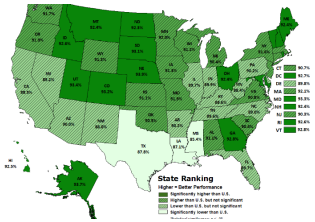
November 2023

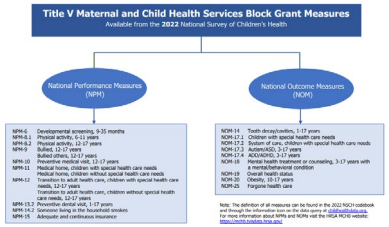
Citation: Child and Adolescent Health Measurement Initiative (2023). "Starting Point Quick Links – Title V Needs Assessment." Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal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

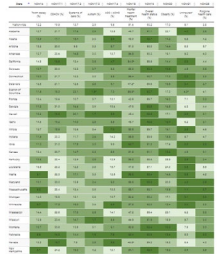
Quick Glance Overview of CAHMI Resources for Your Title V Needs Assessment

Data Resource Center

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

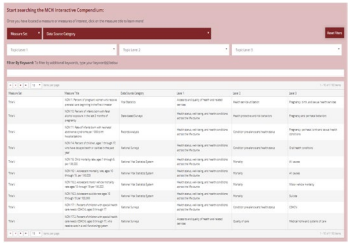


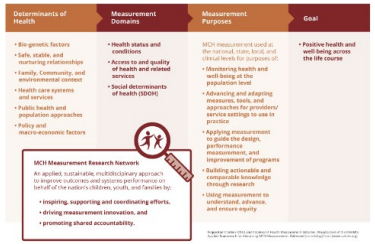




Measurement in Action: Steps 2,3,4,5,6,9

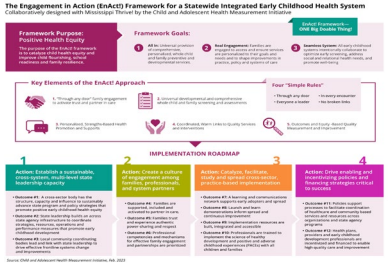
- MCH Measures Compendium
- Measurement Research Network
- National Strategic Measurement Agenda

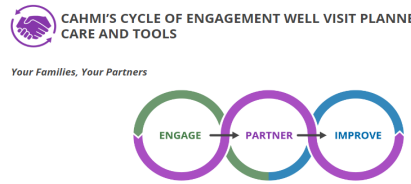




Engagement in Action: Steps 1,6,7

- Engagement in Action (EnAct!) Framework
- Cycle of Engagement Well Visit Planner Approach to
- 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

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

- Toward Measurement for a Whole Child Health Policy: Validity and National and State Prevalence of the Integrated Child Risk Index – *Academic Pediatrics* article showing how to use the NSCH data to identify children's medical, social and relational health needs and risks using a whole child approach documenting the importance of engaging stakeholder to improve child well being

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 ad 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.**

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**

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

Published: 08 October 2013

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, MPH[1] [Director, Professor], Stephen J. Blumberg, PhD[2] [Associate Director for Science], Ruth E. K. Stein, MD[3] [Professor], Bonnie Strickland, PhD[4] [Director], Julie Robertson, MPH, MSW[1] [Former Research Associate], and Paul W. Newacheck, DrPH[5] [Professor]

[1]Child and Adolescent Health Measurement Initiative, Department of Population, Family and Reproductive Health, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD

[2]National Center for Health Sta
Hyattsville, MD

[3]Albert Einstein College of Med

[4]Maternal and Child Health Bur
Rockville, MD

[5]Philip R. Lee Institute for Healt

Abstract

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

Pediatrics. 2004 May;113(5 Suppl):1529-37.

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

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 | (2023)

Download PDF

You have full access to this open access article

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

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RESEARCH ARTICLE

HEALTH AFFAIRS > VOL. 33, NO. 12: CHILDREN'S HEALTH

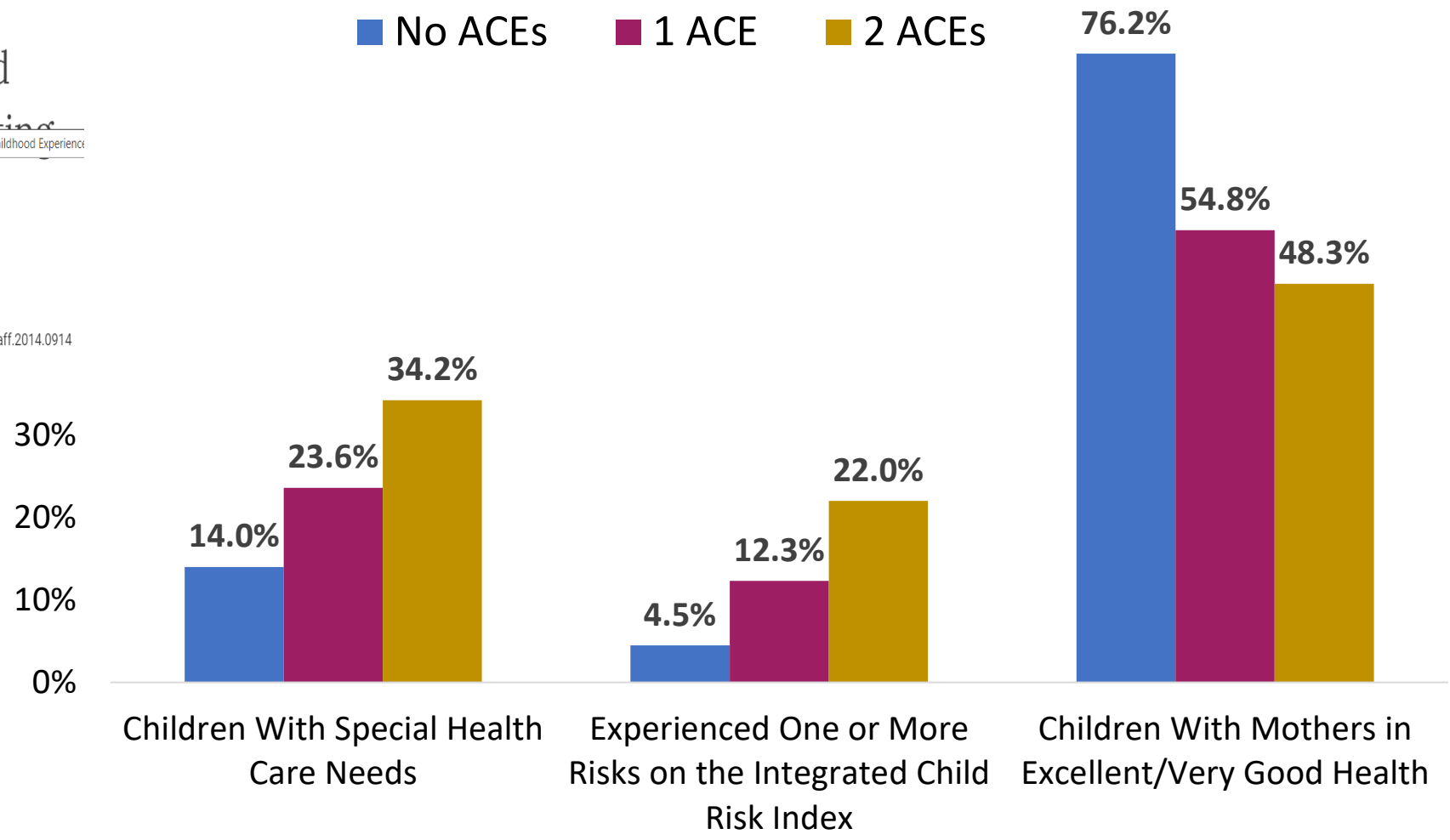
Adverse Childhood Experiences: Assessing The Impact On Health And School Engagement And The Mitigating Role Of Resilience

Christina D. Bethell, Paul Newacheck, Eva Hawes, and Neal Halfon

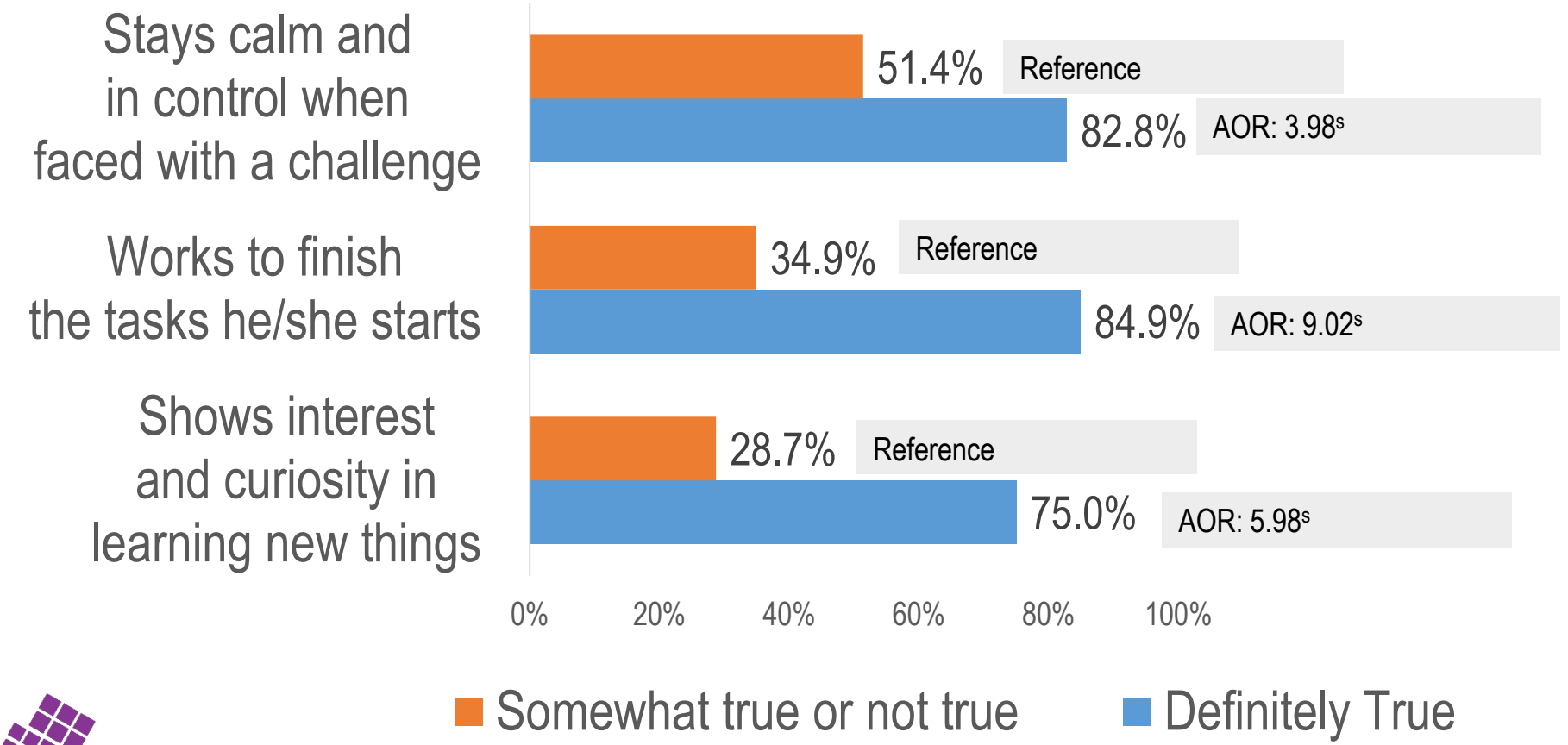
AFFILIATIONS

PUBLISHED: DECEMBER 2014 No Access https://doi.org/10.1377/hlthaff.2014.0914

Prevalence of Children With Special Health Care Needs, Mental Health Problems and Mothers in Very Good/Excellent Health by Adverse Childhood Experiences Levels



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



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Adjusted odds ratios (AOR) are adjusted for age, sex, race/ethnicity, income, CSHCN status and ACEs.
[s]AOR is statistically significant.

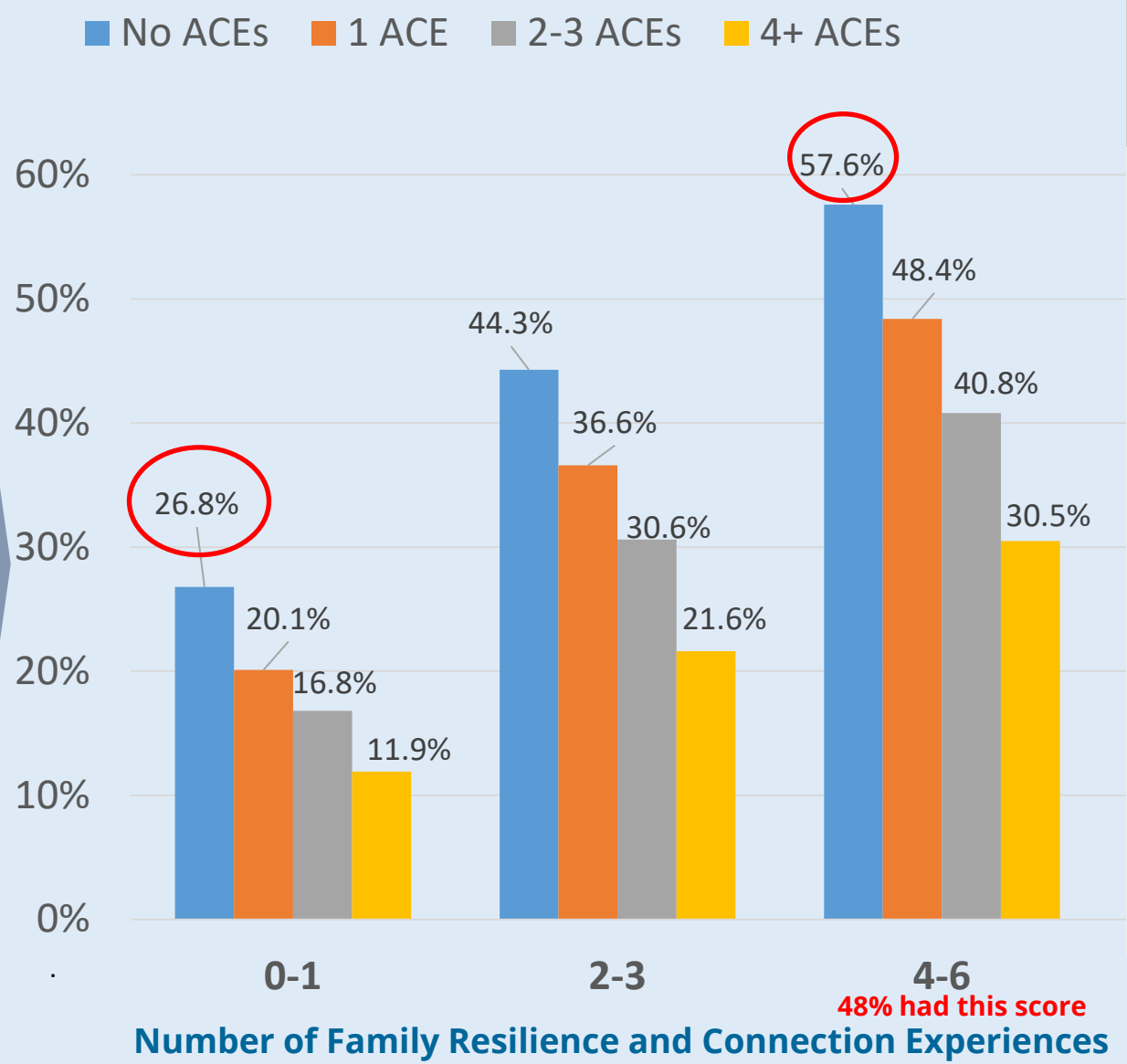
From Trauma As the Problem to Relational Health As The Solution

RESEARCH ARTICLE | CULTURE OF HEALTH

HEALTH AFFAIRS > VOL. 38, NO. 5: SOCIAL DETERMINANTS, CHILDREN & MORE

Family Resilience And Connection Promote Flourishing Among US Children, Even Amid Adversity

Christina D. Bethell, Narangerel Gombojav, and Robert C. Whitaker



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

CAHMI

Bethell CD, Gombojav N, Whitaker RC. Family Resilience And Connection Promote Flourishing Among US Children, Even Amid Adversity. *Health Aff (Millwood)*. 2019;38(5):729-737. doi:10.1377/hlthaff.2018.05425

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

This Issue | Views 119,589 | Citations 195 | Altmetric 1186

Download PDF | More | Cite This | Permissions

Original Investigation

ONLINE ONLY

September 9, 2019

Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample

Associations Across Adverse Childhood Experiences Levels

Christina Bethell, PhD, MBA, MPH[1]; Jennifer Jones, MSW[2]; Narangerel Gombojav, MD, PhD[1]; et al

https://www.pacesconnection.com/resource/7-positive-childhood-experiences-pces

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!

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health

Andrew Garner, MD, PhD, FAAP,[a,b] Michael Yogman, MD, FAAP[c,d]
COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS, COUNCIL ON EARLY CHILDHOOD

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.

Moving Beyond Toxic Stress ... Towards Relational Health

Summary (2013):	Summary (2020):
Toxic stress defines the problem.	**Relational health defines the solution.**
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.	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:

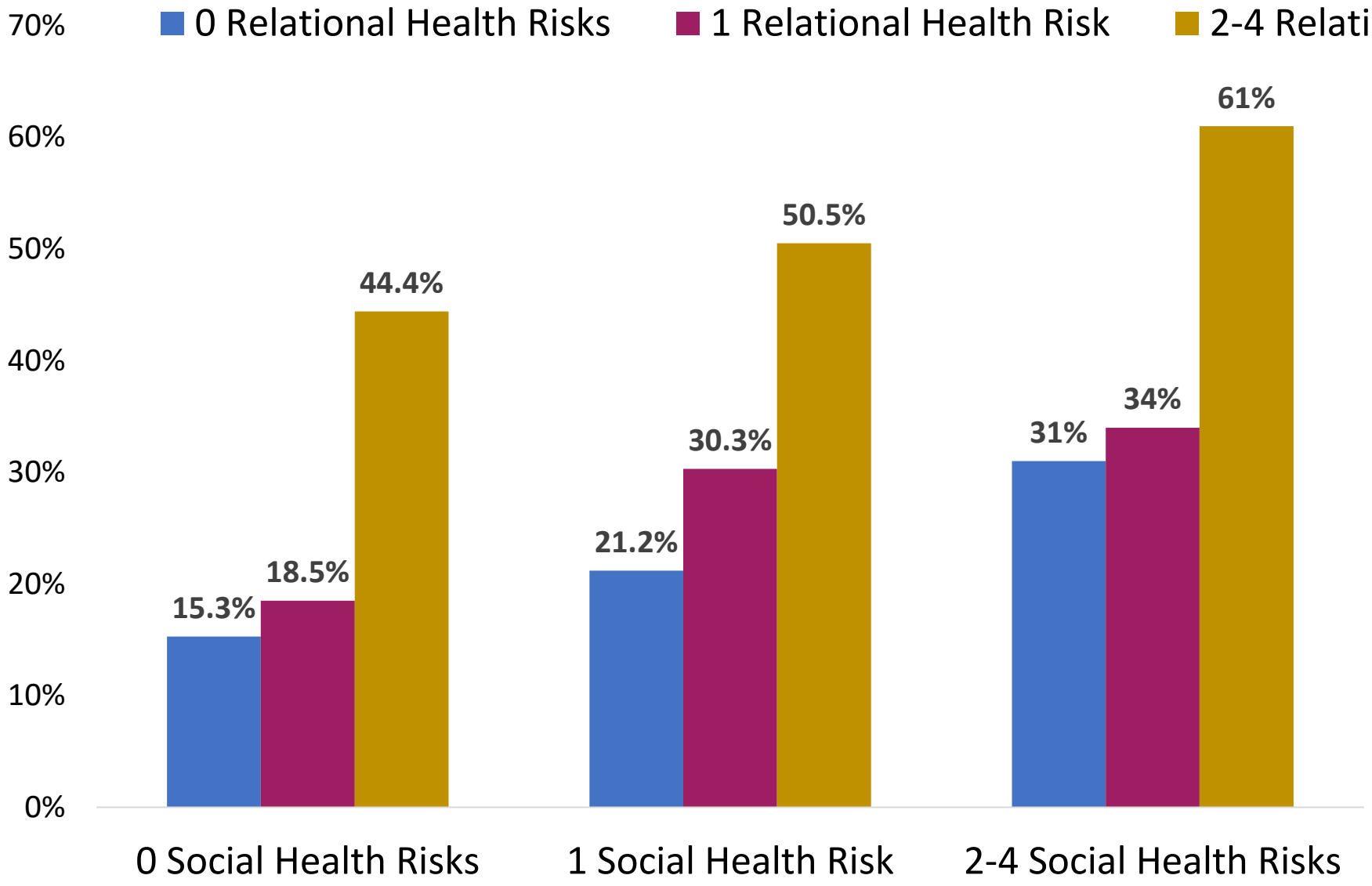
Adverse childhood experiences (ACEs), low parental mental health, low parent emotional support, etc.

