NATIONAL PERFORMANCE MEASURE DETAIL SHEET

01 PERFORMANCE MEASURE	The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.
GOAL	To assure early screening and early intervention for all newborns for special health care needs.
DEFINITION	Numerator: The number of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs. Denominator: The number of newborns screened and confirmed with condition(s) mandated by the State sponsored newborn screening program. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objectives 16.20: (Developmental) Ensure appropriate newborn bloodspot screening, follow-up testing, and referral to services. Related to Objectives 16.21: (Developmental) Reduce hospitalization for life-threatening sepsis among children aged 4 years and under with sickling hemoglobinopathies.
DATA SOURCE(S) AND DATA ISSUES	Data supplied annually by each State to the National Newborn Screening and Genetic Resource Center.
SIGNIFICANCE	Screening programs for newborns and children have been shown to be cost-effective and successful and have been shown to prevent mortality and morbidity. Their success reflects the systems approach from early screening to appropriate early intervention and treatment.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

02 PERFORMANCE MEASURE	The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)
GOAL	To increase the number of families with CSHCN who partner in decision making and are satisfied with the services they receive.
DEFINITION	Numerator: The number of children with special health care needs in the State age 0 to 18 whose families report participating in decision making and being satisfied with the services they received during the reporting period. Denominator: The number of children with special health care needs in the State age 0 to 18 during the reporting period. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objective 16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.
DATA SOURCE(S) AND DATA ISSUES	The National CSHCN Survey provides State level data on the extent to which families perceive that their doctors make the family feel like a partner and the family is very satisfied with the overall care experience. If State uses another data source, please cite source.
SIGNIFICANCE	Family/professional partnerships have been: incorporated into the MCHB Block Grant Application, the MCHB strategic plan. The Omnibus Budget Reconciliation Act of 1989 (OBRA '89 mandated that the States provide and promote family centered, community-based, coordinated care. Family satisfaction is also a crucial measure of system effectiveness.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

03 PERFORMANCE MEASURE	The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)
GOAL	To increase the number of children with special health care needs who have a medical home.
DEFINITION	Numerator: The percent of children with special health care needs in the State age 0 to 18 who have a medical home during the reporting period. Denominator: The number of children with special health care needs in the state age 0 to 18 during the reporting period. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objective 16.22: (Developmental): Increase the proportion of children with special health care needs who have access to a medical home.
DATA SOURCE(S) AND DATA ISSUES	The National CSHCN Survey will provide state and national level data on the extent to which families perceive that their child with a special health care need has access to a medical home. Indicators include having a regular doctor for routine and sick care: access to care that is coordinated with specialty care and community services; ease in obtaining referrals: and receipt of respectful and culturally competent care.
SIGNIFICANCE	Providing primary care to children in a "medical home" is the standard of practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The MCHB uses the AAP definition of "medical home." (AAP Medical Home Policy Statement, presented in Pediatrics, Vol. 110 No. 1, July, 2002)

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

04 PERFORMANCE MEASURE	The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)
GOAL	To increase the percent of children with special health care needs, age 0 to 18, with adequate insurance coverage for all the services they need.
DEFINITION	Numerator: Number of children with special health care needs in the State age 0 to 18 whose families perceive that they have adequate insurance coverage. Denominator: Number of children with special health care needs in the State age 0 to 18 during the reporting period. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objective 16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239. Related to Objective 1.1: Increase the proportion of persons with health insurance to 100 percent.
DATA SOURCE(S) AND DATA ISSUES	The National CSHCN Survey provides State level data on the percent of parents of children with special health care needs reporting private or public health insurance coverage, no gaps in coverage, coverage that meets their child's needs, reasonable out-of-pocket costs, access to needed providers, and lack of unmet needs due to health plan coverage. The National CSHCN Survey will provide national and state estimates in 2002 and periodically thereafter.
SIGNIFICANCE	Children with special health care needs often require an amount and type of care beyond that required by typically developing children and are more likely to incur catastrophic expenses. This population of children and families often have disproportionately low incomes and, therefore, are at higher risk of being uninsured. Since children are more likely to obtain health care if they are insured, insurance coverage and the content of that coverage is an important indicator of access to care. Because children with special health care needs often require more and different services than typically developing children, under-insurance is a major factor in determining adequacy of coverage. Adequacy of insurance ensures comprehensive care, which in turn reduces emergency room visits, hospitalizations, and time lost from school/work.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