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 FAILY INTEGRATED SYSTEMs TRANSFORMATION REQUIRED!
EXAMPLE: Prevalence of Mental, Emotional and/or Behavioral Health Problems By Children's Exposure to Social and Relational Health Risks

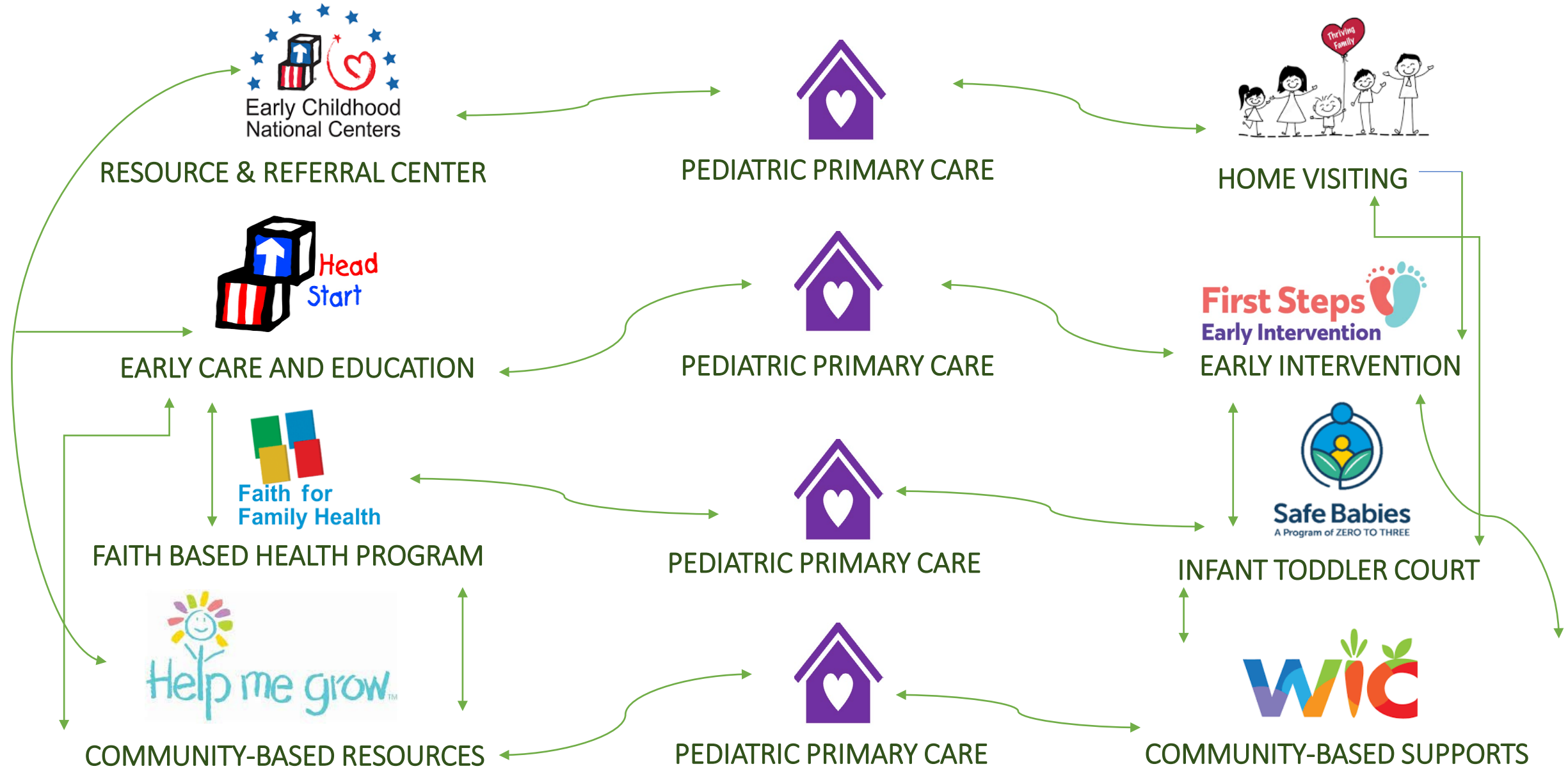


Study Reveals Fourfold Range in Rates of Mental Health Problems Among U.S. Children Based on Relational and Social Risks

Most recent national data, from 2016–2019, also highlight relationship-focused protective factors linked to resilience and school outcomes

Citation: Bethell CD, Garner AS, Gombojav N, Blackwell C, Heller L, Mendelson T. Social and Relational Health Risks and Common Mental Health Problems Among US Children: The Mitigating Role of Family Resilience and Connection to Promote Positive Socioemotional and School-Related Outcomes. Child Adolesc Psychiatr Clin N Am. 2022 Jan;31(1):45-70. doi: 10.1016/j.chc.2021.08.001. PMID: 34801155.

Intentional collaboration across system partners to support families and children based on their agenda is possible with the Well Visit Planner interoperable tool



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

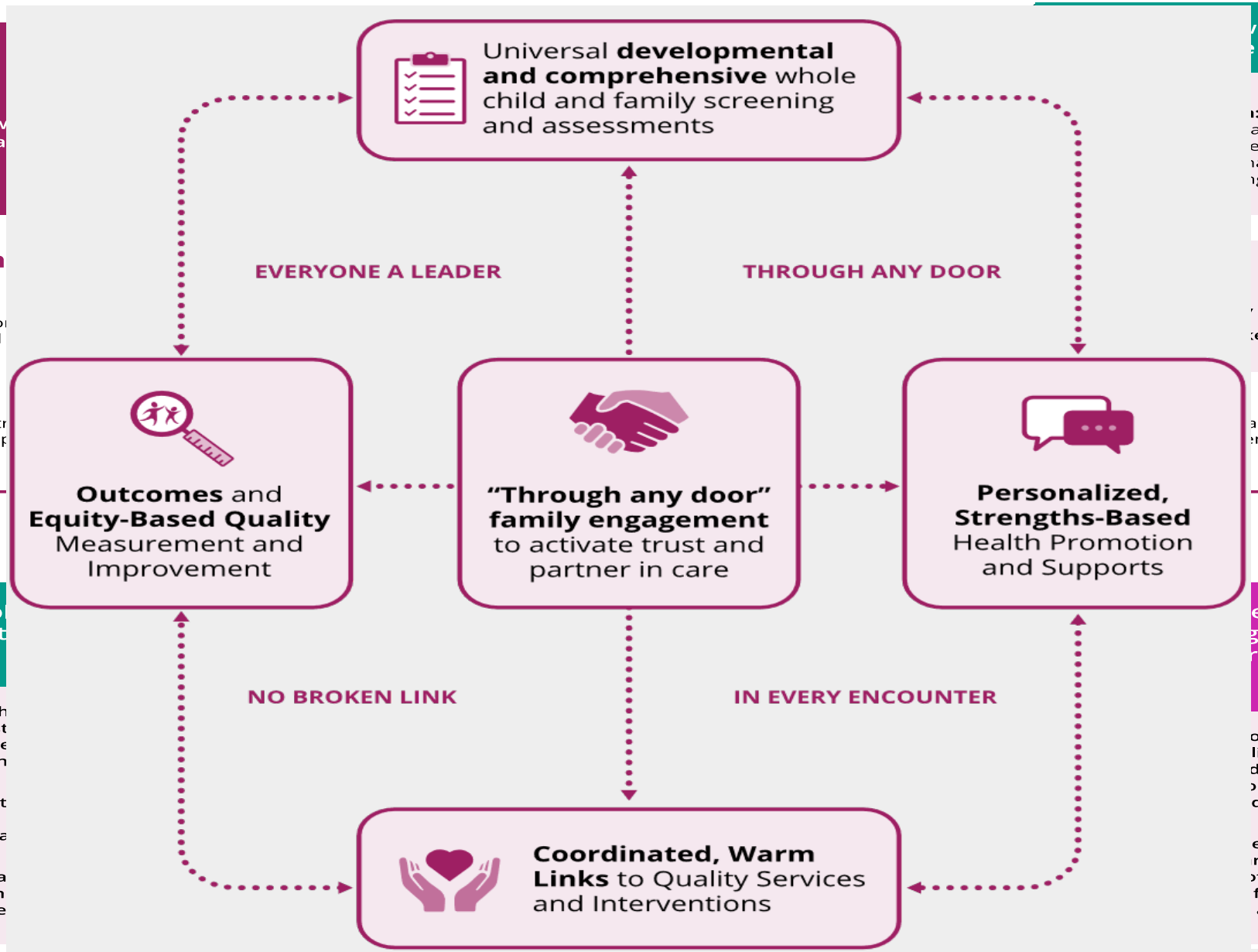
Framework Purpose: Positive Health Equity

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

Key Elements of th

1. "Through any doo
to activate trust and

3. Personalized, Str
Promotion and Sup



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

1

Action: Establish a sustainab
cross-system, multi-level stat
leadership capacity

- **Outcome #1:** A cross-sector body has th
structure, capacity and influence to sust
advance state program and policy strate
promote positive early childhood health
- **Outcome #2:** State leadership builds an
state agency infrastructure to coordinat
strategies, resources, operations and
performance measures that promote ea
childhood development
- **Outcome #3:** Local community coordina
bodies lead and link with state leadersh
drive effective frontline systems change
and improvements

Source: Child and Adolescent Health Measuremer

4

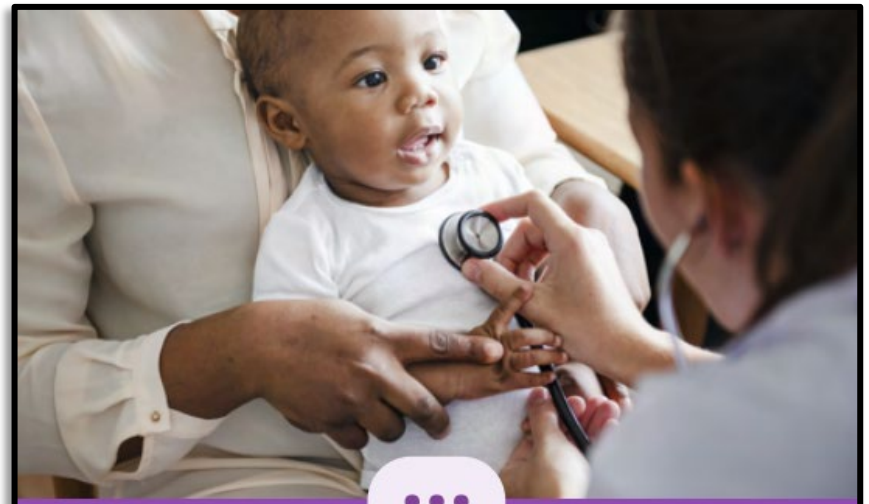
e enabling and
g policies and
rategies critical

olicies support
litate coordination
d community based
ources across
d state agency

ealth plans,
rly childhood
ofessionals are
financed to enable
and improvement

ethell, C. 2023

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

Well Visit Planner®

WELL VISIT PLANNER

Pre-visit planning

PERSONALIZED CONNECTED ENCOUNTER

(In-person, virtual, group)

The Online Promoting Healthy Development Survey

ONLINE PHDS

Post-visit assessment

Before **During** **After**

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ally!

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Data Resource Center for Child & Adolescent Health

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.

CAHMI

www.childhealthdata.org

Ask a Question | Request a Dataset | Stay Connected | What can we help you find?

Data Resource Center for Child & Adolescent Health
A project of the Child and Adolescent Health Measurement Initiative

CAHMI The Child & Adolescent Health Measurement Initiative

Learn About the NSCH | Explore the Data | Spread the Word | About Us

National Survey of Children's Health Interactive Data Query

Video Tour of the Interactive Data Query

2018-2019 (two years combined)

Nationwide

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

Continue

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

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.

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

Compare Data Across States

CAHMI

Your Data ... Your Story
Data Resource Center for Child & Adolescent Health
A project of the Child and Adolescent Health Measurement Initiative

www.childhealthdata.org

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 2025. 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.

Access at MCHneeds.net

Title V Needs Assessment Process[1]	How the Data Resource Center Can Help
Assess Needs and Identify Priorities	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.
Examine Strengths and Capacity	"Point and click" menus allow users to explore disparities and gaps in access to care and services for various subgroups of children and CSHCN.
Select Priorities	User-generated tables and bar charts supply prevalence and count estimates to help guide selection of priority needs.
Set Performance Objectives	"All States" ranking maps and tables provide benchmark data to assist in identifying state-negotiated performance measure targets.
Develop an Action Plan	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.
Monitor Progress	Centralized resource for population-based survey questions to use in collecting standardized child health data, helping to inform local and program-level evaluation efforts.

Priority Need	Priority Topic	Frequency		Population Groups with State Level Information Available on the Data Resource Center (DRC) Website			
		2020 State Count	2020 State %	Early Childhood (0-5 years)	School Age (6-17 years)	All Children (0-17 years)	Children with Special Health Care Needs (CSHCN)
Transition Care	Access to Quality Care	27	45.0%		x (12-17y)		x
Reducing Disparities	Health Equity	25	41.7%			x	x
Developmental Screening	Access to Quality Care	24	40.0%	x (9-35m)			x
Access to Preventive Care	Access to Quality Care	23	38.3%			x	x
Systems of Care for CYSHCN	Access to Quality Care	23	38.3%			x	x
Medical Home	Access to Quality Care	20	33.3%			x	x
Behavioral Health	Access to Quality Care	20	33.3%			x (3-17y)	x
Breastfeeding	Healthy Behaviors	19	31.7%	x			x
Oral Health Services	Access to Quality Care	17	28.3%			x (1-17y)	x
Reducing Disparities	Social Determinants of Health	16	26.7%			x	x
Protective Factors	Access to Quality Care	15	25.0%			x	x
Reducing Disparities	Access to Quality Care	15	25.0%			x	x
Tobacco	Healthy Behaviors	14	23.3%			x	x
Social Emotional Health	Access to Quality Care	13	21.7%			x	x
Obesity	Health Status	13	21.7%		x (10-17y)		x
Low Birth Weight/Very Low Birth Weight/Prematurity	Health Status	13	21.7%			x	x
Economic Stability	Social Determinants of Health	12	20.0%			x	x
Specialized Care	Access to Quality Care	11	18.3%			x	x
Protective Factors	Healthy Behaviors	11	18.3%			x	x
Care Coordination	Access to Quality Care	9	15.0%			x	x
Health Insurance Coverage	Access to Quality Care	9	15.0%			x	x
Bullying/Harassment	Healthy Behaviors	9	15.0%		x		x
Physical Activity	Healthy Behaviors	8	13.3%		x		x

[2] Altarum (2021), State Priorities and Performance Measures Trends Between 2015 and 2020. "Priority needs identified in the FY2021-FY2025 needs assessment cycle are referred to as "2020 priority needs".

Go to www.childhealthdata.org to interactively Explore and Access Information and Resources on the Majority of State Priorities for Improving MCH Outcomes and System Performance

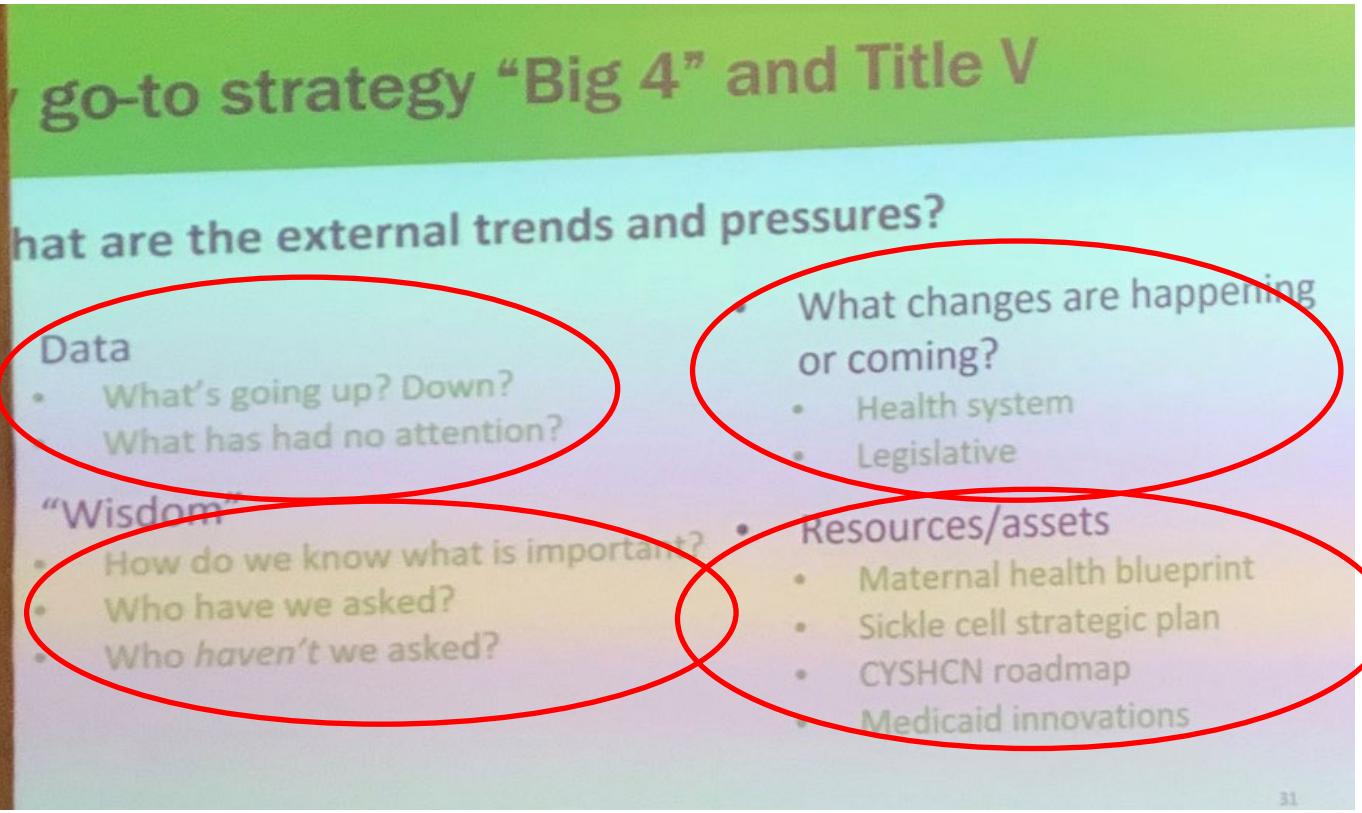
Measure Number	Measure Short Name	Population Domain	Frequency		Population Groups with State Level Data and Resources Available on the Data Resource Center (DRC) Website				NSCH Data Found on DRC						
			Number of States	Percent of States	Early Childhood (0-5 years)	School Age (6-17 years)	All Children (0-17 years)	CSHCN	2016	2017	2018	2019	2020	2021	2022
NPM 6	Developmental Screening	Child Health	38	64.4%	x			x	x	x	x	x	x	x	x
NPM 8	Physical Activity	Child Health, Adolescent Health	20	33.9%		x		x	x	x	x	x	x	x	x
NPM 9	Bullying	Adolescent Health	18	30.5%		x (12-17y)		x	*	*	x	x	x	x	x
NPM 10	Adolescent Well-Visit	Adolescent Health	32	54.2%		x (12-17y)		x	x	x	*	x	x	x	x
NPM 11	Medical Home	Child Health, Adolescent Health, CSHCN	39	66.1%			x	x	x	x	x	x	x	x	x
NPM 12	Transition	Adolescent Health, CSHCN	36	61.0%		x (12-17y)		x	x	x	x	x	x	x	x
NPM 13.2	Preventive Dental Visit	Child Health, Adolescent Health	15	25.4%			x (1-17y)	x	x	x	x	x	x	x	x
NPM 14.2	Smoking - Household	Child Health, Adolescent Health	3	5.1%			x	x	x	x	x	x	x	x	x
NPM 15	Adequate Insurance	Child Health, Adolescent Health	6	10.2%			x	x	x	x	x	x	x	x	x
NOM 14	Tooth Decay or Cavities	-	-	-			x (1-17y)	x	x	x	x	x	x	x	x
NOM 17.1	CSHCN	-	-	-			x		x	x	x	x	x	x	x
NOM 17.2	CSHCN Systems of Care	-	-	-			x		x	x	x	x	x	x	x
NOM 17.3	Autism	-	-	-			x (3-17y)	x	x	x	x	x	x	x	x
NOM 17.4	ADD or ADHD	-	-	-			x (3-17y)	x	x	x	x	x	x	x	x
NOM 18	Mental Health Treatment or Counseling	-	-	-			x (3-17y)	x	x	x	x	x	x	x	x
NOM 19	Overall Health Status	-	-	-			x	x	x	x	x	x	x	x	x
NOM 20	Obesity	-	-	-		x (10-17y)		x	x	x	x	x	x	x	x
NOM 25	Forgone Health Care	-	-	-			x	x	x	x	x	x	x	x	x

[3] Maternal and Child Health Bureau. National Performance Measure Distribution, Available at https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NPMDistribution;

Go to www.childhealthdata.org to interactively Explore and Access Information and Resources on 18 NOMs and NPMs based on NSCH data.

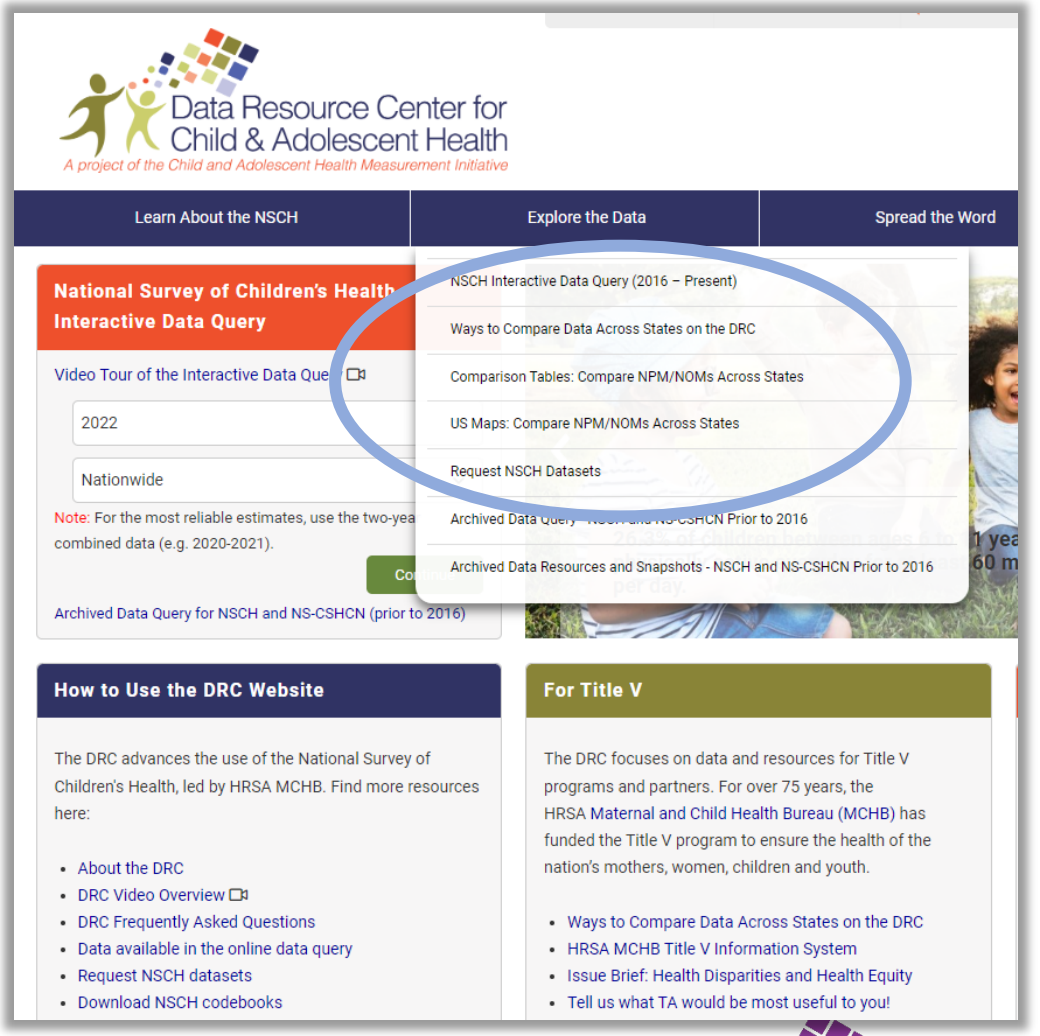
Updated NOMs and NPMs coming soon!

Big-4 Approach to Needs Assessment From Our Morning Plenary—Amy Zapata (Louisiana)



Access Your NSCH Data on the DRC

https://www.childhealthdata.org/



CAHMI

User Friendly Resources to Learn About and Use the NSCH

CAHMI

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.

Keys: ⟷ Measure is comparable across survey years
⊘ Measure is not comparable across survey years

Measure	Comparable across survey years?							Summary of key changes in measure since 2016
	2016	2017	2018	2019	2020	2021	2022	
National Performance Measures (NPMs)								
NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	⟷	⟷	⟷	⟷	⟷	⟷	⟷	**No changes**
NPM 8.1: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day **NPM 8.2:** Percent of adolescents, ages 12 through 17, who are physically active at least 60 minutes per day	⟷	⟷	⟷	⟷	⟷	⟷	⟷	**No changes**
NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others	⟷	⊘	⟷	⟷	⟷	⟷	⟷	**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

https://www.childhealthdata.org/docs/default-source/drc/npm-and-nom-changes_2016-2022.pdf

How do I access data on the DRC?

Interactive Data Query

Ask a Question | Request a Dataset | Stay Connected | What can we help you find?

Data Resource Center for Child & Adolescent Health
A project of the Child and Adolescent Health Measurement Initiative

CAHMI The Child & Adolescent Health Measurement Initiative

Learn About the NSCH | Explore the Data | Spread the Word | About Us

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).

Continue

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

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!

Compare Data Across States

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 and 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

Data Source:

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

Citation:

Child and Adolescent Health Measurement Initiative. [Title of the document] [Insert name and year of survey]. 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). Retrieved [mm/dd/yy] from [www.childhealthdata.org].

1. Select a Survey Year and Geographic Area

Select Year

2020-2021 (two years combined)

Select State/Region

Nationwide

2. Select a Starting Point/Topic

Child and Family Health Measures (Content Map)
Over 300 indicators and survey items for child and family health and well-being

Title V Maternal and Child Health Services Block Grant Measures (Content Map)
Title V Maternal and Child Health Services Block Grant National Performance and Outcome Measures

Your Data ... Your Story
Data Resource Center for Child & Adolescent Health
A project of the Child and Adolescent Health Measurement Initiative

childhealthdata.org

Child and Family Health Measures
2020-2021 National Survey of Children's Health (two years combined)

Physical, Oral Health and Functional Status

1.1 **Health status (NOM-19)**
1.2 Condition of teeth, 1-17 years
1.2a Oral health problems, 1-17 years
Tooth decay/cavities, 1-17 years (NOM-14)
1.3 Breastfed ever, 0-5 years
1.3a Exclusively breastfed, 6 mos-5 years
1.4 **Weight status (BMI), 10-17 years (NOM-20)**
1.4b Ever told that child is overweight
1.5 **Physical activity, 6-17 years (NPM-8.1: 6-11 years, NPM-8.2: 12-17 years)**
1.6 Concern about current weight
1.7 Low birth weight
1.7a Low or very low birth weight
1.8 Premature birth
1.9 One or more health conditions
Prevalence of current or lifelong conditions
Severity of current or lifelong conditions
1.10 One or more functional difficulties
1.11 **Children with special health care needs (NOM-17.1)**
1.12 Effect of conditions on daily activities

Emotional and Mental Health

2.1 Bullied others, 6-17 years
Among children age 12-17 years (NPM-9)
2.2 Bullied, 6-17 years
Among children age 12-17 years (NPM-9)
2.3 Flourishing for young children, 6 months-5 years
2.4 Flourishing for children and adolescents, 6-17 years
2.5 Argues too much, 6-17 years
2.6 Making and keeping friends, 6-17 years
2.7 **Prevalence of ADD/ADHD, 3-17 years (NOM-17.4)**
2.7a Severity of ADD/ADHD, 3-17 years
2.7b Medication for ADD/ADHD, 3-17 years
2.7c Received behavioral treatment for ADD/ADHD, 3-17 years
2.8 **Prevalence of autism/ASD, 3-17 years (NOM-17.3)**
2.8a Severity of autism/ASD, 3-17 years
2.8b Medication for autism/ASD, 3-17 years
2.8c Received behavioral treatment for autism/ASD, 3-17 years
2.8d Age of diagnosis for autism/ASD
2.8e Type of doctor or health care provider first to tell that child had autism/ASD, 3-17 years
2.9 Medication for ADD/ADHD, autism/ASD or other emotional, behavioral difficulties, 3-17 years
2.10 Mental, emotional, developmental or behavioral problems, 3-17 years

Health Insurance Coverage

3.1 Current health insurance status
3.2 Consistency of insurance coverage
3.3 Type of health insurance
3.4 Adequacy of current insurance
3.4a **Adequate and continuous insurance (NPM-15)**
3.5 Adequacy of insurance coverage for mental health care, 3-17 years
3.6 Out-of-pocket cost for medical and health care

Health Care Access and Quality

4.1 Medical care visit
4.1a Preventive care visit/check-up
Among children 12-17 years (NPM-10)
4.1b Time with doctor during preventive care visit/check-up
4.1c Doctor spoke with child privately, 12-17 years
4.2 Dentist visit, 1-17 years
4.2a **Preventive dental visit, 1-17 years (NPM-13.2)**
4.3 Received both preventive medical and dental care
4.4 Received mental health care, 3-17 years
Mental health treatment or counseling, 3-17 years with a mental/behavioral condition (NOM-18)
4.4a Difficulties obtaining mental health care, 3-17 years
4.5 Received care from a specialist doctor
4.5a Difficulties obtaining specialist care
4.7 Hospital emergency room visit
4.7a Hospital admission
4.6 Alternative health care or treatment
4.7 Doctor asked about parental concerns, 0-5 years
4.8 **Developmental screening, 9-35 months (NPM-6)**
4.9 Special services for developmental needs
4.11a Age started receiving special services for developmental needs
4.10 **Medical home**
Among CSHCN and Non-CSHCN (NPM-11)
4.12a Personal doctor or nurse
4.12b Usual source for sick care
4.12c Family-centered care
4.12d Difficulties getting referrals
4.12e Effective care coordination
4.14 Shared decision making
4.15 **Transition to adult health care, 12-17 years**
Among CSHCN and Non-CSHCN (NPM-12)
4.17 System of care
Among CSHCN (NOM-17.2)
4.18 **Forgone health care (NOM-25)**
4.19 Problems paying medical bills
4.20 Frustrated in efforts to get services

Community and School Activities

5.1 Special education or early intervention plan (EIP), 1-17 years
5.1a Age started special education or EIP
5.2 School engagement, 6-17 years
5.3 Repeated grade(s) in school, 6-17 years
5.4 Missed school days, 6-17 years
5.5 Participation in organized activities, 6-17 years
5.6 Parent participation in child's event/activities, 6-17 years
5.7 Participation in community service or volunteer work, 6-17 years
5.8 Work for pay, 12 -17 years
5.9 Has an adult mentor, 6-17 years
This child's learning, individual items, 1-5 years
This child's learning, individual items, 3-5 years

Notes:

- **MCHB Title V National Performance Measures (NOM) and National Outcome Measures (NOM) are in bold types.**
- The definition of all measures can be found in the 2020-2021 NSCH codebook and through the information icon on the data query at childhealthdata.org.
- Estimates are not comparable with estimates from surveys conducted prior to 2016.

Full survey instruments are available at the HRSA's MCHB website.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Humans 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 or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

Family Health and Activities

6.1 Physical health status of mother
6.1a Physical health status of father
6.2 Mental health status of mother
6.2a Mental health status of father
6.3 Overall health status of mother
6.3a Overall health status of father
6.4 **Someone living in the household smokes (NPM-14.2)**
6.4a Someone smokes inside the home
6.5 Caregiver(s) employment status
6.5a Children living in "working poor" families
6.6 Family shares ideas, 6-17 years
6.7 Family reads to children, 0-5 years
6.8 Family sings and tells stories to children, 0-5 years
6.9 Family eats meals together
6.10 Time spent in front of a TV, computer, cellphone or other electronic device
6.12 Family resilience
6.13 Adverse childhood experiences
6.14 Parental aggravation
6.15 Emotional help with parenthood
6.16 Coping with daily demands of raising children
6.17 Job change due to problems with child care, 0-5 years
6.18 Left a job, took a leave of absence, or cut back hours due to child's health
6.19 Avoided changing job to maintain insurance
6.20a Time spent providing at home health care
6.20b Time spent coordinating health care
6.21 Received child care from others at least 10 hours/week, 0-5 years
6.22 Sleep position, 0-12 months
6.24 Child goes to bed same time on weeknights
6.25 Adequate amount of sleep, 4 months-17 years
6.26 Food insufficiency
6.27 Received food or cash assistance

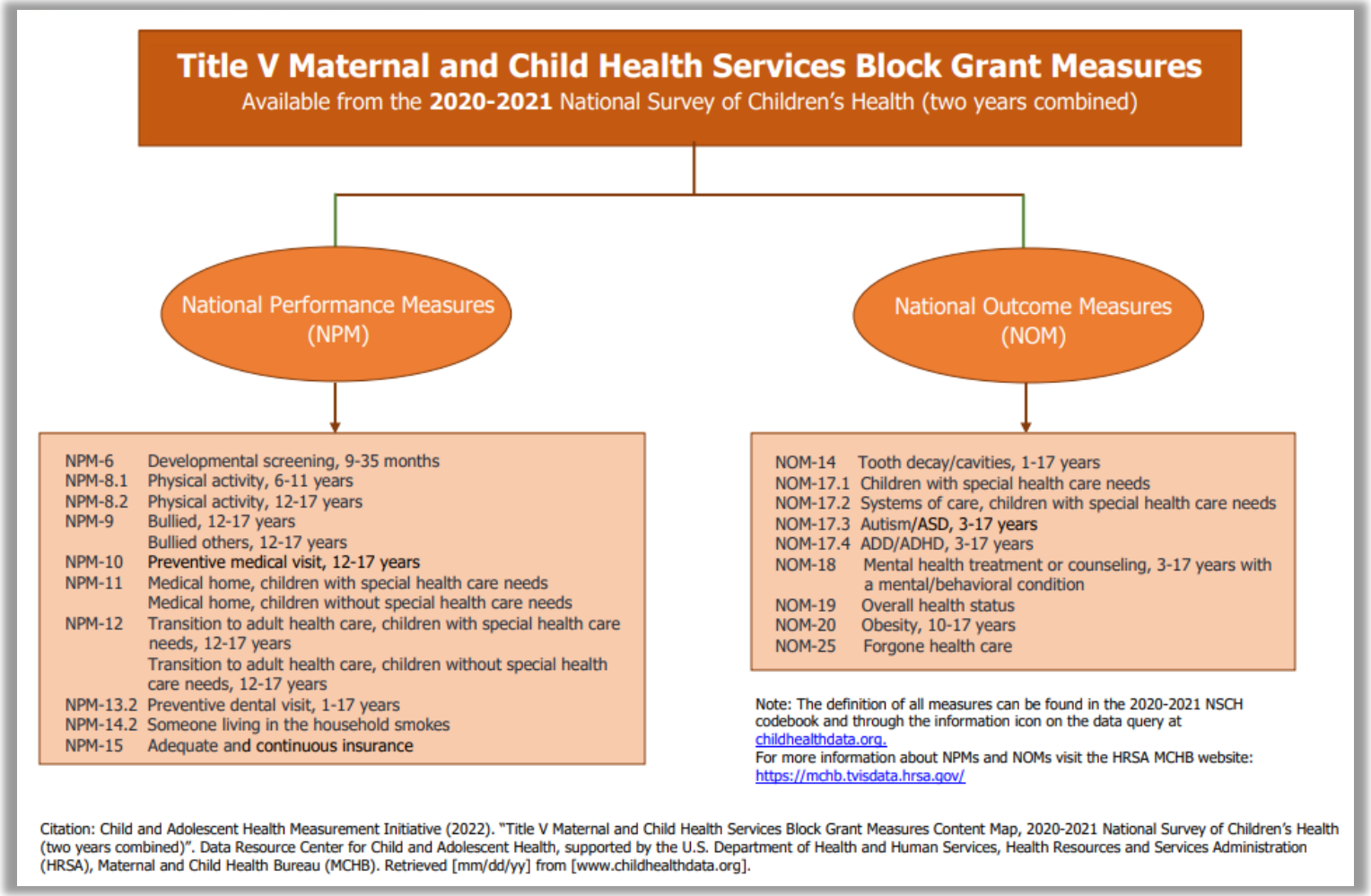
Neighborhood Safety and Support

7.1 Supportive neighborhood
7.2 Safe neighborhood
7.3 Safe school, 6-17 years
7.4 Neighborhood amenities
7.5 Presence of detracting neighborhood elements

Citation: Child and Adolescent Health Measurement Initiative (2022). "Child and Family Health Measures Content Map, 2020-2021 National Survey of Children's Health (two years combined)". 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). Retrieved [mm/dd/yy] from [www.childhealthdata.org].

CAHMI

Currently Available NOMs and NPMs Derived from NSCH



+ Over 300 Child and Family Health Measures

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 – 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

The DRC's 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 and 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

Data Source:

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

Citation:

Child and Adolescent Health Measurement Initiative. [Title of the document] [Insert name and year of survey]. 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). Retrieved [mm/dd/yy] from [www.childhealthdata.org].

1. Select a Survey Year and Geographic Area

Select a Year: 2020-2021 (two years combined)

Select a State/Region: Nationwide

2. Select a Starting Point/Topic

Child and Family Health Measures (Content Map)
Over 300 indicators and survey items for child and family health and well-being

- Physical, Oral Health and Functional Status
- Emotional and Mental Health
- Health Insurance Coverage
- Health Care Access and Quality
- Community and School Activities
- Family Health and Activities
- Neighborhood Safety and Support
- Child and Family Demographics

Title V Maternal and Child Health Services Block Grant Measures (Content Map)
Title V Maternal and Child Health Services Block Grant National Performance and Outcome Measures

- National Performance Measures
- National Outcome Measures

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

CAHMI

View Findings in Tabular & Graphic Format

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 (quick edit)
Topic: National Performance Measures
Question: NPM 11: Medical home, children with special health care needs (CSHCN)

Edit Search Criteria

Select a State or Region to Compare

Select a Subgroup

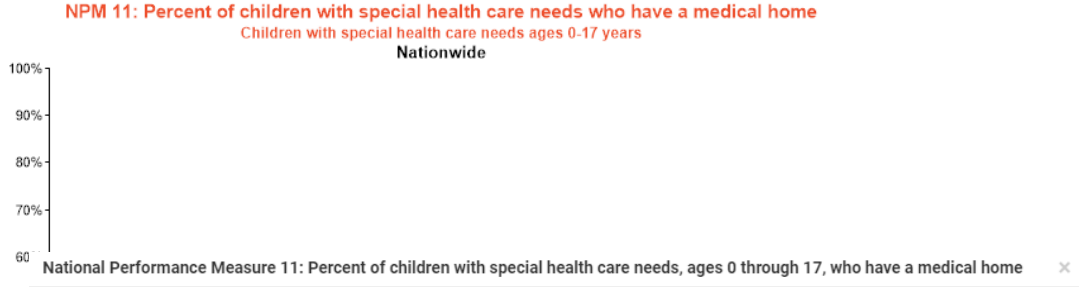
Change Question, Topic or Survey

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

	Care meets medical home criteria	Care does not meet medical home criteria	Total %
%	**42.0**	**58.0**	**100.0**
C.I.	40.5 - 43.4	56.6 - 59.5	
Sample Count	9,852	11,349	
Pop. Est.	5,940,544	8,218,253	

C.I. = 95% Confidence Interval.
Percentages and population estimates (Pop.Est.) are weighted to represent child population in US.

CAHMI



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

Survey Items: Survey instrument item number for children 0-5 years: C1, C8, C9, D1-D4, D7-D12; for children 6-11 years: C1, C8, C9, D1-D4, D7-D12; for children 12-17 years: C1, C9, C10, D1-D4, D7-D12
Variables in public use data file: S4Q01(2020); S4Q01(2021); K4Q01; K4Q02_R; K4Q04_R; K5Q10; K5Q11; K5Q40; K5Q41; K5Q42; K5Q43; K5Q44; K5Q20_R; K5Q21; K5Q22; K5Q30; K5Q31_R; K5Q32

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 it 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, continuous, comprehensive, coordinated, compassionate 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 are:
1. Personal doctor or nurse (Indicator 4.12a: PerDrNs_2021)
2. Usual source for sick care (Indicator 4.12b: UsualSck_2021)
3. Family-centered care (Indicator 4.12c: FamCent_2021)
4. Problems getting needed referrals (Indicator 4.12d: NoRefPrb_2021)
5. Effective Care Coordination when needed (Indicator 4.12e: CareCoor_2021)

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, any children who needed referrals 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 legitimately skipped are 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 S4Q01 asked respondents to include health care visits done by video or phone.

Treatment of Unknown Values: Missing values may be 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 NPMs and NOMs, 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 any of the items, the case will be set to missing. How missing values are handled is documented in the "Additional notes" field above when required.
Missing values are not included in the denominator when calculating prevalence estimates and weighted population counts displayed in the Interactive Data Query results table. In the majority of cases, the proportion of missing values is less than 2%. Exceptions are noted in the form of a Data Alert at the bottom of a results table. The exclusion of these values does not change the prevalence estimates (%) and only marginally affects the weighted population counts (Pop. Est.). To learn about the impact of the missing values on the population count estimates, click here.

History and Development:
Overview of the Title V Block Grant
The Title V Maternal and Child Health (MCH) Services 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 59 states and jurisdictions. The Title V MCH Block Grant Performance Measure Framework enables states to demonstrate the impacts of Title V within a state. The performance measurement system utilizes national data sources, including the NSCH, to track the ultimate outcomes of the program -- National Outcome Measures (NOMs) -- and the key metrics of health behavior or health care access and quality -- National Performance Measures (NPMs) -- that influence NOMs. For more information on NPM and NOM content changes, click here. More information about the Title V MCH Block Grant and performance measurement system can be obtained at the MCHB website.
About NSCH
The National Survey of Children's Health (NSCH), funded and directed by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB), is designed to provide annual national and state-level information on the health and well-being of children ages 0-17 years in the United States. The U.S. Census Bureau administers the survey, oversees the sampling, and produces a final data set of survey results. HRSA's Maternal and Child Health Bureau (MCHB) develops survey content in collaboration with the U.S. Census Bureau and a Technical Expert Panel. The Technical Expert Panel consists of experts in survey methodology and children's health, federal and state stakeholders, clinicians and researchers. In 2016, the NSCH underwent a significant redesign which combined content from both the NSCH and the National Survey of Children with Special Health Care Needs (NS-CSHCN). Further information on that redesign can be found in "The Design and Implementation of the 2016 National Survey of Children's Health".