05 PERFORMANCE MEASURE	Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)
GOAL	To increase the number of families with CSHCN who have access to easy-to-use community-based service systems.
DEFINITION	Numerator: The number of children with special health care needs in the State age 0 to 18 whose families report that community-based service systems are organized so they can use them easily. Denominator: The number of children with special health care needs in the Sate age 0 to 18 whose families report that community-based service systems are organized so they can use them easily. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objective 16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.
DATA SOURCE(S) AND DATA ISSUES	The National CSHCN Survey provides State and national level data on the extent to which families perceive that services are organized for easy use. The National CSHCN Survey will provide national and state estimates in 2002 and periodically thereafter. Data for this measure for 2002 may not be accurate due to small sample sizes in some States. This should not be an issue in future National CSHCN Surveys.
SIGNIFICANCE	Families, service agencies and the Federal Interagency Coordinating Council (FICC) have identified major challenges confronting families in accessing coordinated health and related services that families need for their children with special health care needs. Differing eligibility criteria, duplication and gaps in services, inflexible funding streams and poor coordination among service agencies are concerns across most States. Addressing these issues will lead to more efficient use of public funds and reduced family stress.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

06 PERFORMANCE MEASURE	The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)
GOAL	To increase the percent of children with special health care needs, age 0 to 18, who have received the services necessary to transition to adult health care, work, and independence.
DEFINITION	Numerator: Number of children with special health care needs in the Sate age 0 to 18 whose families perceive that they have received the services necessary to transition to adult health care, work, and independence. Denominator: Number of children with special health care needs in the State age 0 to 18 during the reporting period. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objective 16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.
DATA SOURCE(S) AND DATA ISSUES	The National CSHCN Survey provides State and level data on the percent of parents of children with special health care needs reporting that their child receives support in the transition to adult health care and vocational and career training. The National CSHCN Survey will provide national and state estimates in 2002 and periodically thereafter. Data for this measure for 2002 may not be accurate due to small sample sizes in many States. This should not be an issue in future National CSHCN Surveys.
SIGNIFICANCE	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the President's "New Freedom Initiative: Delivering on the Promise" (March 2002). Over 90 percent of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed. Health and health care are cited as two of the major barriers to making successful transitions.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

07 PERFORMANCE MEASURE	Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
GOAL	To avert all cases of vaccine-preventable morbidity and mortality in children.
DEFINITION	Numerator: Number of resident children who have received the complete immunization schedule for DTP/DTAP, OPV, measles, mumps, rubella (MMR), H. influenza, and hepatitis B before their second birthday. Complete immunization status is generally considered to be: 3 Hepatitis B 4 DtaP 3 Polio 1 MMR 3 Hib Denominator: Number of resident children aged 2 years. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 14-24: Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for at least 5 years. Increase the proportion of children aged 19 through 35 months who received all recommended vaccines to 80 percent. (Baseline: 73 percent in 1998).
DATA SOURCE(S) AND DATA ISSUES	State Immunization Registry, CDC National Immunization Survey, State Vital Records, and Bureau of Census population estimates.
SIGNIFICANCE	Infectious diseases remain important causes of preventable illness in the United States despite significant reductions in incidence in the past 100 years. Vaccines are among the safest and most effective preventive measures.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

08 PERFORMANCE MEASURE	The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
GOAL	To lower the birth rate among teenagers, especially those age 15 through 17 years.
DEFINITION	Numerator: Number of live births to teenagers aged 15-17 years in the calendar year. Denominator: Number of females aged 15 through 17 years in the calendar year. Units: 1,000 Text: Rate per 1,000
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 9-7. Reduce pregnancies among females aged 15-17 to no more than 46 per 1,000 females aged 15-17 years. (Baseline: 72 pregnancies per 1,000 females aged 15-17 years in 1995).
DATA SOURCE(S) AND DATA ISSUES	Vital records are the source of data on mother's age and births. Population records are available from the Census.
SIGNIFICANCE	DHHS is making lowering the rate of teen pregnancies (a major threat to healthy and productive lives) a priority goal in its strategic plan. Teen parenting is associated with the lack of high school completion and initiating a cycle of poverty for mothers.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

09 PERFORMANCE MEASURE	Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
GOAL	To prevent pit and fissure tooth decay (dental caries).
DEFINITION	Numerator: Number of third grade children who have a protective sealant on at least one permanent molar tooth. Denominator: Number of third grade children in the State during the year. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 21.8: Increase the proportion of children who have received dental sealants on their molar teeth to 50 percent. (Baseline: 23 percent of children aged 8 years received sealants on their molars in the years 1988-94.)
DATA SOURCE(S) AND DATA ISSUES	This requires primary data collection, such as examination or screening of a representative sample of school children.
SIGNIFICANCE	Dental caries affects two-thirds of children by the time they are 15 years of age. Developmental irregularities, called pits and fissures, are the sites of 80-90% of childhood caries. Sealants selectively protect these vulnerable sites, which are found mostly in permanent molar teeth. Targeting sealants to those at greatest risk for caries has been shown to increase their cost-effectiveness. Although sealants have the potential to combine with fluorides to prevent almost all childhood tooth decay, they have been underutilized. In addition to being an excellent service in preventing tooth decay, sealants may also be a surrogate indicator of dental access, oral health promotion and preventive activities, and a suitable means to assess the linkages that exist between the public and private services delivery system. Public managed sealant programs are usually school-based or school-linked and target under served children, thus providing entry to other services. It has been stated on several occasions that dental sealants are the oral health equivalent of immunization.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