View Findings by Subgroups

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 (quick edit)
Topic: National Performance Measures
Question: NPM 11: Medical home, children with special health care needs (CSHCN)
Sub Group: Race/ethnicity of child -- 7 categories

Edit Search Criteria

Select a State or Region to Compare

Race/ethnicity of child -- 7 categories

Change Question, Topic or Survey

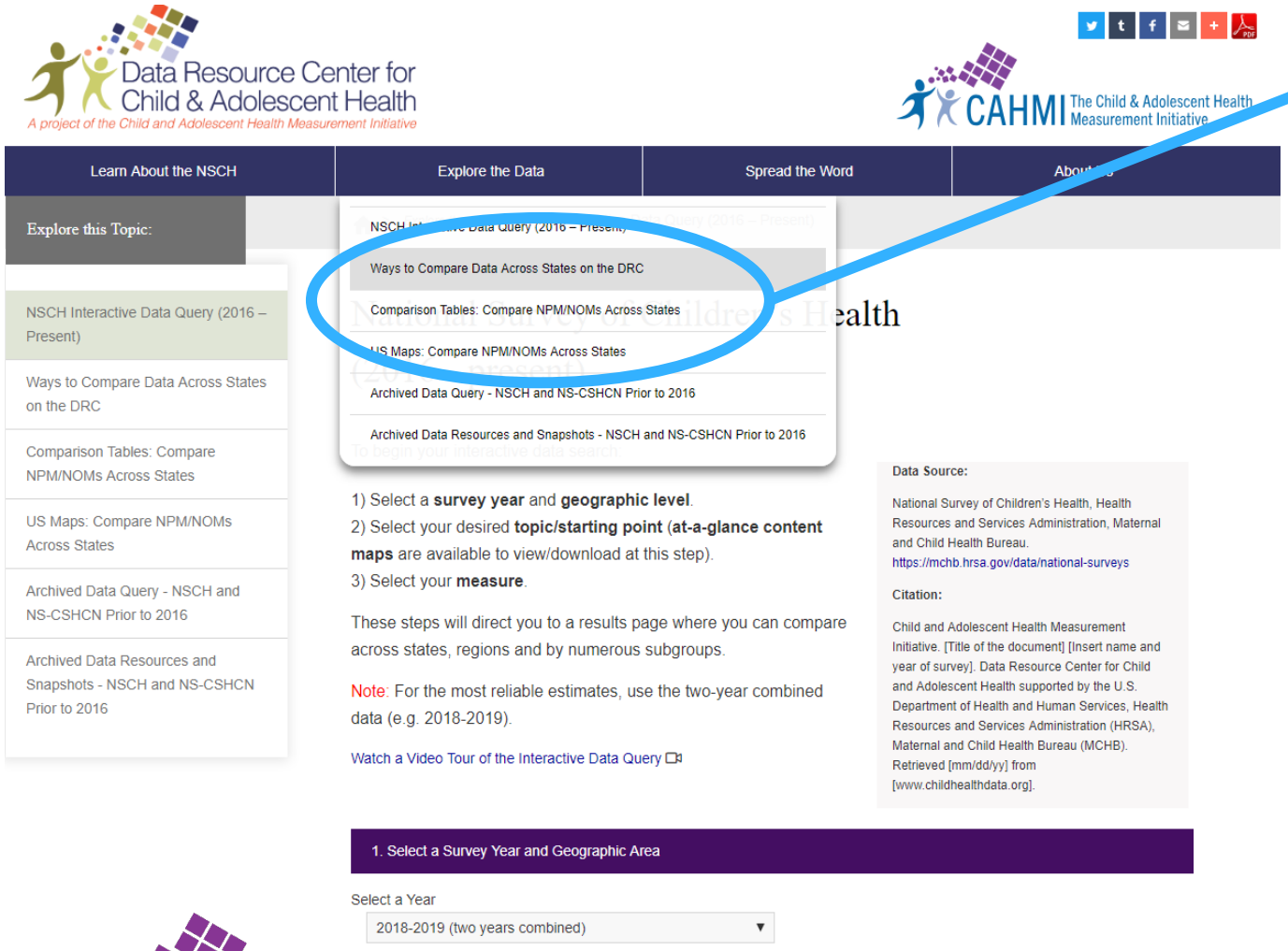
National Performance Measure 11: Percent of children with special health care needs, ages 0 through 17, who have a medical home

		Care meets medical home criteria	Care does not meet medical home criteria	Total %
Hispanic	%	**35.6**	**64.4**	**100.0**
	C.I.	31.6 - 39.8	60.2 - 68.4	
	Sample Count	1,014	1,670	
	Pop. Est.	1,159,900	2,095,605	
White, non-Hispanic	%	**46.3**	**53.7**	**100.0**
	C.I.	44.8 - 47.8	52.2 - 55.2	
	Sample Count	7,055	7,278	
	Pop. Est.	3,397,210	3,946,187	
Black, non-Hispanic	%	**36.8**	**63.2**	**100.0**
	C.I.	33.1 - 40.6	59.4 - 66.9	
	Sample Count	639	977	
	Pop. Est.	829,053	1,424,009	
Asian, non-Hispanic	%	**43.2**	**56.8**	**100.0**
	C.I.	34.9 - 51.9	48.1 - 65.1	
	Sample Count	275	370	

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

CAHMI

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 subgroups) 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 NSCH 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

CAHMI

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)

Edit Search Criteria

Maryland

Select a Subgroup

Change Question, Topic or Survey

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

		Care meets medical home criteria	Care does not meet medical home criteria	Total %
Nationwide	%	**42.0**	**58.0**	**100.0**
	C.I.	40.5 - 43.4	56.6 - 59.5	
	Sample Count	9,852	11,349	
	Pop. Est.	5,940,544	8,218,253	
Maryland	%	**49.5**	**50.5**	**100.0**
	C.I.	42.6 - 56.5	43.5 - 57.4	
	Sample Count	177	184	
	Pop. Est.	131,816	134,279	

C.I. = 95% Confidence Interval.
Percentages and population estimates (Pop.Est.) are weighted to represent child population in US.

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: All States (quick edit)
Topic: National Performance Measures
Question: NPM 11: Medical home, children with special health care needs (CSHCN)

Edit Search Criteria

Select a State:

Select a State or Region

Select a Subgroup

Change Question, Topic or Survey

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

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.

	State	Care meets medical home criteria %	Care does not meet medical home criteria %	Total %
1	Alabama	47.3	52.7	100.0
2	Alaska	41.3	58.7	100.0
3	Arizona	36.2	63.8	100.0
4	Arkansas	46.8	53.2	100.0
5	California	40.6	59.4	100.0
6	Colorado	44.0	56.0	100.0
7	Connecticut	44.9	55.1	100.0
8	Delaware	38.3	61.7	100.0
9	District of Columbia	44.8	55.2	100.0
10	Florida	32.6	67.4	100.0
11	Georgia	48.5	51.5	100.0
12	Hawaii	43.7	56.3	100.0
13	Idaho	45.4	54.6	100.0
14	Illinois	42.4	57.6	100.0
15	Indiana	41.0	59.0	100.0
16	Iowa	52.5	47.5	100.0
17	Kansas	49.1	50.9	100.0
18	Kentucky	42.1	57.9	100.0
19	Louisiana	39.7	60.3	100.0
20	Maine	47.4	52.6	100.0

Across-State Comparison Tables

Compare states on NSCH derived NOMs and NPMs

Title V National Performance Measures (NPMs)
Across State Comparison Table, 2020-2021 NSCH

- To sort a measure by state prevalence, click the arrows at the top of the column.
- Hover over each measure title to see the full measure description, learn whether high or lower prevalence means better performance and see the data source.
- Click on any prevalence estimate to compare national and state level data and to access subgroup level data (i.e. age, race, income, insurance type) for individual measures.

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

- State had Significantly **Lower Performance**
- State had **Lower Performance**, but not statistically significant
- State had **Higher Performance**, but not statistically significant
- State had Significantly **Higher Performance**

State	NPM1	NPM6	NPM8.1	NPM8.2	NPM9	NPM9	NPM10	NPM11	NPM11	NPM12	NPM12	NPM13.2	NPM14.2	NPM15
	Well-woman visit^ (%)	Develop-mental screening (%)	Physical activity (ages 6-11) (%)	Physical activity (ages 12-17) (%)	Bullied others (%)	Bullied (%)	Preventive Medical Visit (%)	Medical home (CSHCN) (%)	Medical home (non-CSHCN) (%)	Transition to adult health care (CSHCN) (%)	Transition to adult health care (Non-CSHCN) (%)	Preventive dental visit (%)	Someone living in the household smokes (%)	Adequate and continuous insurance (%)
Nationwide	69.7	34.8	26.3	14.8	10.7	28.8	69.6	42.0	47.7	20.5	16.0	75.1	13.8	68.2
Alabama	72.0	32.2	31.1	16.6	11.5	30.6	65.6	47.3	48.8	22.5	11.9	74.3	18.7	75.4
Alaska	61.9	42.0	31.9	20.9	14.2	30.3	67.4	41.3	48.1	30.4*	19.1	75.2	15.8	67.0
Arizona	64.3	18.9	20.9	13.0	11.3	27.8	63.3	36.2	41.9	14.0	10.8	75.0	11.3	63.3
Arkansas	75.5	28.4	28.8	19.5	11.0	30.0	65.3	46.8	45.7	20.5	13.7	73.8	19.5	68.8
California	61.6	34.4	24.0	11.0	6.9	18.9	59.8	40.6	41.9	11.6	13.5	74.3	9.2	71.1
Colorado	67.7	39.6	30.5	14.7	13.9	38.2	73.9	44.0	54.1	23.2	24.4	82.0	12.1	64.8
Connecticut	75.0	36.8*	27.6	16.8	8.0	28.5	76.0	44.9	51.7	25.4	10.4	81.2	10.9	66.9
Delaware	75.9	32.1	29.7	16.0	9.8	23.8	71.8	38.3	48.4	14.4	13.9	77.3	12.5	68.8
District of Columbia	71.6	33.8	18.6	13.3	8.6	19.5	70.5	44.8	44.5	17.6	18.2	80.3	9.2	74.1
Florida	N/A**	20.1	20.8	15.2	9.9	31.8	75.1	32.6	41.9	16.3	13.9	69.5	13.1	66.0
Georgia	72.5	33.1	27.0	16.8	8.9	26.5	67.0	48.5	49.2	14.9	14.2	74.4	13.0	64.4

NPM10	NPM11
Preventive Medical Visit (%)	Medical home (CSHCN) (%)
69.6	42.0

State	NPM1	NPM6	NPM8.1	NPM8.2	NPM9	NPM9	NPM10	NPM11	NPM11
	Well-woman visit^ (%)	Develop-mental screening (%)	Physical activity (ages 6-11) (%)	Physical activity (ages 12-17) (%)	Bullied others (%)	Bullied (%)	Preventive Medical Visit (%)	Medical home (CSHCN) (%)	Medical home (non-CSHCN) (%)
Nationwide	69.7	34.8	26.3	14.8	10.7	28.8	69.6	42.0	47.7
Nevada	66.8	21.6	17.0	10.0	8.1	25.4	58.5	37.9	34.1
California	61.6	34.4	24.0	11.0	6.9	18.9	59.8	40.6	41.9
Mississippi	74.7	34.1	30.1	20.5	12.7	27.8	60.5	43.2	45.2
Arizona	64.3	18.9	20.9	13.0	11.3	27.8	63.3	36.2	41.9
New Mexico	59.4	36.8*	24.5	16.9	11.7	30.8	63.7	32.5	41.0
South Dakota	77.4	32.9	32.3	16.3	19.7	43.2	63.8	49.4	51.7
Texas	62.3	42.1	18.8	12.5	8.0	26.9	64.6	28.8	42.6
Oklahoma	69.1	35.1	27.1	16.2	13.2	32.6	64.7	47.1	49.3
Wyoming	67.6	34.6	40.3	18.2	24.5	52.2	65.0	47.7	48.7
Arkansas	75.5	28.4	28.8	19.5	11.0	30.0	65.3	46.8	45.7
Alabama	72.0	32.2	31.1	16.6	11.5	30.6	65.6	47.3	48.8
Hawaii	69.5	41.0	21.4	13.3	9.2	22.7	66.3	43.7	48.5
Virginia	72.4	34.4	26.2	13.9	9.9	27.1	66.4	43.9	51.4
Oregon	65.6	50.6	27.8	14.1	12.7	33.0	66.9	45.7	53.2
Georgia	72.5	33.1	27.0	16.8	8.9	26.5	67.0	48.5	49.2
Alaska	61.9	42.0	31.9	20.9	14.2	30.3	67.4	41.3	48.1
Montana	70.1	45.7	37.0	18.4	20.3	45.0	67.5	46.8	54.6
North Dakota	69.4	41.2	38.2	20.8	15.8	42.3	67.6	37.5	56.2
Illinois	76.1	36.5	31.1	15.4	8.5	23.1	68.3	42.4	50.4
Nebraska	69.5	32.0	35.4	17.3	13.3	32.4	68.5	50.1	52.9
Washington	63.4	46.4	31.5	13.7	15.6	28.1	68.9	45.0	51.0
Idaho	71.7	23.6	32.9	13.5	13.3	35.4	69.6	45.4	50.3
Wisconsin	71.8	43.9	29.9	17.1	16.5	37.0	69.6	46.6	55.0
Louisiana	74.5	24.2	22.4	12.8	12.2	37.0	69.8	39.7	47.3
Utah	65.3	40.3	22.8	12.6	13.7	36.2	69.9	55.7	54.4
District of Columbia	71.6	33.8	18.6	13.3	8.6	19.5	70.5	44.8	44.5
Minnesota	68.2	48.7	35.6	14.1	11.1	32.9	70.7	47.6	55.3
Rhode Island	78.2	45.7*	24.7	13.7	9.0	27.4	71.5	50.1	53.3
Missouri	72.4	21.6	34.3	18.2	12.8	32.0	71.7	48.5	50.4
Delaware	75.9	32.1	29.7	16.0	9.8	23.8	71.8	38.3	48.4
Indiana	73.4	19.2	32.5	18.0	16.9	35.5	72.2	41.0	47.4
North Carolina	75.9	39.5*	25.7	13.0	13.2	29.5	72.4	36.3	51.8
South Carolina	72.5	40.8	28.5	12.5	10.7	28.1	72.5	49.7	49.9
New York	75.9	28.7	24.1	15.5	8.0	26.9	72.8	39.6	48.5
Kansas	72.4	40.2	29.6	19.3	16.7	34.2	73.4	49.1	53.8
Tennessee	72.6	44.1*	27.7	13.8	10.4	29.1	73.7	49.3	51.2
Colorado	67.7	39.6	30.5	14.7	13.9	38.2	73.9	44.0	54.1
West Virginia	73.9	44.6*	33.9	21.5	13.7	34.2	74.7	43.3	50.0
Michigan	73.3	44.3*	28.1	17.1	11.9	32.8	74.9	43.4	51.4
Pennsylvania	71.3	31.4	31.1	19.3	14.0	29.0	75.1	45.6	48.8

Click on measure and state to access the interactive query and continue exploring!

State	NPM1	NPM6	NPM8.1	NPM8.2	NPM9	NPM9	NPM10	NPM11	NPM11	NPM12	NPM12	NPM13.2	NPM14.2	NPM15
	Well-woman visit^ (%)	Develop-mental screening (%)	Physical activity (ages 6-11) (%)	Physical activity (ages 12-17) (%)	Bullied others (%)	Bullied (%)	Preventive Medical Visit (%)	Medical home (CSHCN) (%)	Medical home (non-CSHCN) (%)	Transition to adult health care (CSHCN) (%)	Transition to adult health care (Non-CSHCN) (%)	Preventive dental visit (%)	Someone living in the household smokes (%)	Adequate and continuous insurance (%)
Nationwide	69.7	34.8	26.3	14.8	10.7	28.8	69.6	42.0	47.7	20.5	16.0	75.1	13.8	68.2
Alabama	72.0	32.2	31.1	16.6	11.5	30.6	65.6	47.3	48.8	22.5	11.9	74.3	18.7	75.4
Alaska	61.9	42.0	31.9	20.9	14.2	30.3	67.4	41.3	48.1	30.4*	19.1	75.2	15.8	[illegible]
Arizona	64.3	18.9	20.9	13.0	11.3	27.8	63.3	36.2	41.9	14.0	10.8	75.0	[illegible]	63.3
Arkansas	75.5	28.4	28.8	19.5	11.0	30.0	65.3	46.8	45.7	20.5	13.7	[illegible]	19.5	68.8
California	61.6	34.4	24.0	11.0	6.9	18.9	59.8	40.6	41.9	11.6	[illegible]	74.3	9.2	71.1
Colorado	67.7	39.6	30.5	14.7	13.9	38.2	73.9	44.0	54.1	[illegible]	24.4	82.0	12.1	64.8
Connecticut	75.0	36.8*	27.6	16.8	8.0	28.5	76.0	44.9	[illegible]	25.4	10.4	81.2	10.9	66.9
Delaware	75.9	32.1	29.7	16.0	9.8	23.8	[illegible]	[illegible]	48.4	14.4	13.9	77.3	12.5	68.8
District of Columbia	71.6	33.8	18.6	13.3	8.6	19.5	70.5	44.8	44.5	17.6	18.2	80.3	9.2	74.1
Florida	N/A**	20.1	20.8	15.2	9.9	31.8	75.1	32.6	41.9	16.3	13.9	69.5	13.1	66.0
Georgia	72.5	33.1	27.0	16.8	8.9	26.5	67.0	48.5	49.2	14.9	14.2	74.4	13.0	64.4
Hawaii	69.5	41.0	21.4	13.3	9.2	22.7	66.3	43.7	48.5	21.9	15.3	84.9	14.7	81.0
Idaho	71.7	23.6	32.9	13.5	13.3	35.4	69.6	45.4	50.3	23.2	23.4	81.9	11.5	66.0
Illinois	76.1	36.5	31.1	15.4	8.5	23.0	68.3	42.4	50.4	31.0	19.1	73.8	11.7	65.8
Indiana	73.4	19.2	32.5	18.0	16.9	35.5	72.2	41.0	47.4	20.8	19.8	74.8	19.7	64.5
Iowa	76.5	35.0	31.6	18.0	16.7	42.8	77.7	52.5	55.6	32.3	25.8	79.5	15.3	71.8
Kansas	72.4	40.2	29.6	19.3	16.7	34.2	73.4	49.1	53.8	26.3	18.4	77.5	12.6	66.4
Kentucky	73.0	25.9	32.7	14.8	17.2	37.3	75.5	42.1	52.8	26.4	21.7	73.7	22.6	71.8

NPM 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)

	District of Columbia	Nationwide
%	70.5	69.6
C.I.	(62.4 - 77.5)	(68.3 - 70.8)

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 (quick edit)
Topic: National Performance Measures
Question: NPM 10: Preventive medical visit, age 12-17 years

Edit Search Criteria

District of Columbia

Select a Subgroup

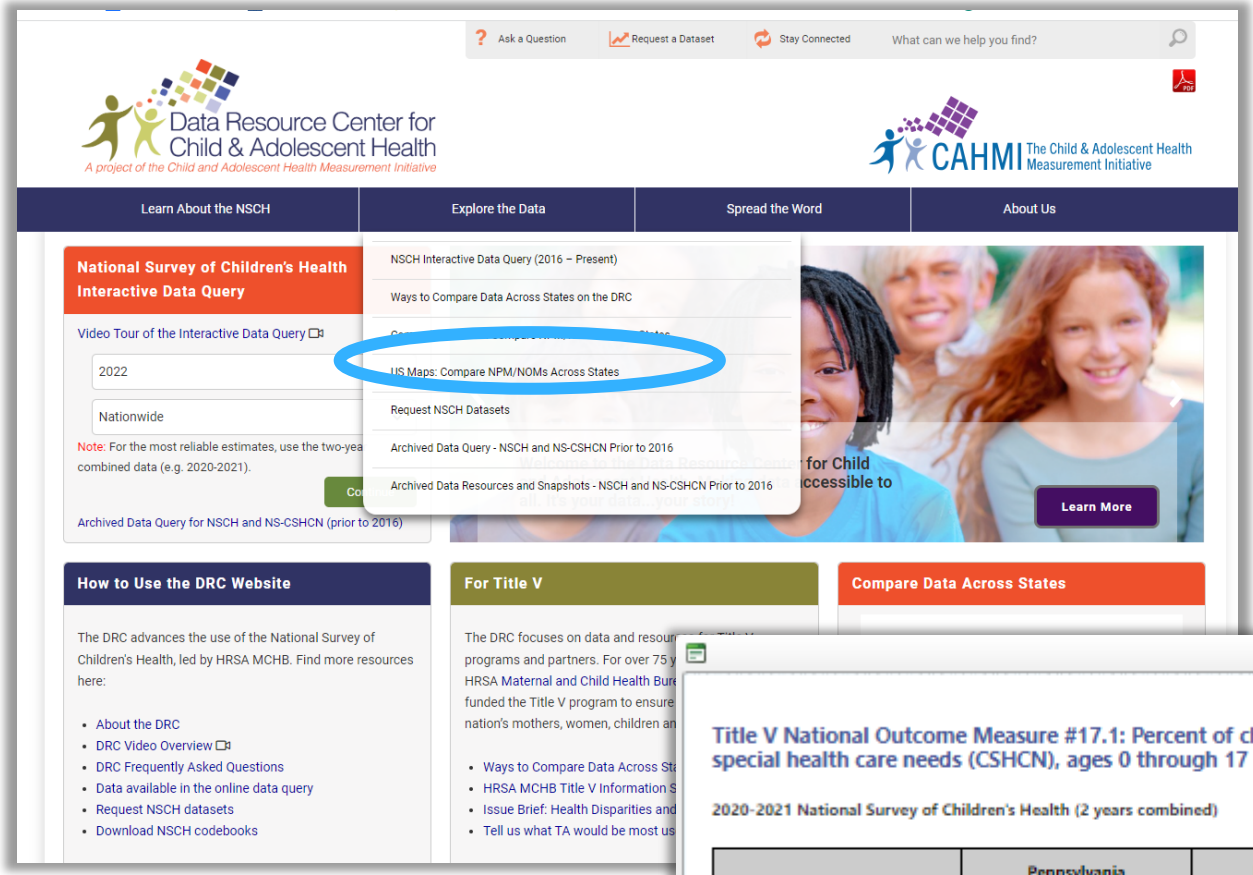
Change Question, Topic or Survey

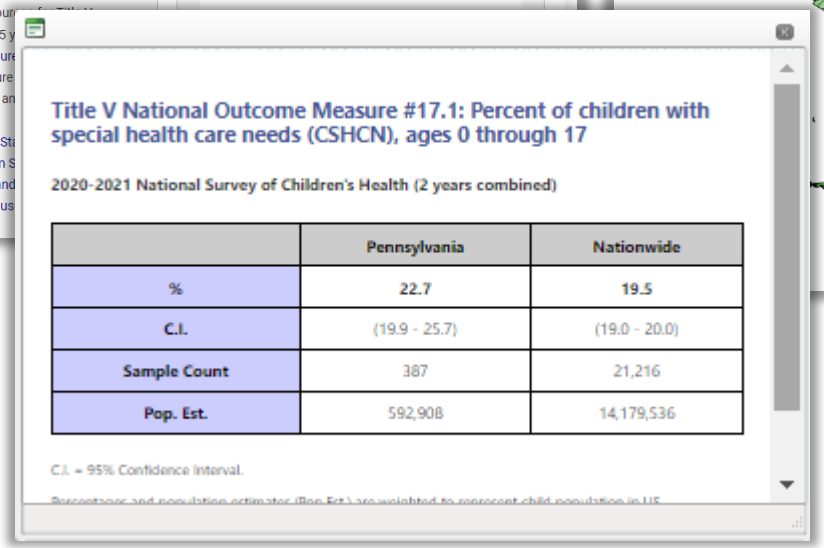
National Performance Measure 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

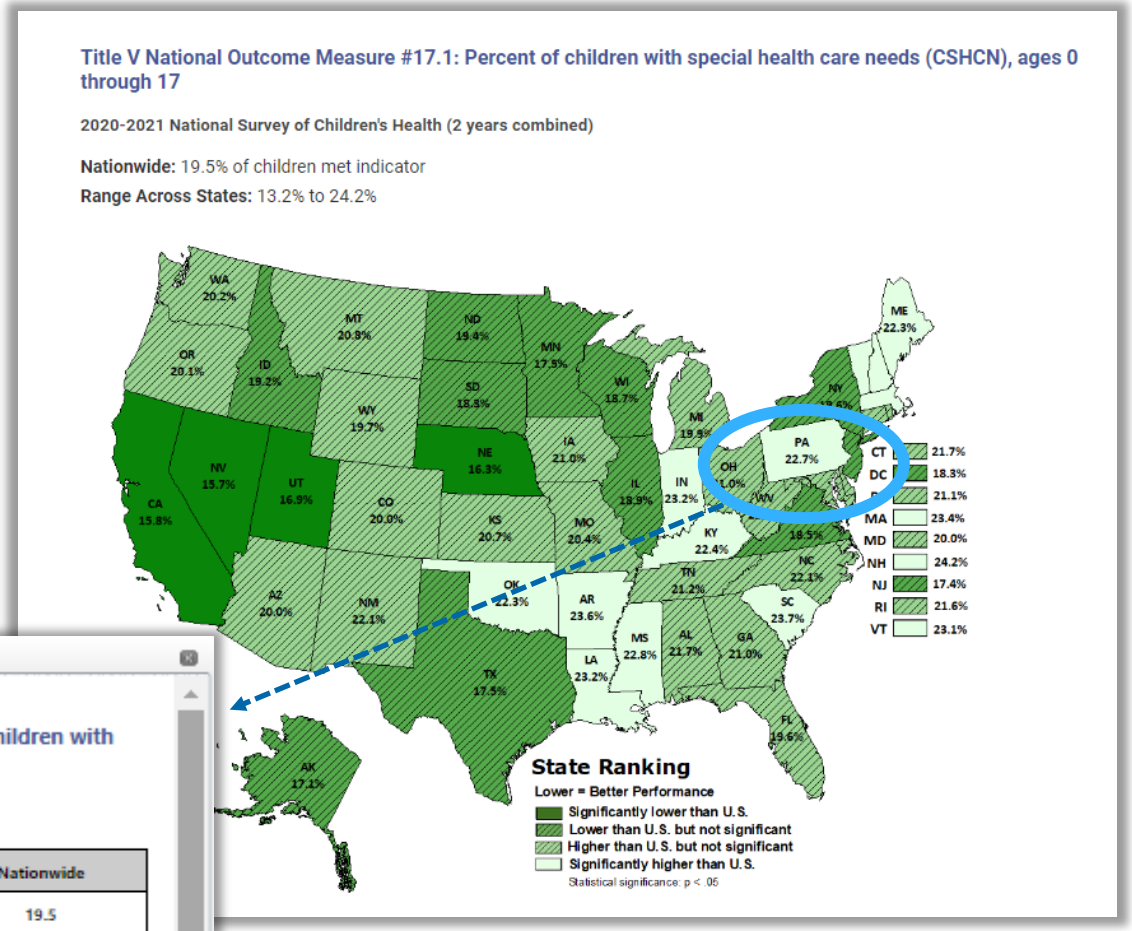
		1 or more preventive medical visits	No preventive medical visit	Total %
Nationwide	%	69.6	30.4	100.0
	C.I.	68.3 - 70.8	29.2 - 31.7	
	Sample Count	24,757	8,780	
	Pop. Est.	17,375,117	7,596,792	
District of Columbia	%	70.5	29.5	100.0
	C.I.	62.4 - 77.5	22.5 - 37.6	
	Sample Count	326	74	
	Pop. Est.	22,780	9,550	

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







CAHMI

Guidelines to Optimize Data for Local Areas Using Synthetic Estimate

www.childhealthdata.org

Your Data ... Your Story
Data Resource Center for Child & Adolescent Health
A project of the Child and Adolescent Health Measurement Initiative

Your State Data... Your Local Story

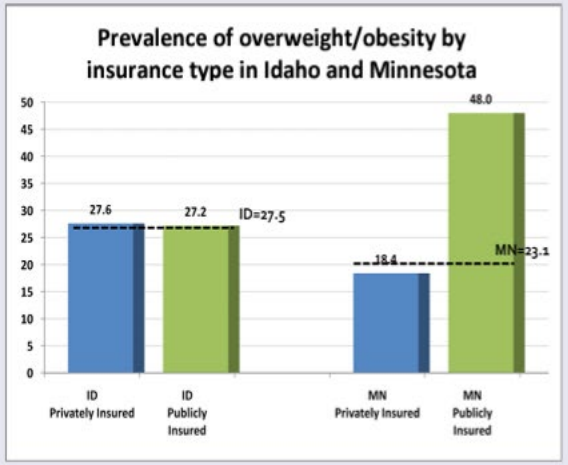
Local Uses of National and State Data

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.



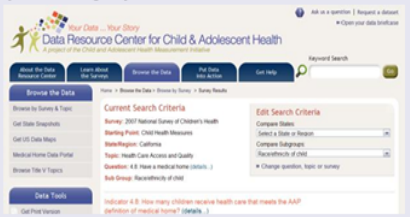
The graph to the left is an example of when summary measures do not tell the whole story. In Idaho, the state overweight/obesity prevalence is quite similar to that for both privately and publicly insured children within the state. However, in Minnesota that is not the case. While Minnesota has a lower 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.

Race/Ethnicity Category	Distribution in Marin County
Latino/Hispanic	16,241
White	31,583
Black	1,269
Multiracial	2,570
Other	1,968
Total	53,631

We got the 2007 race distribution in Marin County directly from KidsData.org (California only).

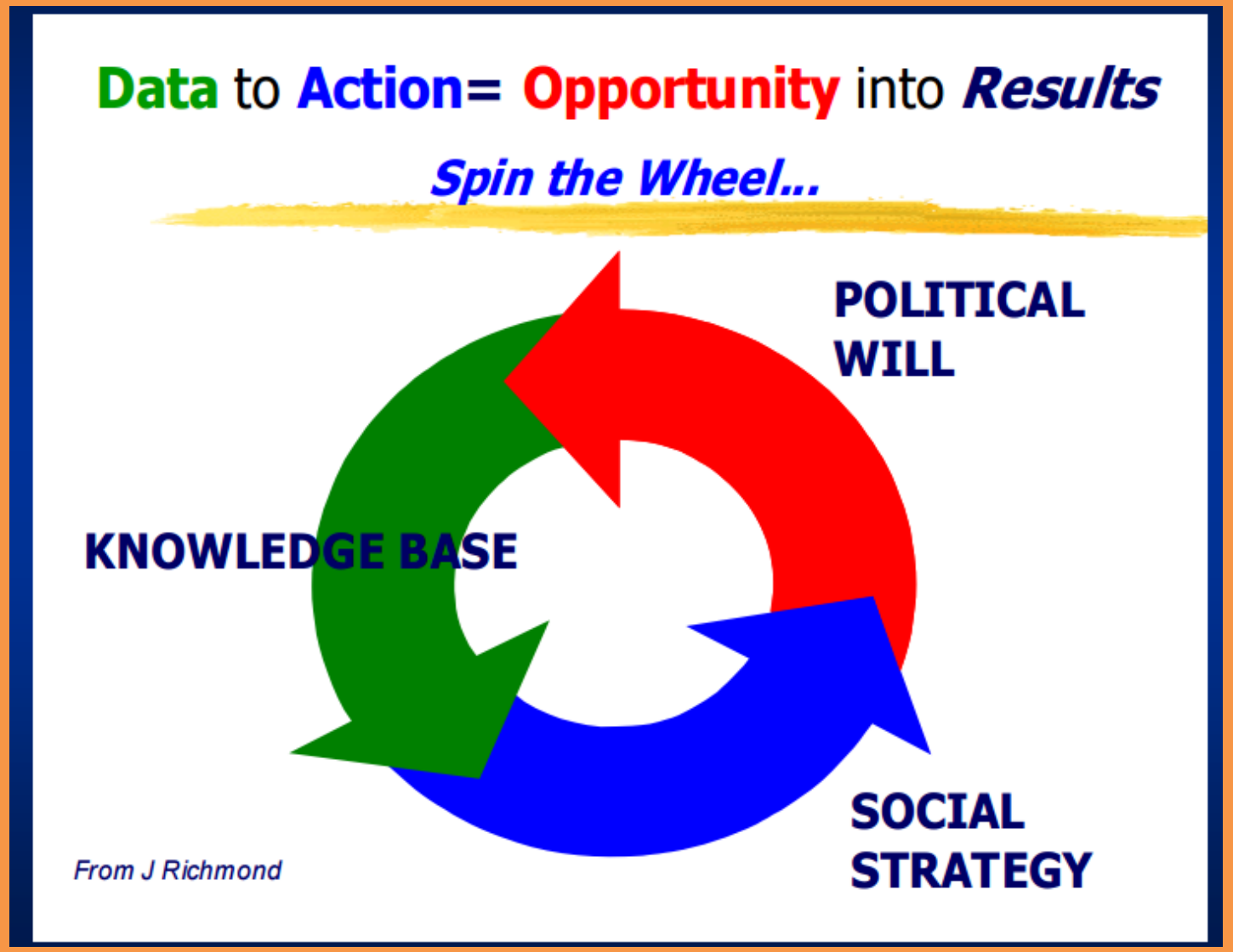
Note that we combined the Native American and Asian/Pacific Islander groups from the KidsData website into an "other" category to match categories in the 2007 NSCH. *It is important to make sure the groupings in your two data sources match!* You can also access county-level information from places such as: www.KidsCount.org, www.census.gov and your state department of finance.

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

Race/Ethnicity Category	Distribution in Marin County	% with medical home by race in CA	# with medical home by race in Marin County
Latino/Hispanic	16,241	37.6%	16,241*0.376= 6,107
White	31,583	65.7%	20,750
Black	1,269	42.2%	536
Multiracial	2,570	71.0%	1,825
Other	1,968	50.6%	996
Total	**53,631**		**30,214**

Transformational Change and the Creative and Effective Use of Data



-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

CAHMI
The Child & Adolescent Health Measurement Initiative

A project of CAHMI
Data Resource Center for Child & Adolescent Health

Health Disparities and Health Equity: Maximizing the Power of the National Survey of Children's Health to Promote Social Justice Among the Nation's Children

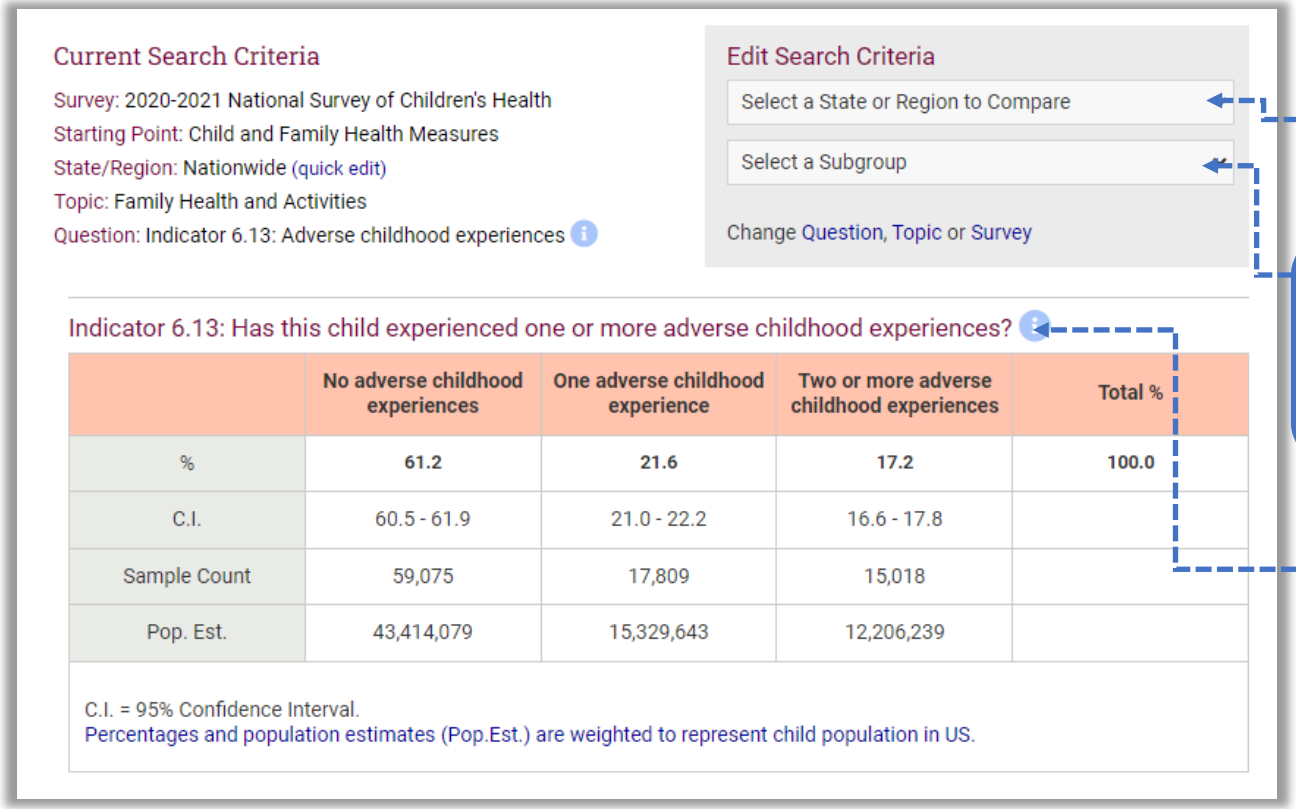
Health equity and health disparities are two important, intertwined terms in health care delivery in the United States. Health equity refers to social justice in health—equal access to care for all persons, disadvantaged or not, and the right to be healthy. Health disparities are one metric by which we can measure progress toward achieving health equity.[1]

The National Survey of Children's Health (NSCH) is an excellent source of information on health-related disparities among the nation's children. The survey annually includes information on children's race and ethnicity along with other variables related to disadvantage in the United States: education level, income level, neighborhood safety and amenities, and experiences of trauma.

The Child and Adolescent Health Measurement Initiative's Data Resource Center for Child and Adolescent Health has partnered with Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB) since 2003 to provide the public with quick access to NSCH data findings, including the ability to assess health disparities. These data provide an excellent jumping-off point for addressing health equity in your state.

Visit www.childhealthdata.org to get data on children in your state.

Resources:
Introduction to the Data Resource Center for Child & Adolescent Health
How to use the interactive data query
Ask a question
Request a dataset



Select State or Region

Select Subgroup: Race/ethnicity of child

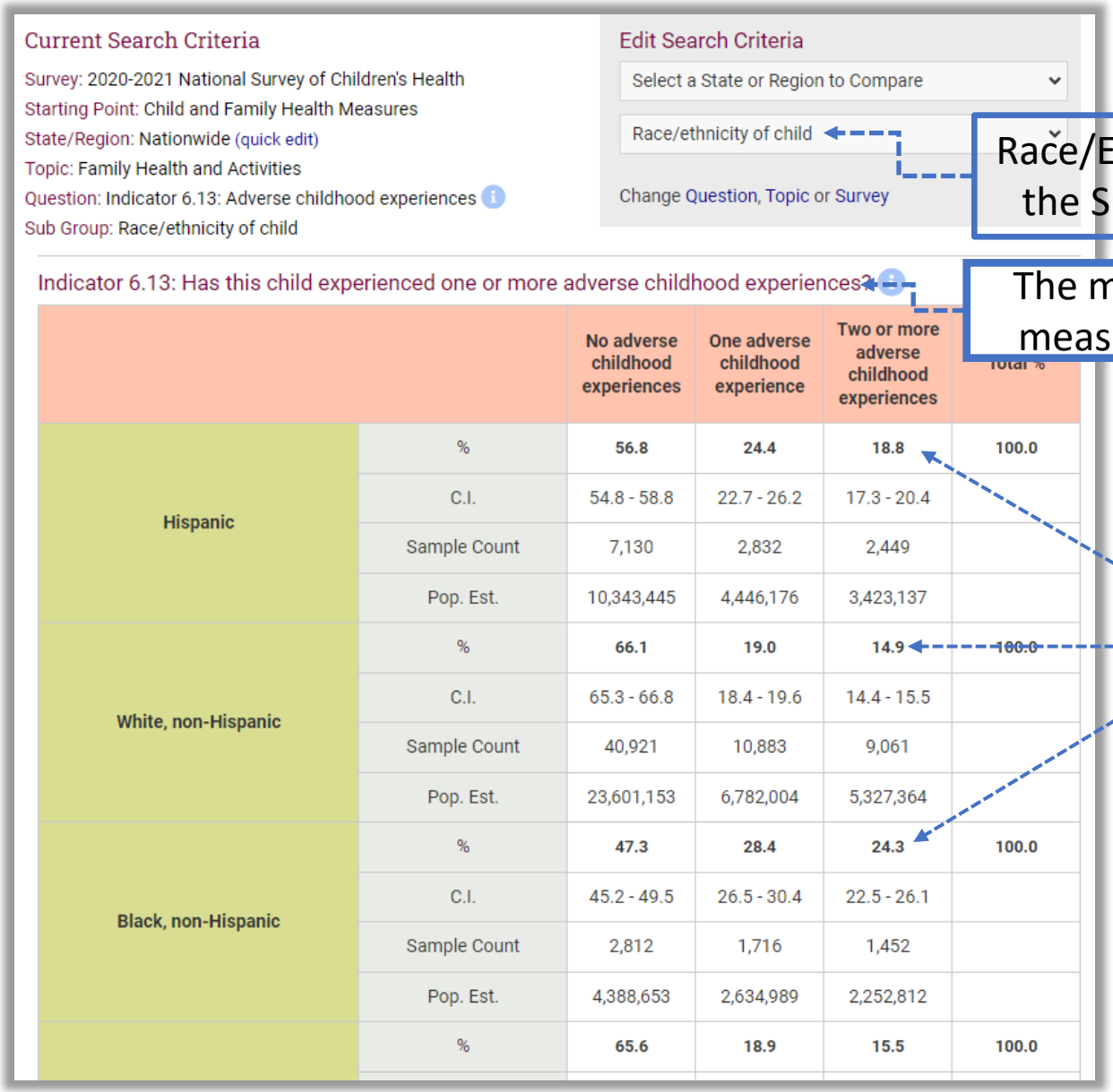
Click to learn more

https://www.childhealthdata.org/docs/default-source/nsch-docs/health-disparities-and-health-equity_11-5-21.pdf

CAHMI

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

Subgroup Comparison Nationwide



Current Search Criteria

Survey: 2020-2021 National Survey of Children's Health
Starting Point: Child and Family Health Measures
State/Region: Nationwide (quick edit)
Topic: Family Health and Activities
Question: Indicator 6.13: Adverse childhood experiences
Sub Group: Race/ethnicity of child

Edit Search Criteria

Select a State or Region to Compare

Race/ethnicity of child

Change Question, Topic or Survey

Indicator 6.13: Has this child experienced one or more adverse childhood experiences?

		No adverse childhood experiences	One adverse childhood experience	Two or more adverse childhood experiences	Total %
Hispanic	%	**56.8**	**24.4**	**18.8**	**100.0**
	C.I.	54.8 - 58.8	22.7 - 26.2	17.3 - 20.4	
	Sample Count	7,130	2,832	2,449	
	Pop. Est.	10,343,445	4,446,176	3,423,137	
White, non-Hispanic	%	**66.1**	**19.0**	**14.9**	**100.0**
	C.I.	65.3 - 66.8	18.4 - 19.6	14.4 - 15.5	
	Sample Count	40,921	10,883	9,061	
	Pop. Est.	23,601,153	6,782,004	5,327,364	
Black, non-Hispanic	%	**47.3**	**28.4**	**24.3**	**100.0**
	C.I.	45.2 - 49.5	26.5 - 30.4	22.5 - 26.1	
	Sample Count	2,812	1,716	1,452	
	Pop. Est.	4,388,653	2,634,989	2,252,812	
	%	**65.6**	**18.9**	**15.5**	**100.0**

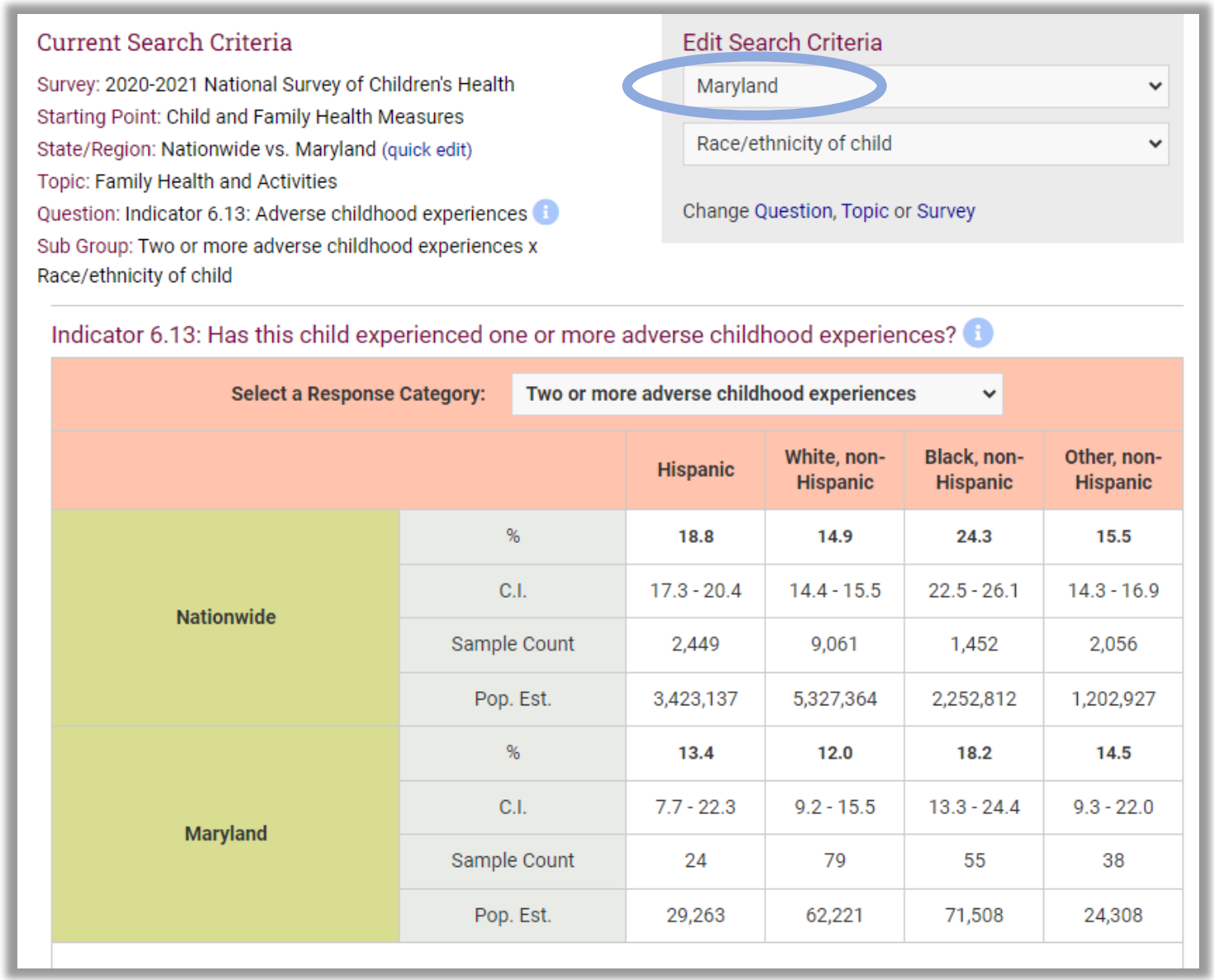
Race/Ethnicity is the Subgroup

The main measure

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?