10 PERFORMANCE MEASURE	The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
GOAL	To reduce the number of deaths to children aged 14 years old and younger caused by motor vehicle crashes.
DEFINITION	Numerator: Number of deaths to children aged 14 years and younger caused by motor vehicle crashes. This includes all occupant, pedestrian, motorcycle, bicycle, etc. deaths caused by motor vehicles. Denominator: All children in the State aged 14 years and younger. Units: 100,000 Text: Rate per 100,000
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 15-15: Reduce deaths caused by motor vehicle crashes to 9.0 deaths per 100,000 population. (Baseline: 15 deaths per 100,000 population by motor vehicle crashes in 1998. Baseline for children aged 14 years and under, 4.2 deaths per 100,000 in 1998).
DATA SOURCE(S) AND DATA ISSUES	Fatal Accident Reporting System (FARS), U.S. Department of Transportation, and Vital Statistics Systems are sources of the data.
SIGNIFICANCE	About 50% of all deaths to children aged 14 years and younger are due to injuries, and around 80% of these are from motor vehicle crashes. Injuries are the leading cause of mortality in this age group and they are the most significant health problems affecting the Nation's children.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

11 PERFORMANCE MEASURE	The percent of mothers who breastfeed their infants at 6 months of age.
GOAL	To increase the percent of mothers who breastfeed their infants at 6 months of age.
DEFINITION	Numerator: Number of mothers who indicate that breastmilk is at least one of the types of food their infant is fed at 6 months of age. Denominator: Number of mothers with infants at 6 months of age. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-19b: Increase the proportion of mothers who breastfeed their infants at 6 months of age to 50 percent. (Baseline: 29 percent in 1998).
DATA SOURCE(S) AND DATA ISSUES	CDC's National Immunization Survey (NIS), Ross Laboratories Mothers Survey, State WIC data, CDC's Pediatric Nutrition Surveillance System (PedNSS), and HRSA's National Survey of Children's Health (NSCH).
SIGNIFICANCE	Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits.

* Breastfeeding is defined as including any amount of breast milk in the infant's diet, regardless of additional food substances consumed by an infant.

* Exclusive breastfeeding is defined as being fed breast milk or water only. Introduction of other substances to an infant such as formula, cow's milk, juice and solid foods in addition to breast milk does not qualify as "exclusive" breastfeeding.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

12 PERFORMANCE MEASURE	Percentage of newborns who have been screened for hearing before hospital discharge.
GOAL	To reduce the morbidity associated with hearing impairment through early detection.
DEFINITION	Numerator: The number of infants in the State whose hearing has been screened before hospital discharge by tests of either otoacoustic emissions or auditory brainstem responses. Denominator: Number of births in the State in the calendar year. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 28-11: Increase the proportion of newborns who are screened for hearing loss by age 1 month, have audiologic evaluation by age 3 months, and are enrolled in appropriate intervention services by age 6 months.
DATA SOURCE(S) AND DATA ISSUES	State birth certificates, newborn hearing registries, tests of otoacoustic emissions and auditory brainstem responses. Potential data source - State based Early Hearing Detection and Intervention (EDHI) Program Network, CDC.
SIGNIFICANCE	The advantages of early detection of hearing impairments are indisputable and include necessary follow-up of free and appropriate enrollment in habilitation and education programs.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

13 PERFORMANCE MEASURE	Percent of children without health insurance.
GOAL	To ensure access to needed and continuous health care services for children.
DEFINITION	Numerator: Number of children under 18 in the State who are not covered by any private or public health insurance (Including Medicaid or risk pools) at some time during the reporting year. Denominator: Number of children in the State under 18 (estimated by Census in March). Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objectives 1-1: Increase the proportion of persons with health insurance to 100 percent. (Baseline: 86 percent of the population was covered by health insurance in 1997).
DATA SOURCE(S) AND DATA ISSUES	There is no current uniform source of data at the State level, but data may be available by State estimate beginning in 1997 from the March CPS, U.S. Bureau of the Census. States need to choose among existing estimating techniques and use one consistently.
SIGNIFICANCE	There is a well-documented association between insurance status and utilization of health care services among adults. Less is known about the utilization of services in children. A 1996 study by the Harvard School of Public Health, The Henry J. Kaiser Foundation and the National Opinion Research Center found the uninsured are four more times likely to have an episode of needing and not getting medical care. As noted in the 1997 "Families USA Report," children without health insurance have an average of 1 less visit per year and receive less treatment than insured children with similar problems.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

14 PERFORMANCE MEASURE	Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (1) (BMI) at or above the 85th percentile.
GOAL	To reduce the proportion of children, ages 2 to 5 years, who are at risk of overweight or obese. (2)
DEFINITION	Numerator: The number of children, ages 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile. Denominator: Number of children, ages 2 to 5 years that receive WIC services during the reporting period. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objective 19.3: Reduce the proportion of children and adolescents who are overweight or obese. (1988-1994 Baseline for children aged 6 to 11 years of age: 11%)
DATA SOURCE(S) AND DATA ISSUES	State WIC Data, CDC's Pediatric Nutrition Surveillance System (PedNSS), and HRSA's National Survey of Children's Health (NSCH).
SIGNIFICANCE	Childhood overweight is a serious health problem in the United States, and the prevalence of overweight among preschool children has doubled since the 1970s. There have been significant increases in the prevalence of overweight in children younger than 5 years of age across all ethnic groups. Onset of overweight in childhood accounts for 25 percent of adult obesity; but overweight that begins before age 8 and persists into adulthood is associated with an even greater degree of adult obesity. Childhood overweight is associated with a variety of adverse consequences, including an increased risk of cardiovascular disease, type 2 diabetes mellitus, asthma, social stigmatization, and low self-esteem.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

15 PERFORMANCE MEASURE	Percentage of women who smoke in the last three months of pregnancy.
GOAL	Decrease smoking during pregnancy.
DEFINITION	Numerator: The number of women reporting smoking in the last three months of pregnancy during the calendar year. Denominator: The number of women delivering babies during the calendar year. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 27-6. Increase smoking cessation during pregnancy.
DATA SOURCE(S) AND DATA ISSUES	Birth certificate. States are encouraged to use US Standard Certificate of Live Birth (revised 11/2003); Pregnancy Risk Assessment Monitoring System (PRAMS).
SIGNIFICANCE	Birth weight is the single most important determinant of a newborn's survival during the first year. Maternal smoking during pregnancy has been directly related to low birth weight.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

16 PERFORMANCE MEASURE	The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
GOAL	To eliminate self-induced, preventable morbidity and mortality.
DEFINITION	Numerator: Number of deaths attributed to suicide among youths aged 15 through 19. Denominator: Number of youths aged 15 through 19. Units: 100,000 Text: Rate per 100,000
HEALTHY PEOPLE 2010 OBJECTIVE	Related to Objectives 18-1: Reduce the suicide rate to 6.0 deaths per 100,000 population. (Baseline: 10.8 suicide deaths per 100,000 in 1997). Related to Objective 18-2: Reduce the rate of suicide attempts by adolescents in grades 9 through 12 to a 12 month average of 1 percent. (Baseline: 12 month average of 2.6 percent among adolescents in grades 9 through 12 in 1997).
DATA SOURCE(S) AND DATA ISSUES	State vital records are the source.
SIGNIFICANCE	Suicide is the third leading cause of death in the United States among youths aged 15 through 19, and in many States it ranks as the second leading cause of death in this population.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

17 PERFORMANCE MEASURE	Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
GOAL	To ensure that higher risk mothers and newborns deliver at appropriate level hospitals.
DEFINITION	Numerator: Number of infants with a birth weight less than 1,500 grams born at sub-specialty facilities (Level III facility). Denominator: Total number of infants born with a birth weight of less than 1,500 grams. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-9: Increase the proportion of very low birth weight (VLBW) infants born at Level III hospitals or sub-specialty perinatal centers to 90 percent. (Baseline: 73 percent of VLBW born at level III hospitals or sub-specialty perinatal centers in the years 1996-97).
DATA SOURCE(S) AND DATA ISSUES	There is no national data source for this at present. Vital records and hospital discharge records would be sources.
SIGNIFICANCE	Very low birth weight infants are more likely to survive and thrive if they are born/cared for in an appropriately staffed and equipped facility with a high volume of high-risk admissions.