How to Use DRC to Address Health Equity



Current Search Criteria

Survey: 2020-2021 National Survey of Children's Health
Starting Point: Child and Family Health Measures
State/Region: Nationwide vs. Maryland (quick edit)
Topic: Family Health and Activities
Question: Indicator 6.13: Adverse childhood experiences
Sub Group: Two or more adverse childhood experiences x Race/ethnicity of child

Edit Search Criteria

Maryland

Race/ethnicity of child

Change Question, Topic or Survey

Indicator 6.13: Has this child experienced one or more adverse childhood experiences?

Select a Response Category: Two or more adverse childhood experiences

		Hispanic	White, non-Hispanic	Black, non-Hispanic	Other, non-Hispanic
Nationwide	%	**18.8**	**14.9**	**24.3**	**15.5**
	C.I.	17.3 - 20.4	14.4 - 15.5	22.5 - 26.1	14.3 - 16.9
	Sample Count	2,449	9,061	1,452	2,056
	Pop. Est.	3,423,137	5,327,364	2,252,812	1,202,927
Maryland	%	**13.4**	**12.0**	**18.2**	**14.5**
	C.I.	7.7 - 22.3	9.2 - 15.5	13.3 - 24.4	9.3 - 22.0
	Sample Count	24	79	55	38
	Pop. Est.	29,263	62,221	71,508	24,308

Subgroup Comparison in Your State

Compare your state with the national average

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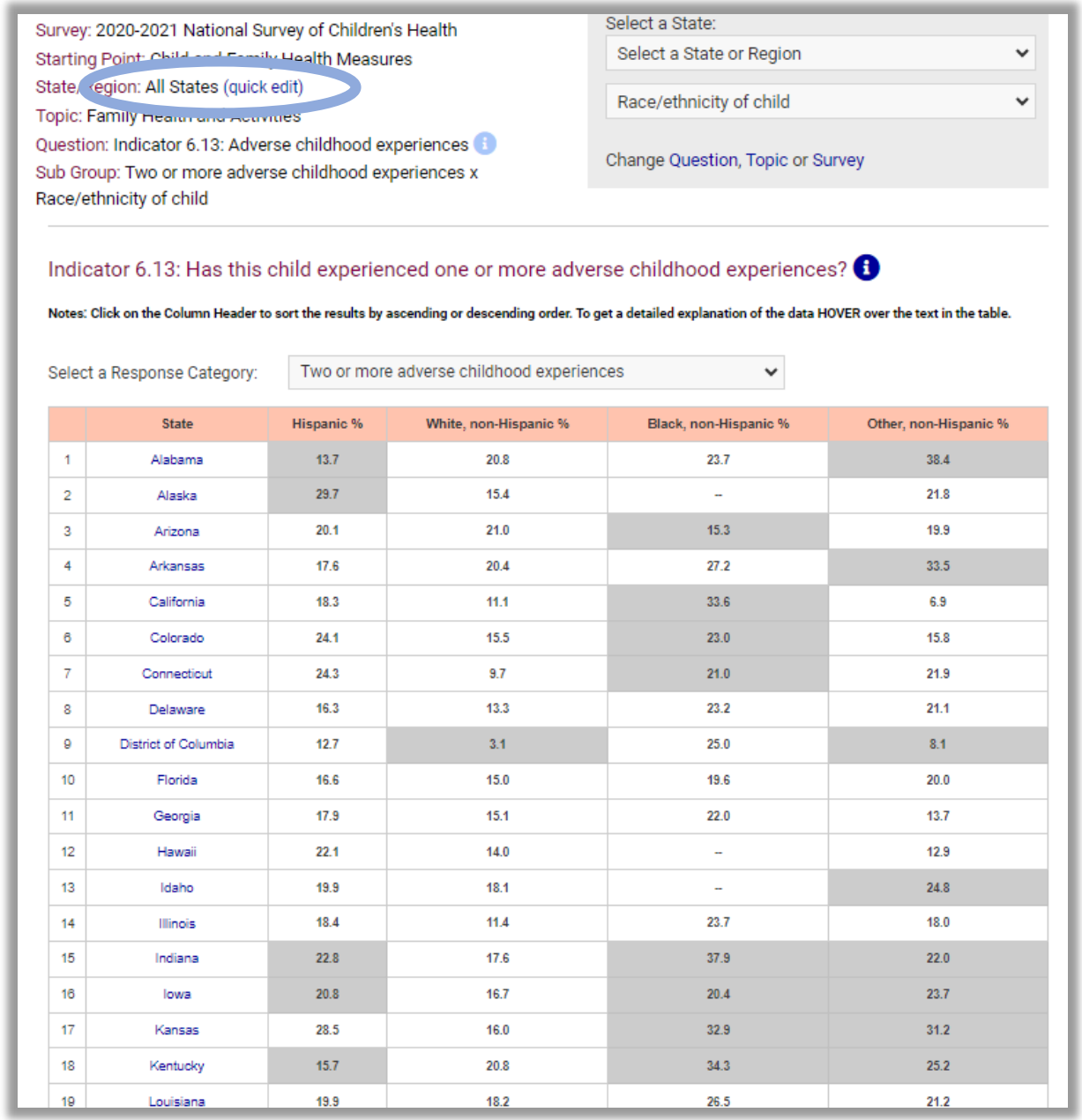


Survey: 2020-2021 National Survey of Children's Health
Starting Point: Child and Family Health Measures
State/Region: All States (quick edit)
Topic: Family Health and Activities
Question: Indicator 6.13: Adverse childhood experiences
Sub Group: Two or more adverse childhood experiences x Race/ethnicity of child

Select a State:
Select a State or Region
Race/ethnicity of child
Change Question, Topic or Survey

Indicator 6.13: Has this child experienced one or more adverse childhood experiences?

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.

Select a Response Category: Two or more adverse childhood experiences

	State	Hispanic %	White, non-Hispanic %	Black, non-Hispanic %	Other, non-Hispanic %
1	Alabama	13.7	20.8	23.7	38.4
2	Alaska	29.7	15.4	--	21.8
3	Arizona	20.1	21.0	15.3	19.9
4	Arkansas	17.6	20.4	27.2	33.5
5	California	18.3	11.1	33.6	6.9
6	Colorado	24.1	15.5	23.0	15.8
7	Connecticut	24.3	9.7	21.0	21.9
8	Delaware	16.3	13.3	23.2	21.1
9	District of Columbia	12.7	3.1	25.0	8.1
10	Florida	16.6	15.0	19.6	20.0
11	Georgia	17.9	15.1	22.0	13.7
12	Hawaii	22.1	14.0	--	12.9
13	Idaho	19.9	18.1	--	24.8
14	Illinois	18.4	11.4	23.7	18.0
15	Indiana	22.8	17.6	37.9	22.0
16	Iowa	20.8	16.7	20.4	23.7
17	Kansas	28.5	16.0	32.9	31.2
18	Kentucky	15.7	20.8	34.3	25.2
19	Louisiana	19.9	18.2	26.5	21.2

Subgroup Comparison with Other States (Across States)

This Reports:

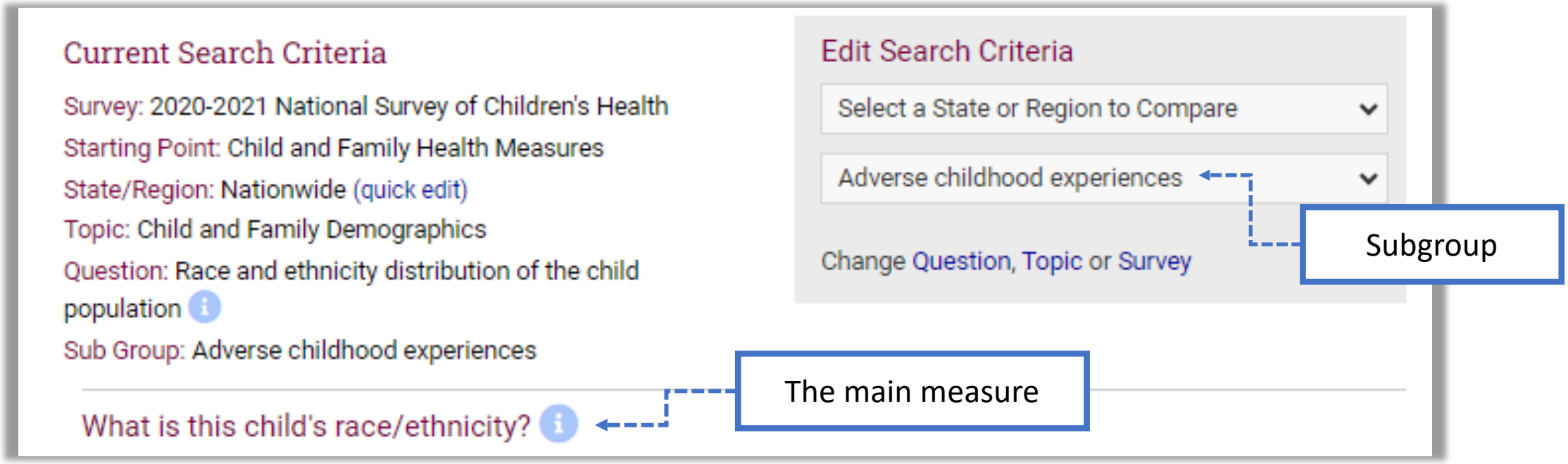
Does the prevalence of 2+ ACEs across race/ethnicity groups vary across states?

Example Question: Are there states with lower inequities in ACEs than others?

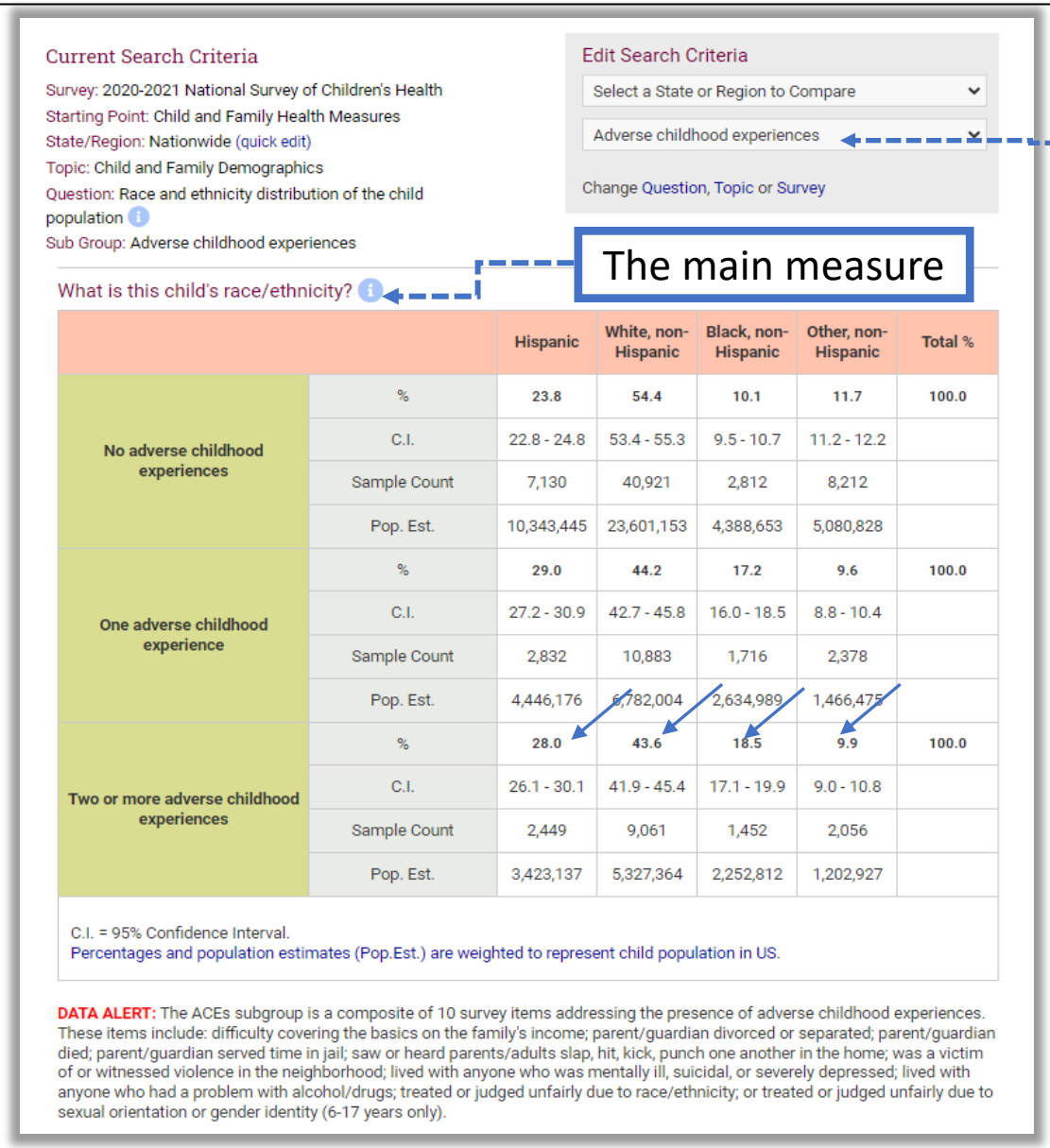
CAHMI

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.



Current Search Criteria

Survey: 2020-2021 National Survey of Children's Health
Starting Point: Child and Family Health Measures
State/Region: Nationwide (quick edit)
Topic: Child and Family Demographics
Question: Race and ethnicity distribution of the child population
Sub Group: Adverse childhood experiences

Edit Search Criteria

Select a State or Region to Compare

Adverse childhood experiences

Change Question, Topic or Survey

What is this child's race/ethnicity?

		Hispanic	White, non-Hispanic	Black, non-Hispanic	Other, non-Hispanic	Total %
No adverse childhood experiences	%	23.8	54.4	10.1	11.7	100.0
	C.I.	22.8 - 24.8	53.4 - 55.3	9.5 - 10.7	11.2 - 12.2	
	Sample Count	7,130	40,921	2,812	8,212	
	Pop. Est.	10,343,445	23,601,153	4,388,653	5,080,828	
One adverse childhood experience	%	29.0	44.2	17.2	9.6	100.0
	C.I.	27.2 - 30.9	42.7 - 45.8	16.0 - 18.5	8.8 - 10.4	
	Sample Count	2,832	10,883	1,716	2,378	
	Pop. Est.	4,446,176	6,782,004	2,634,989	1,466,475	
Two or more adverse childhood experiences	%	28.0	43.6	18.5	9.9	100.0
	C.I.	26.1 - 30.1	41.9 - 45.4	17.1 - 19.9	9.0 - 10.8	
	Sample Count	2,449	9,061	1,452	2,056	
	Pop. Est.	3,423,137	5,327,364	2,252,812	1,202,927	

C.I. = 95% Confidence Interval.
Percentages and population estimates (Pop.Est.) are weighted to represent child population in US.

DATA ALERT: The ACEs subgroup is a composite of 10 survey items addressing the presence of adverse childhood experiences. These items include: difficulty covering the basics on the family's income; parent/guardian divorced or separated; parent/guardian died; parent/guardian served time in jail; saw or heard parents/adults slap, hit, kick, punch one another in the home; was a victim of or witnessed violence in the neighborhood; lived with anyone who was mentally ill, suicidal, or severely depressed; lived with anyone who had a problem with alcohol/drugs; treated or judged unfairly due to race/ethnicity; or treated or judged unfairly due to sexual orientation or gender identity (6-17 years only).

ACEs is the Subgroup

The main measure

This reports:
The proportion of all children meeting criteria for an indictor 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

CAHMI

Ask Us A Question (info@cahmi.org)

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

Data Resource Center for Child & Adolescent Health

A project of the Child and Adolescent Health Measurement Initiative

CAHMI

The Child & Adolescent Health Measurement Initiative

SCAN ME

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

SCAN ME

DRC Quick Links to get started:

Data Resource Center Home Page	**Home (childhealthdata.org)**
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!

SCAN ME

Contact Us

Email us at: info@cahmi.org

Visit “Ask a Question” page on the DRC

CAHMI
The Child & Adolescent Health Measurement Initiative

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!

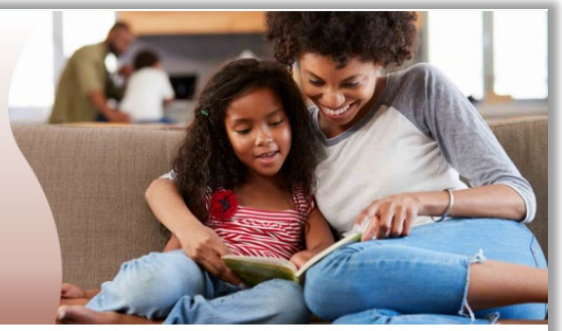
Measure Set | Data Source Category | Reset Filters

Topic Level 1 | Topic Level 2 | Topic Level 3

Filter By Keyword: To filter by additional keywords, type your keyword(s) below

10 items per page — 1 - 10 of 1192 items

Measure Set	Measure Title	Data Source Category	Level 1	Level 2	Level 3
Title V	NOM 1. Percent of pregnant women who receive prenatal care beginning in the first trimester	Vital Statistics	Access to and quality of health and related services	Health service utilization	Pregnancy, birth, and sexual health services
Title V	NOM 10. Percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	State-based Surveys	Health status, well-being, and health conditions across the life course	Health protective and risk behaviors	Pregnancy and perinatal behaviors
Title V	NOM 11. Rate of infants born with neonatal abstinence syndrome per 1000 birth hospitalizations	Records Analysis	Health status, well-being, and health conditions across the life course	Condition prevalence and health status	Pregnancy, perinatal, birth and sexual health conditions
Title V	NOM 14. Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	National Surveys	Health status, well-being, and health conditions across the life course	Condition prevalence and health status	Oral health conditions



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 13 weeks' gestation) in the calendar year

Denominator Statement: Number of live births

Measure Set: Title V

Data Source: National Vital Statistics System (NVSS)

Target Population: Women

Categories: Access to and quality of health and related services, Health service utilization, Pregnancy, birth, and sexual health services

Additional Information: https://mchb.tvisdata.hrsa.gov/PrioritiesAndMeasures/NationalOutcomeMeasures

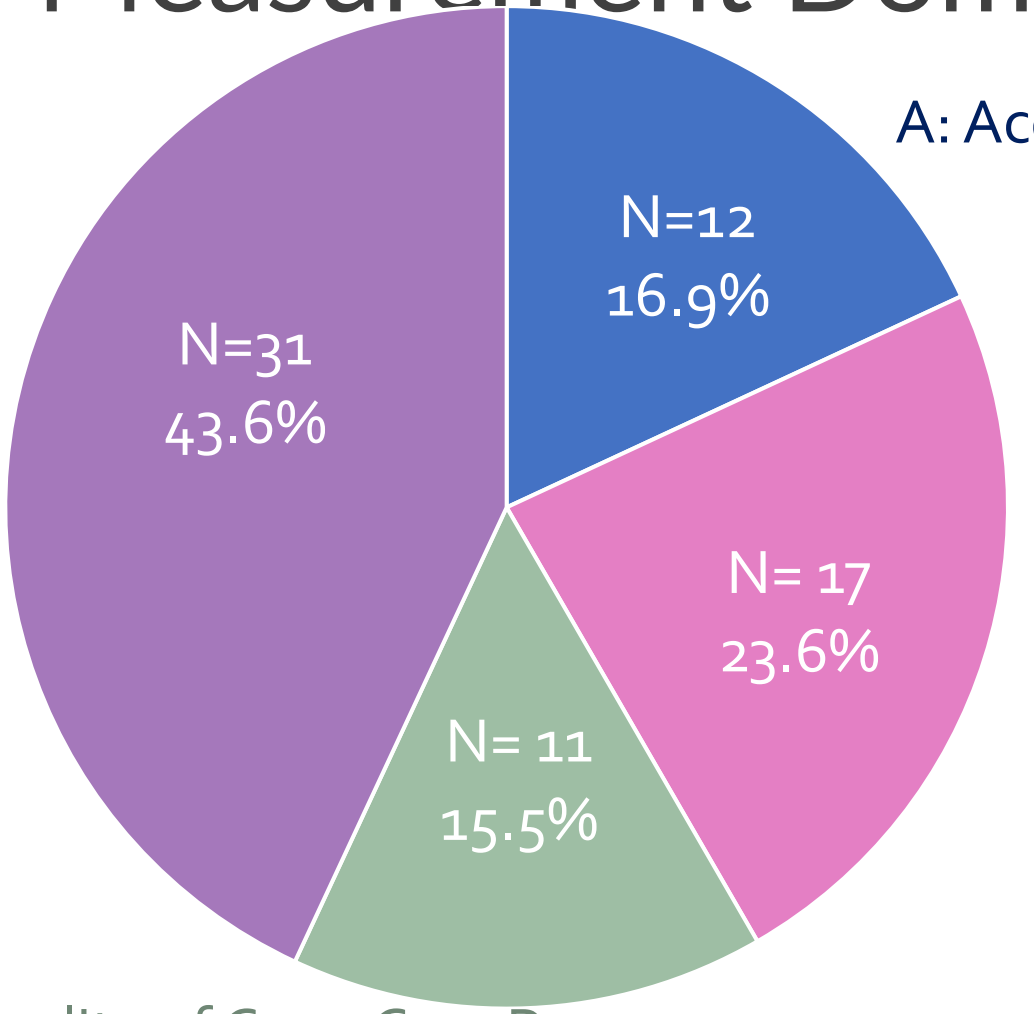
Keywords: Maternal child health

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

B: Quality of Care: Screening, Referral, and Follow Up

C: Quality of Care: Care Processes, Education, and Counseling

D: Health and Intermediate Outcomes

Bethell, C. 4.13.2023

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

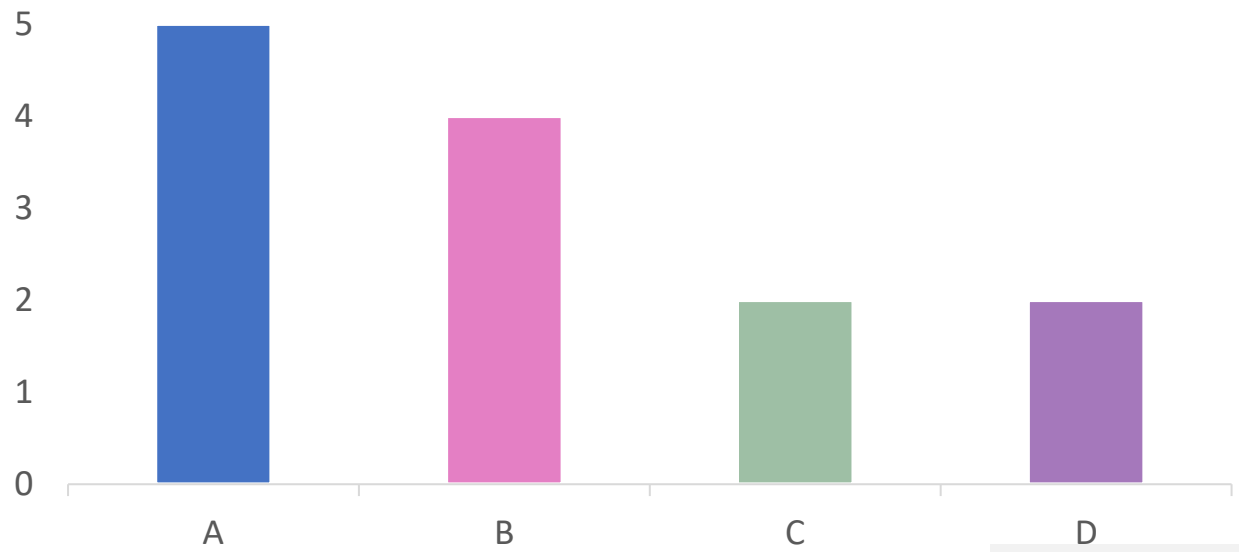
13 Topical Areas Shared Across 3+ MCH Programs
(out of 71 topical areas and 309 measures)

5 agencies involved:

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

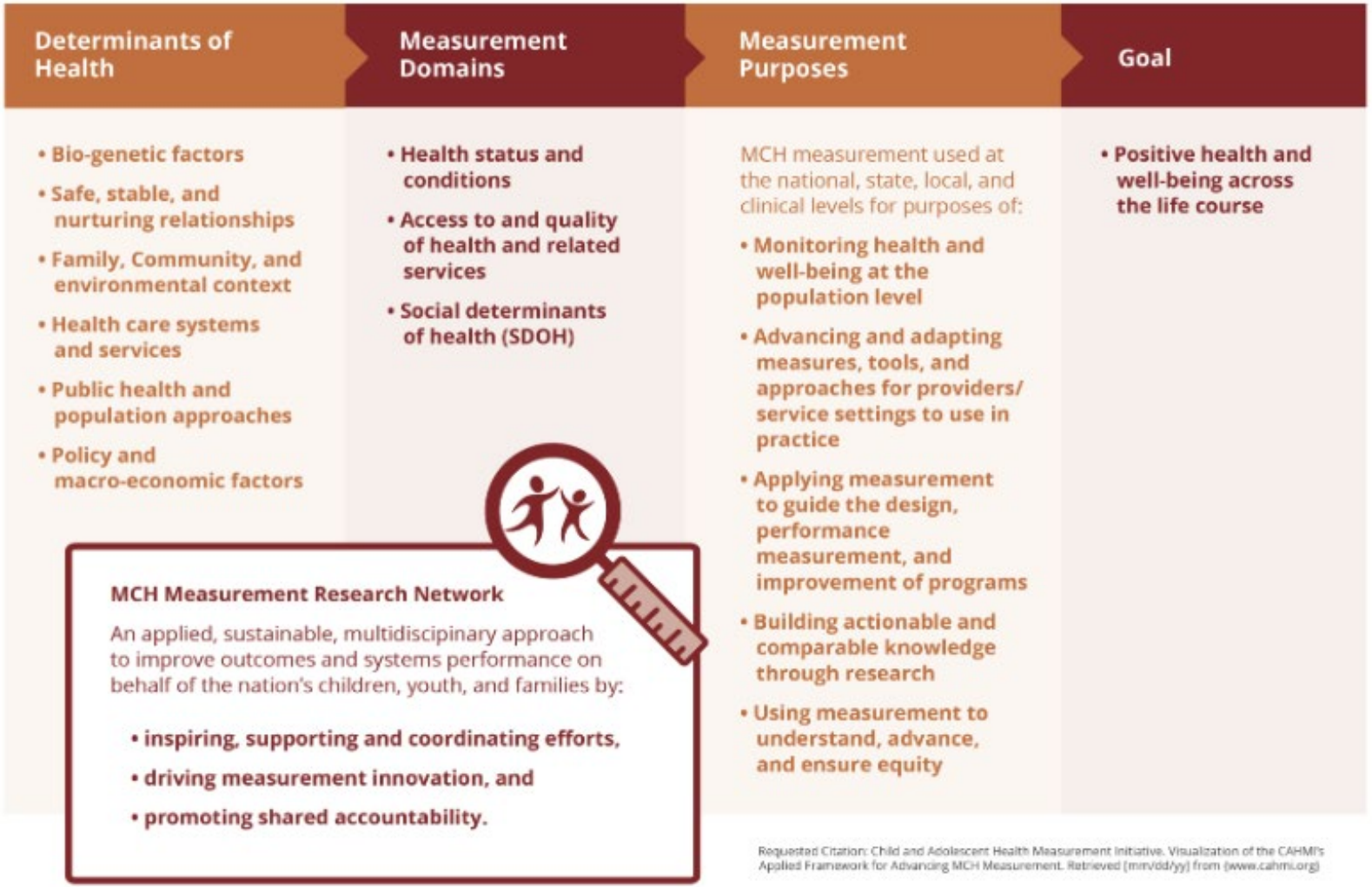
Note: In 2024 Medicaid/CHIP, MIIECHV, Title V and CHCs/FQHCs will be required to report on Development Screening rates

Depression Screening and Prenatal/Postpartum Care are aligned across all five



Bethell, C. 4.13.2023

Visualization of the CAHMI's Applied Framework for Advancing MCH Measurement



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:

EnAct! Framework— ONE Big Doable Thing!

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

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

Bethell, C. 2023

Bethell C, Gombojav, N. (August 2023) Early Childhood Developmental Health Systems Evidence to Impact Center State Sites N al Survey of Children's Health Early Childhood Data Summary. Child and Adolescent Health Measurement Initiative, Johns Hopkins University, Baltimore, Maryland.

Only 2 in 5 Are ready for school

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

Bethell, C. 4.13.2023

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

Sources: Bethell C, Reuland CH, Halfon N, Schor EL. Measuring the quality of preventive and developmental services for young children: national estimates and patterns of clinicians' performance. Pediatrics. 2004 Jun;113(6 Suppl):1973-83. PMID: 15173469; Hirai AH, Kogan MD, Kandasamy V, Reuland C, Bethell C. Prevalence and Variation of Developmental Screening and Surveillance in Early Childhood. *JAMA Pediatr.* 2018;172(9):857–866. Medical Home/ MH Service Data: Child and Adolescent Health Measurement Initiative, Data Resource Center, Accessed 3/27/22 at www.childhealthdata.org

Why are well visits important?

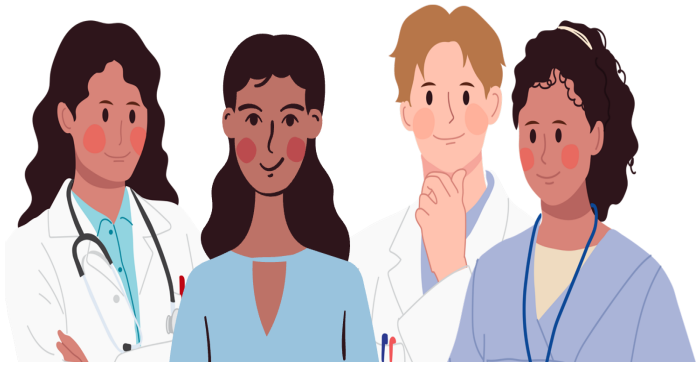
Well visits are an opportunity for families and health providers to connect and celebrate what's going well, meet family needs, and address child health concerns. These visits allow for age-specific:

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

Bright Futures Guidelines recommend **15 well visits** in the first **six years** of life.

One Big Doable Thing: Equitable access to high-quality well-child care services for all young children and families-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.

☐ 1wk ☐ 1m ☐ 2m ☐ 4m ☐ 6m ☐ 9m ☐ 12m ☐ 15m ☐ 18m



☐ 2y ☐ 30m ☐ 3y ☐ 4y

☐ 5y ☐ 6y

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?

General health information

e.g. special needs, insurance, family health history, etc.

Context and environmental assessments

(e.g., lead, fluoride, etc.)

Overall goals and concerns

Developmental surveillance and screening - SWYC

Autism screening - M-CHAT-RTM

Concerns about speaking, vision, hearing

Caregiver depression - PHQ-2 & EPDS

Healthy relationships and social determinants (IPV/WAST-Short; ACEs/PEARLS, SEEK; economic hardship)

Caregiver anticipatory guidance and education priorities

Parent/caregiver emotional support, coping and self-care

Household smoking and substance use

Other options:

- Child social and emotional development
- Family resilience
- Child flourishing
- + More

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

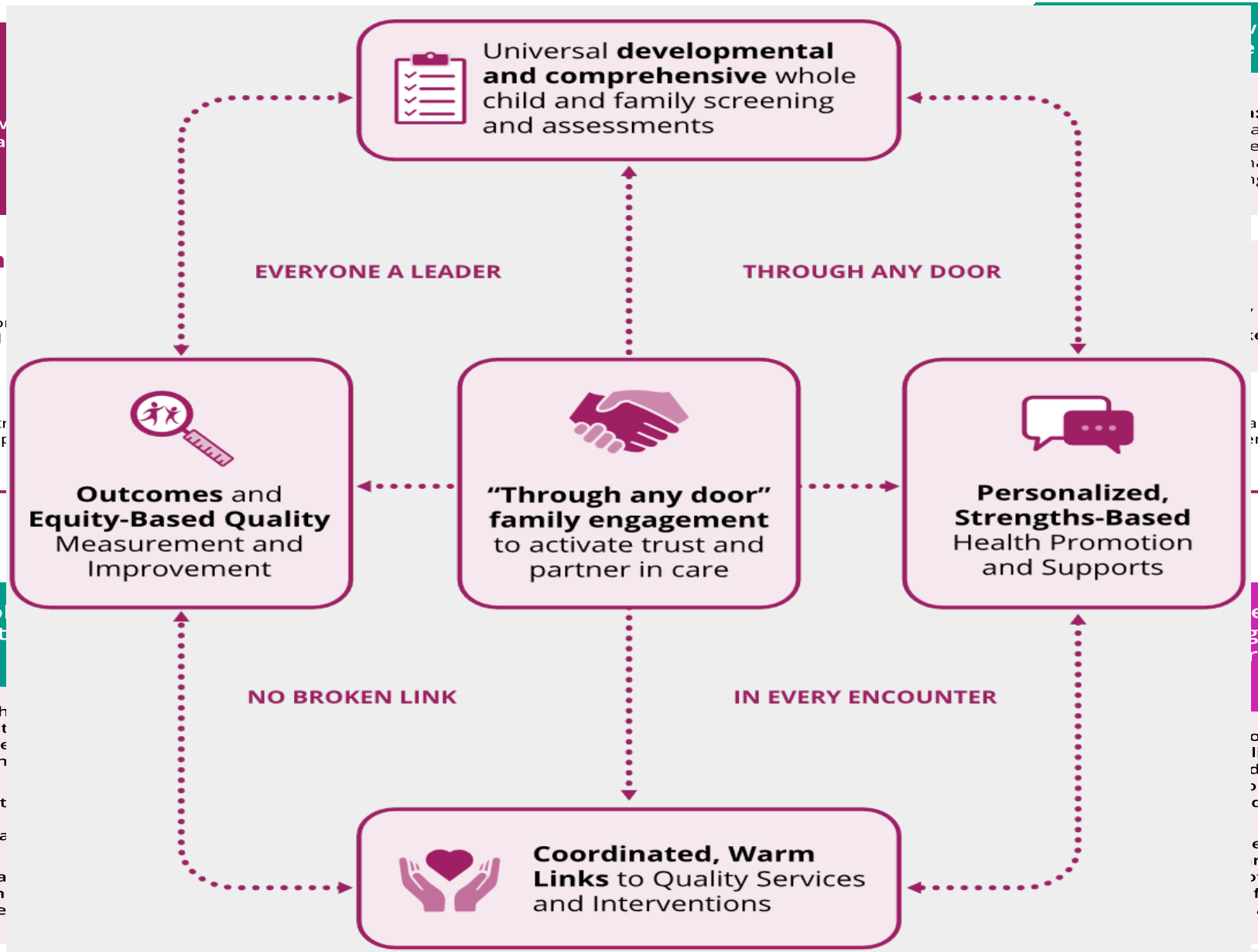
Framework Purpose: Positive Health Equity

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

Key Elements of th

1. "Through any doo
to activate trust and

3. Personalized, Str
Promotion and Sup



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

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Source: Child and Adolescent Health Measuremer

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and improvement

ethell, C. 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.

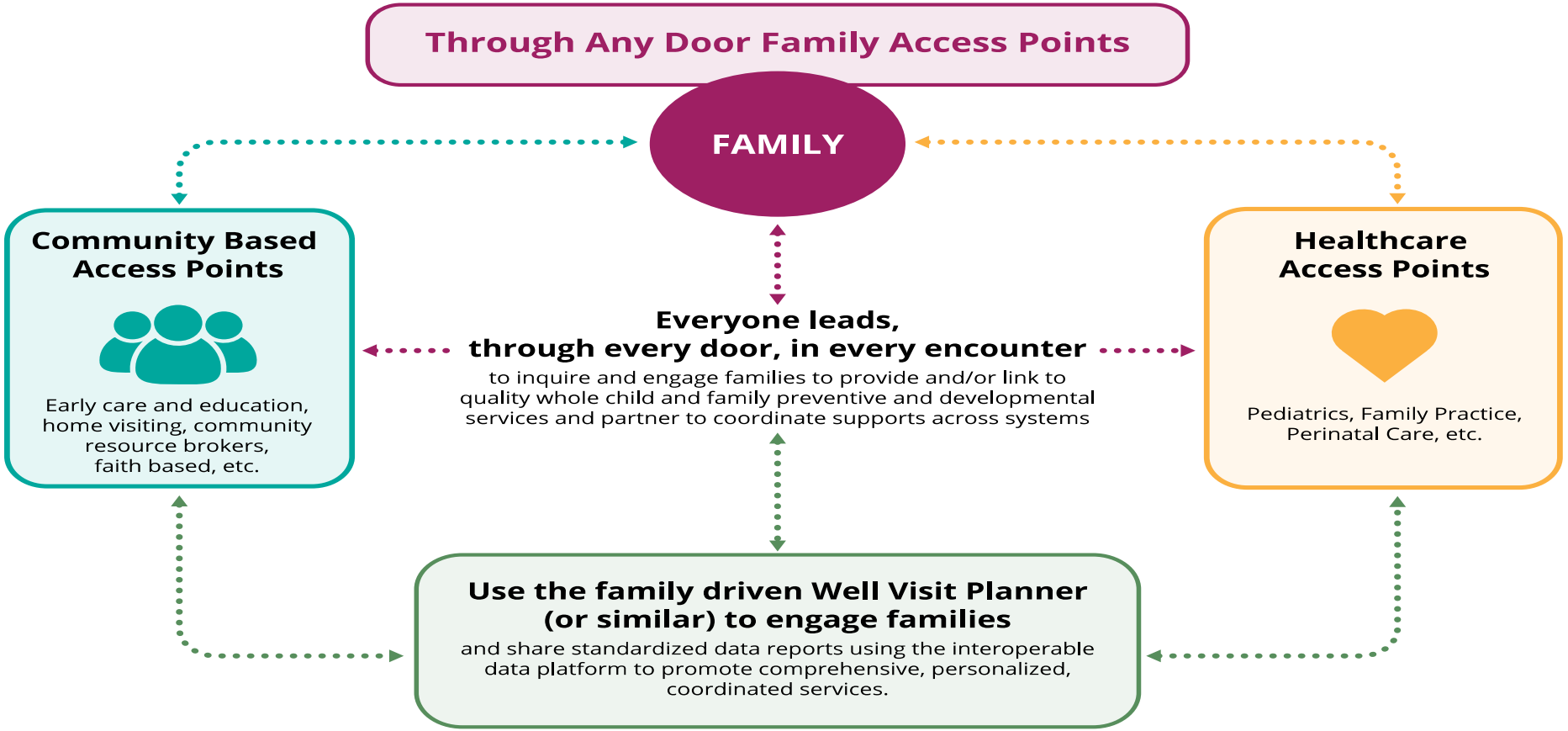
Framework Goals:

EnAct! Framework—
ONE Big Doable Thing!

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

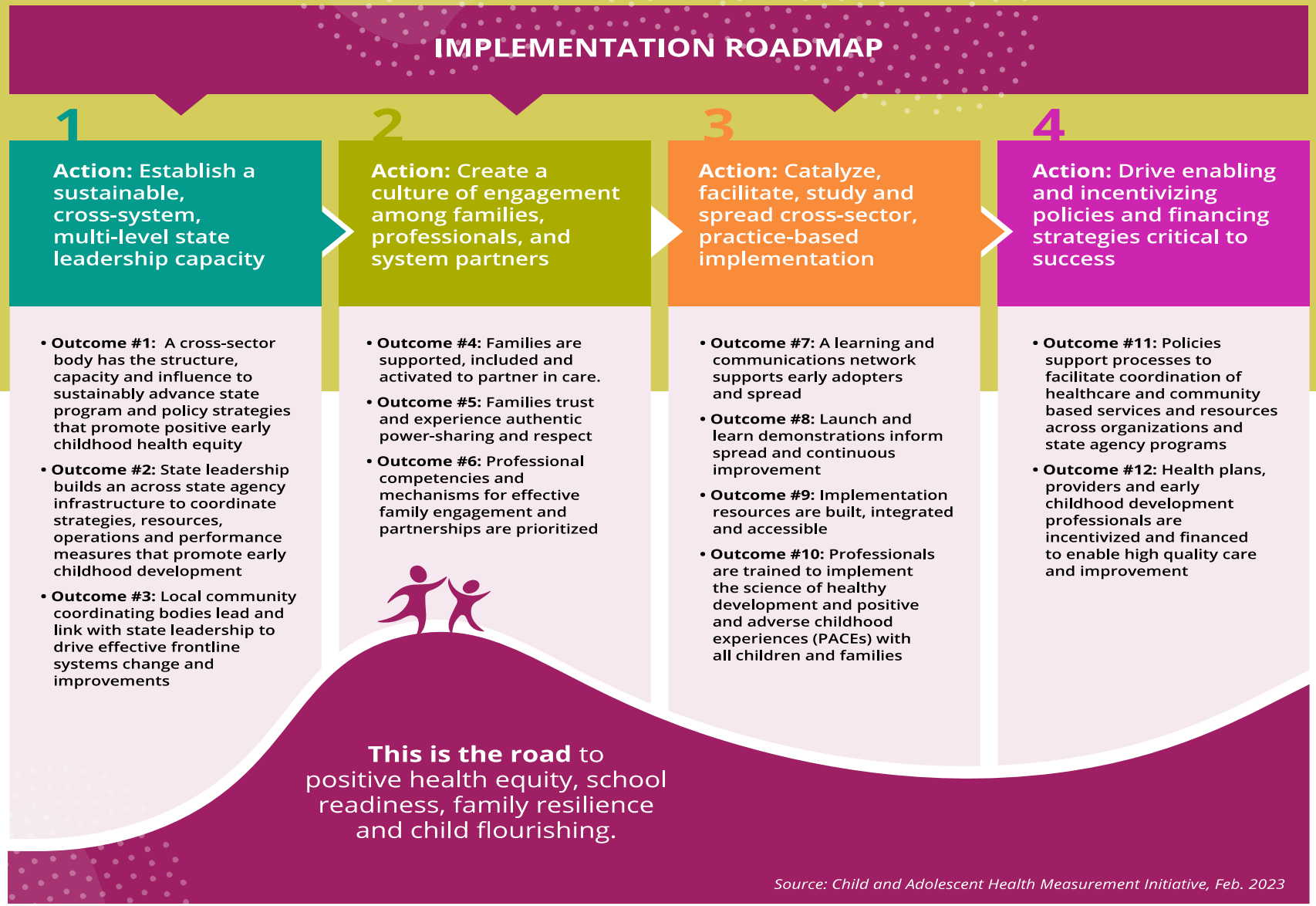
Through Any Door Family and Engagement And Supports

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



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



Bethell, C. 4.13.2023

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 withholds:**
   Employ a payment withhold 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 mechanisms 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 family, provider, community partners.
3. **Standardize coding:**
   Require uniform coding and payment rates across heath plans for specific services to streamline provider and system uptake of EnAct! Framework care approach.
4. **Improvement 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

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/B 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 Organization (EQRO) 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, HSIs 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

Partner Landscape Mapping

Roles and relevance defined for 25 current and potential partners in the EnAct! Framework

Landscape of key partners in the Engagement In Action (EnAct!) Integrated Early Childhood Health System Framework Illustration of the relevance of and roles across key partners in implementing the EnAct! framework

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	Federal/State Funded Agencies and Programs	Healthcare System and Services	County, City and Other Local Partners
Mississippi Priority Partners	Families as Allies 12467C	MS Dept of Health, Healthy Families/MIECHV 1234567ABC		
	Mississippi Families for Kids/Help Me Grow 1234567C	MS Dept of Health, First Steps/Early Intervention Part C (and Part B) 1234567ABC		
	Faith-Based Organizations 124567C	MS Dept of Health, Healthy Moms, Healthy Babies (high risk) 24567BC		
		Community Health Centers (Federally Qualified Health Centers) 34567ABC		
				County and City Health Departments 1234567BC
		Division of Medicaid 1234567ABC	Medicaid Health Plans, CCO's 1234567ABC	MS Early Childhood Association; MS Early Learning Association, Barksdale Reading Institute 234567C
		MS Dept of Human Services: Division of ECCD (CCDF) 1234567ABC	University of MS Medical Center 1234567BC	
		MS Dept of Health, Title V 1234567ABC	Health Professionals', Hospital, Early Childhood Professional Associations 1234567BC	Excel by 5; SPARK MS 123457C
		Head Start/Early Head Start 4567ABC		Parent Support/Advocacy: Parent Training Institute; OneVoice; Teen Health MS, etc.; Media 234567C
		Women, Infants and Children (WIC) Nutritional Program 4567ABC	All child health providers, clinics, hospitals	
		Dept. Child Protective Services 24567ABC	Retail, Concierge, Telehealth Services 24C	Private Foundations, Businesses, MS Children's Museum, UProot Mississippi and Other Partners 234C
		Department of Insurance 234567	Private Sector Commercial Health Plans 234567ABC	
				Health and Social Science Research Centers (MSU SSRC, CMHP, etc.) 123BC

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

Use Application Stories to Spark Action!