NATIONAL PERFORMANCE MEASURE DETAIL SHEET

18 PERFORMANCE MEASURE	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.
GOAL	To ensure early entrance into prenatal care to enhance pregnancy outcomes.
DEFINITION	Numerator: Number of live births with reported first prenatal visit during the first trimester (before 13 weeks = gestation) in the calendar year. Denominator: Number of live births in the State in the calendar year. Units: 100 Text: Percent
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-16a: Increase the proportion of pregnant women who receive early and adequate perinatal care beginning in the first trimester of pregnancy to 90 percent. (Baseline: 83 percent in 1998.)
DATA SOURCE(S) AND DATA ISSUES	Birth certificate data in the State vital records are available for over 99% of births.
SIGNIFICANCE	Early identification of maternal disease and risks for complications of pregnancy or birth are the primary reason for first trimester entry into prenatal care. This can help ensure that women with complex problems and women with chronic illness or other risks are seen by specialists. Early high-quality prenatal care is critical to improving pregnancy outcomes.

STATE PERFORMANCE MEASURE DETAIL SHEET

SPM#1 PERFORMANCE MEASURE	The percentage of Part C eligible children receiving service
STATUS	Active
GOAL	To increase the number of eligible children who receive a service.
DEFINITION	Numerator: Number of eligible children who receive a service. Denominator: Number of children eligible. Units: 100 Text: percent
HEALTHY PEOPLE 2010 OBJECTIVE	21.5 Clinical preventive services from publicly funded programs
DATA SOURCE(S) AND DATA ISSUES	Department of Health data
SIGNIFICANCE	Increasing the percentage of Part C eligible children receiving a service has a positive effect on the outcome measures related to reducing infant, neonatal, postneonatal and perinatal morbidity.

STATE PERFORMANCE MEASURE DETAIL SHEET

SPM#2 PERFORMANCE MEASURE	The percentage of births with inter pregnancy interval less than 18 months.
STATUS	Active
GOAL	To increase time intervals between pregnancies.
DEFINITION	Numerator: Number of women who have a subsequent birth within 18 months of a previous delivery. Denominator: Number of live births in the calendar year. Units: 100 Text: percent
HEALTHY PEOPLE 2010 OBJECTIVE	9-2: Reduce the proportion of births occurring within 24 months of a previous birth.
DATA SOURCE(S) AND DATA ISSUES	The data source is the Florida Department of Health, Vital Statistics Office. The data is taken directly from the Live Birth Certificate data.
SIGNIFICANCE	Increasing the time interval between pregnancies lowers the risk of adverse perinatal outcomes, including low birth weight, preterm birth, and small-for-size gestational age.

STATE PERFORMANCE MEASURE DETAIL SHEET

SPM#3 PERFORMANCE MEASURE	The percentage of women having a live birth who received preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care provider prior to pregnancy.
STATUS	Active
GOAL	To increase the number of women who received preconception screening and counseling prior to pregnancy.
DEFINITION	Numerator: Women having a live birth who received preconception counseling on 11 topics prior to pregnancy. Denominator: Number of live births in the calendar year. Units: 100 Text: percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to: 16-10 Reduce low birth weight (LBW) and very low birth weight (VLBW); 16-11 Reduce preterm births.
DATA SOURCE(S) AND DATA ISSUES	An optional question on preconception health counseling with a listing of 11 preconception health topics on Phase 6 PRAMS Survey in Florida starting in 2009.
SIGNIFICANCE	Improving the preconception health of women prior to pregnancy is believed to be the best new strategy to improve perinatal and child health. This includes promoting family planning and birth spacing, ceasing substance abuse, managing chronic conditions, and improving health behaviors.

STATE PERFORMANCE MEASURE DETAIL SHEET

SPM#4 PERFORMANCE MEASURE	The percentage of infants not bed sharing.
STATUS	Active
GOAL	To increase the number of infants who do not often share a common bed surface with others when sleeping.
DEFINITION	Numerator: Statistically weighted number of live births to PRAMS respondents who are most often do not sleep in the same bed as others. Denominator: Statistically weighted number of live births to PRAMS respondents in the calendar year. Units: 100 Text: percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to 16-13: Increase the percentage of healthy full-term infants who are put down to sleep on their backs.
DATA SOURCE(S) AND DATA ISSUES	Phase 5 and 6 PRAMS Survey in Florida starting in 2004.
SIGNIFICANCE	Infants who share a common bed surface with others are at risk for suffocation, positional asphyxia, and strangulation. In addition, they are also at increased risk of SIDS.

STATE PERFORMANCE MEASURE DETAIL SHEET

SPM#5 PERFORMANCE MEASURE	The percentage of infants back sleeping.
STATUS	Active
GOAL	To increase the number of infants who are placed most often on their backs to sleep.
DEFINITION	Numerator: Statistically weighted number of live births to PRAMS respondents who are most often place infants on their back to sleep. Denominator: Statistically weighted number of live births to PRAMS respondents in the calendar year. Units: 100 Text: percent
HEALTHY PEOPLE 2010 OBJECTIVE	16-13: Increase the percentage of healthy full-term infants who are put down to sleep on their backs.
DATA SOURCE(S) AND DATA ISSUES	Phase 6 PRAMS Survey in Florida starting in 2009.
SIGNIFICANCE	Placing an infant on their back to sleep greatly reduces the risk of SIDS in both healthy full-term and preterm infants.

STATE PERFORMANCE MEASURE DETAIL SHEET

SPM#6 PERFORMANCE MEASURE	The percentage of teen births, ages 15-17, that are subsequent (repeat) births.
STATUS	Active
GOAL	To lower the percentage of subsequent births to teens age 15 to 17.
DEFINITION	Numerator: Number of females age 15-17 under with a second or higher order birth. For multiple births only the first of the multiple births are used in this measure. Denominator: Number of live births to females ages 15-17 in the calendar year. Units: 100 Text: percent
HEALTHY PEOPLE 2010 OBJECTIVE	Related to 9-7 Reduce pregnancies among adolescent females; 9-10 Increase the proportion of sexually active, unmarried adolescents aged 15 to 17 years who use contraception that both effectively prevents pregnancy and provides barrier protection against disease.
DATA SOURCE(S) AND DATA ISSUES	Birth certificates are the source of data on mother's age, births, and teen with a second or higher order birth.
SIGNIFICANCE	A second teen birth is associated with the lack of high school completion, inability to work, solidifying the cycle of poverty for young mothers, creating welfare dependency, and increased risk of infant mortality.

STATE PERFORMANCE MEASURE DETAIL SHEET

SPM#7 PERFORMANCE MEASURE	The percentage of low-income children who access dental care
STATUS	Active
GOAL	To increase access to dental services for low-income children in order to provide clinical preventive and treatment services needed to improve and maintain oral health.
DEFINITION	Numerator: Number of children who receive services through Medicaid providers, county health departments and community health centers. Denominator: The number of low-income children below 200% of the federal poverty level. Units: 100 Text: percent
HEALTHY PEOPLE 2010 OBJECTIVE	13.2 Untreated dental caries Reduce untreated dental disease to no more than 20 percent among children 6 through 8 and no more than 15 percent among adolescents age 15.
DATA SOURCE(S) AND DATA ISSUES	Data are compiled from annual ad hoc reports provided by the Medicaid program, from county health department data maintained by the Public Health Dental Program, and community health center data extracted from the annual Uniform Data System report.
SIGNIFICANCE	Low-income children are at high risk for dental disease because of the lack of access to professional care. Dental caries is the most common chronic disease of children, but amenable to early intervention. Early dental disease can be reversed and more advanced disease can be treated before it progresses to pain, infection and the need for more expensive intervention.

OUTCOME MEASURE DETAIL SHEET

01 OUTCOME MEASURE	The infant mortality rate per 1,000 live births.
GOAL	To reduce the number of infant deaths.
DEFINITION	Numerator: Number of deaths to infants from birth through 364 days of age. Denominator: Number of live births. Units: 1,000 Text: Rate per 1,000
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-1c: Reduction of infant deaths (within 1 year) to 4.5 per 1,000 live births. (Baseline: 7.2 in 1998)
DATA SOURCE(S) AND DATA ISSUES	Vital records collected by the State.
SIGNIFICANCE	All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate, but the rate of decline has slowed in the last 10 years. There is still significant racial disparity, as noted in the Healthy People 2000 Mid-course Review. Rates are much higher in the lower social class and in the lowest income groups across all populations.

OUTCOME MEASURE DETAIL SHEET

02 OUTCOME MEASURE	The ratio of the black infant mortality rate to the white infant mortality rate.
GOAL	To reduce the disparity (ratio) between the black and white infant mortality rates.
DEFINITION	Numerator: The black infant mortality rate per 1,000 live births. Denominator: The white infant mortality rate per 1,000 live births. Units: 1 Text: Ratio
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-1c: Reduce all infant deaths (within 1 year) to 4.5 per 1,000 live births. Objective 16-1d: Reduce all neonatal deaths (within the first 28 days of life) to 2.9 per 1,000 live births. Objective 16-1e: Reduce all post-neonatal deaths (between 28 days and 1 year) to 1.5 per 1,000 live births. (Baselines [all 1997] - Infant deaths: White = 6.0 and Black = 13.7; Neonatal deaths: White = 4.0 and Black = 9.2; Post-neonatal deaths: White = 2.1 and Black = 4.5)
DATA SOURCE(S) AND DATA ISSUES	Vital records collected by the State.
SIGNIFICANCE	All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate, but the rate of decline has slowed in the last 10 years. There is still significant racial disparity, as noted in the Healthy People 2000 Mid-course Review. Rates are much higher in the lower social class and in the lowest income groups across all populations. The disparity (ratio) for black infant mortality is over twice the white rate. Black women are twice as likely as white women to experience prematurity, low birth weight, and fetal death.