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 Engagement 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 wellbeing.

The EnAct! approach supports Medicaid's obligation to ensure use and quality provision of EPSDT services and health plan requirements under the Affordable Care Act to provide and drive use of quality Bright Futures Guidelines aligned preventive services. Implementation population health and lower avoidable 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.

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 Guidelines by engaging families, feasibly conducting comprehensive assessments, linking to community resources and learning and improving population health and performance. Hospitals and specialists are also key partners.

Community-Based Family Resource Brokers

Engaging families to personalize and accelerate connections to services and supports.

The EnAct! approach advances the Mississippi Families for Kids' Help Me Grow vision to conduct comprehensive developmental, social and relational health needs screening and connecting families to primary care and community resources and streamlines coordinated care and data sharing.

Home Visiting Programs

Meeting the needs of families through home-based personalized relationships and comprehensive support.

Healthy Families MS can advance improved performance on 16 of 19 MIECHV performance measures using the EnAct! approach to care. Other MS home visiting programs can use the EnAct! approach to assess and track needs of the high-risk families and infants they serve and coordinate personalized care.

Early Intervention, Child Find

Using family-centered care to meet the unique needs of children at-risk for developmental delay.

The EnAct! approach can catalyze achievement of early intervention's broader set of required services to proactively find and serve children needing developmental services as set forth in both Part C and Part B Early Intervention statute and detailed through Mississippi's Child Find system.

Head Start/Early Head Start (HS/EHS)

Building on the strengths of child care and early education to help children thrive!

The EnAct! approach helps HS/EHS meet goals to promote children's mental, social and emotional development and link them with primary care medical homes. At least 21 of 57 HS/EHS practice standards are directly advanced by the EnAct! approach. The HS/EHS program in Mississippi are essential to educate families about well visits and link them to care.

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 can help the MS Department of Human Services use the Child Care and Development Block Grant to ensure childcare providers and family navigators meet goals to engage families, conduct screenings, link to resources, and support healthy child development and school readiness.

Child Welfare Professionals

Strengthening children and families to optimize well-being, healing, and stability.

The EnAct! approach supports child welfare professionals and programs, like the Infant Toddler Court Program, by providing tools to engage and build trust with families to address social and relational risks, addressing trauma and linking to supports to prevent child maltreatment and unnecessary foster care placement, support the well-being of children and families.

Faith-Based Organizations, Community Centers

Igniting faith-based and trusted community centers to activate families and optimize use and value of preventive services and supports

Faith-based and community centers are welcoming environments where families feel cared for by a close community. These institutions can promote the wellbeing of the families they serve by advancing the EnAct! approach, ultimately improving use and value of preventive services to close gaps in health.

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

Community-Based Family Resource Brokers

Engaging families to personalize and accelerate connections to services and supports

What's Working Now

Even 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 Families for Kids (MFFK), proactively partner with families to help them identify their needs and receive high quality services and supports in their local community. Mississippi families with young children can benefit from the array of direct services, supports, and resources provided by MFFK and its new Help Me Grow (HMG) program. Additionally, their longstanding 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 with children, MFFK/HMG seeks to ensure that all young children in Mississippi receive required developmental screenings and referrals for additional support if needed. MFFK's direct work with families and children make them important advocates for local and state policy and program improvements to optimize supports for all children and families in Mississippi. With 220 children served through HMG and 100 developmental screenings completed in the last year (2021-2022), MFFK is looking to build its current partnership with MST and its operational capacity statewide to support more families given their capacity and drive to assist a wider population.[1,2]

The Engagement in Action Opportunity

The Engagement in Action (EnAct!) Approach to care sets forth critical resources to help MFFK/HMG 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 whole child and family assessments, which are enabled through the inclusion of the Child and Adolescent Health Measurement Initiative's (CAHMI) Well Visit Planner (WVP) family facing digital tools. While the rate of developmental screening improved from 18% to 34.1% in Mississippi during the 5-year Mississippi Thrive! project, still, only one third of young children in Mississippi are estimated to receive developmental screening. MFFK/HMG has used the Ages and Stages Questionnaire (ASQ) for developmental screening and can also employ the comprehensive, family-driven, online Well Visit Planner (WVP) digital tool which uses the equally valid Survey of Well-Being of Young Children (SWYC), along with the range of age-specific child and family health, social and relational 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 Visit Guide (for families) and Clinical Summary (for care coordinators) can help MFFK/HMG care coordinators to quickly identify how to personalize supports for children and families. MFFK/HMG 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 EnAct! Approach to care, MFFK/HMG created a customized WVP website that care coordinators can use with families. Families take about 10 minutes to complete MFFK/HMG's

[1] https://mffk.org/services/
[2] https://mffk.org/wp-content/uploads/2022/03/MFFK-2021-Year-In-Review-Impact-Report.pdf

7

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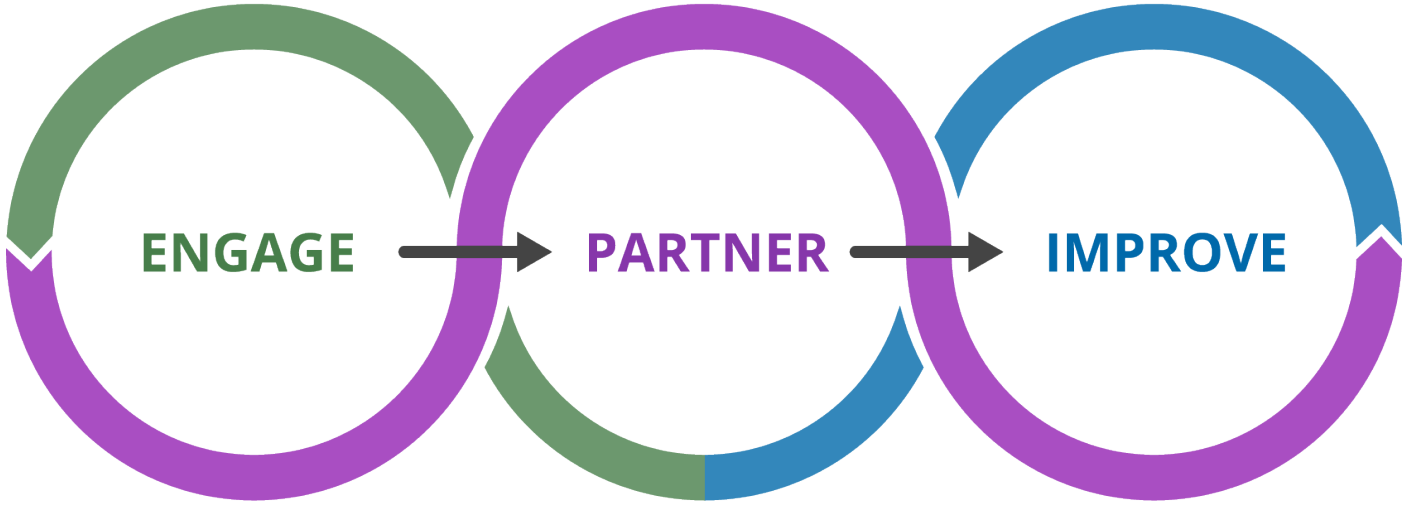
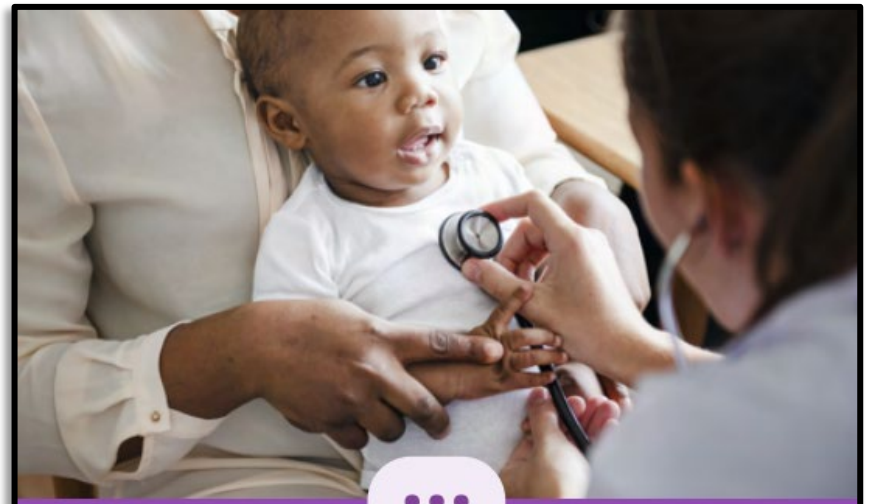
The Cycle of Engagement Well Visit Planner Approach to Care

Leveraging the Well Child Visit to Optimize Child and Family Wellbeing With Families and Across Systems



CAHMI The Child & Adolescent Health Measurement Initiative

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

Well Visit Planner®

WELL VISIT PLANNER

Pre-visit planning

PERSONALIZED CONNECTED ENCOUNTER

(In-person, virtual, group)

The Online Promoting Healthy Development Survey

ONLINE PHDS

Post-visit assessment

Before **During** **After**

ted
ally!

CAHMI

Well Visit Planner
The Child & Adolescent Health Measurement Initiative

Select Language English

Login to your family account
Have a provider ID code? Use it here

Share with others!

Home/WVP | About | Family Resources | FAQ | Provider Info | Contact Us

Welcome to the Well Visit Planner®

Your Child, Your Well Visit

A quick and free pre-visit planning tool to focus care on your unique needs and goals.

Get started now:

Covers all 15 age-specific well visits from your child's first week of life to age 6

Enter provider ID code | Continue without code

Take about 10 minutes to get a personalized Well Visit Guide. Get the best care focused on your child and family's unique goals and needs.

What families like about using the Well Visit Planner (WVP):

- ✓ **Saves time** filling out forms during visits
- ✓ **Gives you a personalized Well Visit Guide** with results specific to your child and family
- ✓ **Provides easy to read resources** on your needs and priorities
- ✓ **Helps you and your child's providers** focus care on your goals and needs
- ✓ **Builds confidence** that your child's care meets expert guidelines
- ✓ **You choose** what sections to complete and share.

Do you want to use the WVP with the children and families you serve?

Learn more here!

What is a Well Visit: Well visits are regular check-ups with your child's personal doctor, nurse, or other child health professional. At least 15 visits are recommended in the first six years of life when children are

Three Easy Steps for Using the Well Visit Planner

1 REFLECT & ASSESS

Reflect on what's going well and identify your goals and concerns. Assess your child's healthy development and family's unique needs.

2 PRIORITIZE

Prioritize what you want to discuss during visits. Pick from recommended topics specific to your child's age and add your own topics.

3 PARTNER

Partner with your child's provider(s). Your Well Visit Guide helps you and your provider focus care on your goals, concerns, needs and priorities.

The Well Visit Planner was created to be used in partnership with your provider.
If you have a unique code from your provider, enter it here now:

Enter provider ID code

"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

Christina Bethell, 2023

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 no or low risk ☑ family response indicated some risk or concern ▣ family did not respond; nonresponse could indicate risk

Well Visit Planner®

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

Child Development

Developmental Surveillance and Screening

☑ **Developmental Screening SWYC milestones score[1]:** 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 bottle?" 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
- Runs
- 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**

Relational Health Risks

☐ **Intimate partner violence risk[2]**
- Caregiver and partner work out arguments with some difficulty
- Some tension in relationship with partner

Social Factors/Determinants

☐ **Lives with both parents:** Yes
☑ **Economic Hardship:** Somewhat/very often hard to cover costs of basic needs, like food or housing
☐ **Negative impact of COVID-19:** Not a lot
☑ **Impact of Covid-19 on family's well-being:** Somewhat

Caregiver Emotional Health

☑ **Depression risk: PHQ-2[4] Score: 3:**
- Down, 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

Other assessments added by provider:

Autism spectrum disorder screen (M-CHAT R/F): Score unknown (incomplete)
PEARLS ACEs score[3]: 3
PEARLS Toxic Stress Risk Factor score[3]: 1
Child flourishing: At Risk
Family resilience: At Risk
Parent-child connection: At Risk

See details on 2nd page

Additional caregiver/parent goals and/or concerns to address during the visit: Would like to discuss about my child's development and expectations.

About This Child

Name: Sara **Initials** (F M L): 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[5])**
☐ **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.

AT-A-GLANCE CLINICAL SUMMARY
Powers the Personalized Connected Encounter

Your Child, Your Well Visit

Celebrate joys and strengths

Do we have any concerns? Child Family You

Should we act? Yes No

What do you think you need? What resources can we draw on? What else can we do?

Promote possibilities. Speak hopes.

Let's Address Your Top Priorities — Dig Deeper · Find Core Needs · Honor Preferences · Commit to action, engagement & partnership

Let's make progress: Next Steps

Well Being Themes — Nurture Positive Experiences · Build Family Strengths & Resilience · Practice Positive Communication · Prioritize attachment & Social & Emotional Skills

Mathematica Independent Evaluation Across End User Groups

Equity-focused benefits

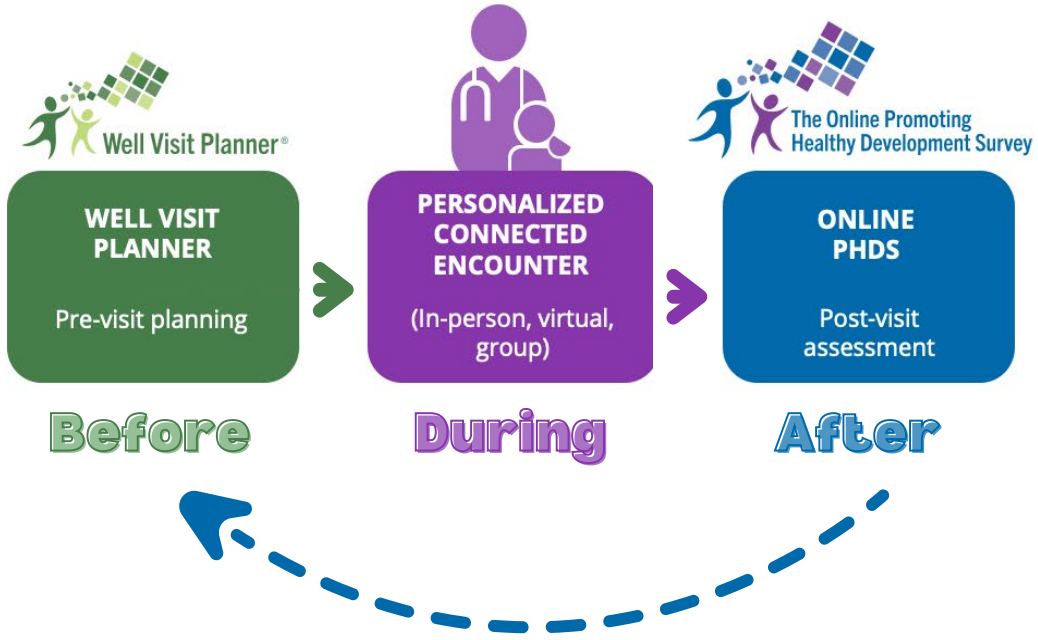
- Brings screening to 100%. Equalizes family knowledge. Aligns health literacy. In Spanish. Families given ways to express concerns about racism. Addresses challenges driven by structural racism
- Provides families with information about what to expect from a provider and gives tools to communicate during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

Equity-focused strategics

- 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

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

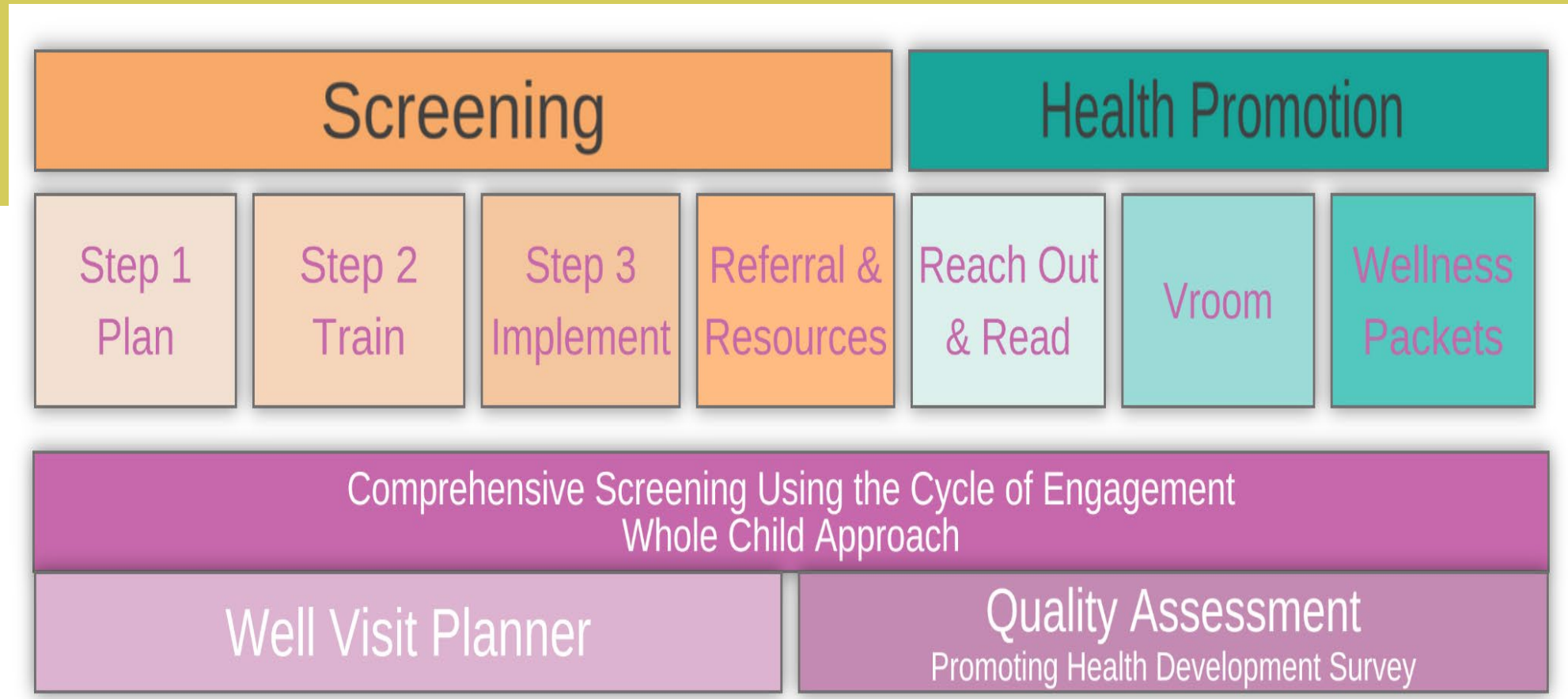


A QUICK OVERVIEW OF THE WELL VISIT PLANNER

A Toolkit for Comprehensive Developmental Screening and Health Promotion Using a Whole Child and Family Approach*

A Pathway to Operationalize Bright Futures Early Childhood Guidelines

CLICK HERE FOR AN OVERVIEW



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!

SCAN ME

Contact Us

Email us at: info@cahmi.org

Visit “Ask a Question” page on the DRC

CAHMI
The Child & Adolescent Health Measurement Initiative