OUTCOME MEASURE DETAIL SHEET

03 OUTCOME MEASURE	The neonatal mortality rate per 1,000 live births.
GOAL	To reduce the number of neonatal deaths.
DEFINITION	Numerator: Number of deaths to infants under 28 days. Denominator: Number of live births. Units: 1,000 Text: Rate per 1,000
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-1d: Reduce all neonatal deaths (within the first 28 days of life) to 2.9 per 1,000 live births. (Baseline: 4.8 in 1998)
DATA SOURCE(S) AND DATA ISSUES	Vital records collected by the State.
SIGNIFICANCE	Neonatal mortality is a reflection of the health of the newborn and reflects health status and treatment of the pregnant mother and of the baby after birth.

OUTCOME MEASURE DETAIL SHEET

04 OUTCOME MEASURE	The post-neonatal mortality rate per 1,000 live births.
GOAL	To reduce the number of post-neonatal deaths.
DEFINITION	Numerator: Number of deaths to infants 28 through 364 days of age. Denominator: Number of live births. Units: 1,000 Text: Rate per 1,000
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-1e: Reduce all post-neonatal deaths (between 28 days and 1 year) to 1.5 per 1,000 live births. (Baseline: 2.4 in 1998)
DATA SOURCE(S) AND DATA ISSUES	Vital records collected by the State.
SIGNIFICANCE	This period of mortality reflects the environment and the care infants receive. SIDS deaths occur during this period and have been recently reduced due to new infant positioning in the U.S. Poverty and a lack of access to timely care are also related to late infant deaths.

OUTCOME MEASURE DETAIL SHEET

05 OUTCOME MEASURE	The perinatal mortality rate per 1,000 live births plus fetal deaths.
GOAL	To reduce the number of perinatal deaths.
DEFINITION	Numerator: Number of fetal deaths > 28 weeks gestation plus deaths occurring under 7 days. Denominator: Live births + fetal deaths. Units: 1,000 Text: Rate per 1,000
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-1b: Reduce the death rate during the perinatal period (28 weeks of gestation to 7 days or less after birth) to 4.5 per 1,000 live births plus fetal deaths. (Baseline: 7.5 in 1997)
DATA SOURCE(S) AND DATA ISSUES	Vital records collected by the State.
SIGNIFICANCE	Perinatal mortality is a reflection of the health of the pregnant woman and newborn and reflects the pregnancy environment and early newborn care.

OUTCOME MEASURE DETAIL SHEET

06 OUTCOME MEASURE	The child death rate per 100,000 children aged 1 through 14.
GOAL	To reduce the death rate of children aged 1 through 14.
DEFINITION	Numerator: Number of deaths among children aged 1 through 14 years. Denominator: Number of children aged 1 through 14. Units: 100,000 Text: Rate per 100,000
HEALTHY PEOPLE 2010 OBJECTIVE	Combination of Objectives 16-2a: Reduce deaths in children aged 1 to 4 years to 25.0 per 100,000 in that age group. (Baseline: 34.2 in 1998) Objectives 16-2b: Reduce deaths in children aged 5 to 9 years to 14.3 per 100,000 in that age group. (Baseline: 17.6 in 1998) Objectives 16-3a: Reduce deaths in adolescents aged 10 to 14 years to 16.8 per 100,000 in that age group. (Baseline: 21.8 in 1998)
DATA SOURCE(S) AND DATA ISSUES	Child death certificates are collected by State vital records. Data on total number of children comes from the Census.
SIGNIFICANCE	While children's likelihood of survival increases dramatically after the first year of life, the child death rate remains certain. The child death rate has decreased in the last decade, falling from 33.8 in 1985 to 28.8 in 1992. The DHH's strategic plan identifies improvements in the rates of preventable death as part of priority goals for children and youth.

STATE OUTCOME MEASURE DETAIL SHEET

01 OUTCOME MEASURE	Pregnancy-related death ratio per 100,000 live births
GOAL	To reduce the number of pregnancy-related deaths.
DEFINITION	Numerator: Number of pregnancy-related deaths as determined by review of the Florida Pregnancy Associated Mortality Review Committee. Denominator: Number of live births. Units: 100,000 Text: Ratio per 100,000
HEALTHY PEOPLE 2010 OBJECTIVE	Objective 16-4: Reduce maternal deaths. Target for 2010: 3.3 maternal deaths per 100,000 live births. (Baseline: 7.1 in 1998)
DATA SOURCE(S) AND DATA ISSUES	Pregnancy Associated Mortality Review (PAMR) data base and vital records collected by the state.
SIGNIFICANCE	Pregnancy-related mortality is a reflection of the health status and treatment of the mother prior to and during pregnancy.

VIII - GLOSSARY

Adequate prenatal care - Prenatal care where the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index)**.**

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment").

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. ***(For planning and systems development)*** - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations

States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities

State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems

A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level

A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services).

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competence – a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals and which enables them to work effectively cross culturally. Further, it refers to the ability to honor and respect the beliefs, language, inter-personal styles and behaviors of individuals and families receiving services, as well as staff who are providing such services. At a systems, organizational, or program level, cultural competence requires a comprehensive and coordinated plan that includes interventions at all the levels from policy-making to the individual, and is a dynamic, ongoing, process that requires a long-term commitment. A component of cultural competence is linguistic competence, the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who are not literate or have low literacy skills, and individuals with disabilities.

Regarding the principles of cultural competence, an organization should value diversity in families, staff, providers and communities; have the capacity for cultural self-assessment; be conscious of the dynamics inherent when cultures interact, e.g. families and providers; institutionalize cultural knowledge; and develop adaptations to service delivery and partnership building reflecting an understanding of cultural diversity. An individual should examine one's own attitude and values; acquire the values, knowledge, and skills for working in cross cultural situations; and remember that every one has a culture.

Sources: Maternal and Child Health Bureau (MCHB), Guidance and Performance Measures for Discretionary Grants, Health Resources and Services Administration, U.S. Department of Health and Human Services, Denboba and Goode, 1999 and 2004.

Cross, Bazron, Dennis and Isaacs, Towards a Culturally Competent System of Care, 1989.

Goode and Jones, Definition of Linguistic Competence, National Center for Cultural Competence, Revised 2004.

Denboba, "Federal Viewpoint," Special Additions Newsletter for Children with Special Health Care Needs, Spring/Summer 2005.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and

language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Early Neonatal – Infants less than or equal to 6 days of age.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment **-** a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care – Approach that assures the health and well-being of children and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-Centered Care is the standard of practice which results in high quality services.

Family/Professional Partnerships – The foundation of family-centered care is the partnership between families and professionals. The following key principles to this partnership are:

- Families and professionals work together in the best interest of the child and the family. As the child grows, s/he assumes a partnership role;
- Everyone respects the skills and expertise brought to the relationship;
- Trust is acknowledged as fundamental;
- Communication and information sharing are open and objective;
- Participants make decisions together; and
- There is a willingness to negotiate.

Based on this partnership, family-centered care:

- Acknowledges the family as the constant in a child's life;
- Builds on family strengths;
- Supports the child in learning about and participating in his/her care and decision-making;
- Honors cultural diversity and family traditions;
- Recognizes the importance of community-based services;
- Promotes an individual and developmental approach;
- Encourages family-to-family and peer support;
- Supports youth as they transition to adulthood;
- Develops policies, practices, and systems that are family-friendly and family-centered in all settings; and
- Celebrates successes.

Sources: National Center for Family-Centered Care. Family-Centered Care for Children with Special Health Care Needs. (1989). Bethesda, MD: Association for the Care of Children's Health.

Bishop, Woll and Arango (1993). Family/Professional Collaboration for Children with Special Health Care Needs and their Families. Burlington, VT: University of Vermont, Department of Social Work.

Family-Centered Care Projects 1 and 2 (2002-2004). Bishop, Woll, Arango. Algodones, NM; Algodones Associates.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children less than one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care.*

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see "Types of Services").

Measures - (see "Performance Measures").

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining:1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing.

Neonatal – Infants less than 28 days of age.

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCH targeted funds from CDC, and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Perinatal – Period from gestation of 28 weeks or more to 7 days or less after birth.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than

results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, Medicaid reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (Medicaid) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (Medicaid) program.

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the ***Federal*** Title V Block grant allocation, the ***Applicant's*** funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the ***State*** funds (the total matching funds for the Title V allocation - match and overmatch), ***Local*** funds (total of MCH dedicated funds from local jurisdictions within the state), ***Other*** federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and ***Program Income*** (those collected by State MCH agencies from insurance payments, Medicaid, HMO's, etc.)

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building," "Population Based Services," "Enabling Services" and "Direct Medical Services."

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.