ANNOUNCING: TITLE V MCH PERFORMANCE MEASURES

FY 2016

WHAT WE'LL COVER TODAY…

- Title V MCH Transformation
- Needs Assessment Process
- Selection of National Performance Measures
- Next Steps

TITLE V MCH BLOCK GRANT TRANSFORMATION

TRIPLE AIMS OF THE MCH BLOCK GRANT TRANSFORMATION

Reduce Burden: Streamline the Annual Report/Application

- Summary Needs Assessment, 20 pages
- Pre-populate State data
- Eliminate Health Systems Capacity Indicator
- Reduce number of forms from 21 to 11
- Simplify, clarify and reduce redundancies

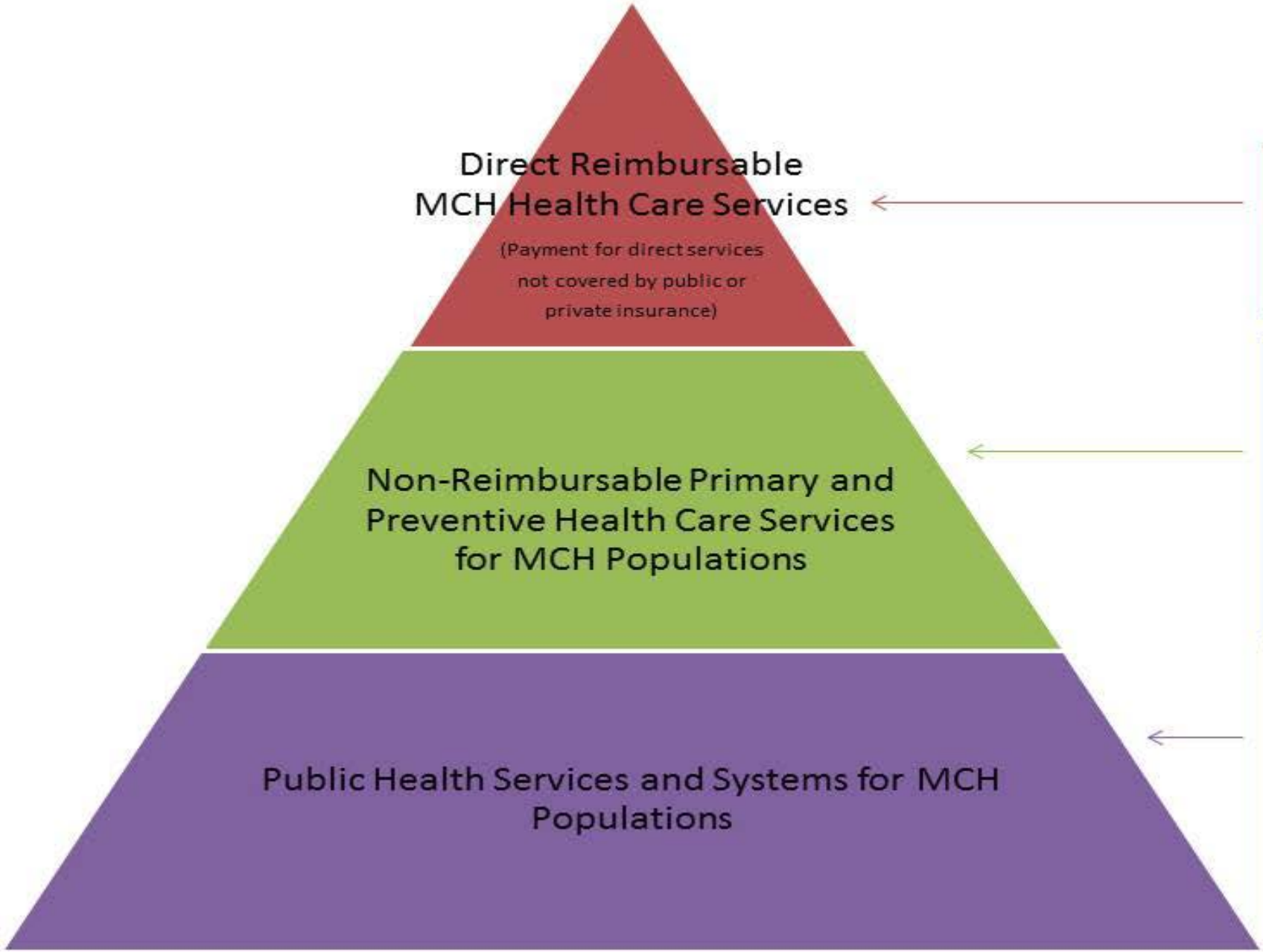
Maintain Flexibility: Apply a Logic Model

- Continuously analyze and reassess performance measures
- Implement 3-tiered performance measures with:
  - national outcome measures,
  - national performance measures, &
  - structural-process measures
- Measures for 6 domains

Increase Accountability: New Accountability Framework

- One-stop maternal & child health data center
- States develop structural process measures
- Realign SPRANS and other HRSA Projects to “move the needle” on maternal & child health

Public Health Services for MCH Populations: The Title V MCH Services Block Grant



MCH Essential Services/Public Health Standards

Provide Access to Care
Investigate Health Problems Inform and Educate the Public Engage Community Partners Promote/Implement Evidence-Based Practices
Assess and Monitor MCH Health Status Maintain the Public Health Work Force Develop Public Health Policies and Plans Enforce Public Health Laws Ensure Quality Improvement

NEEDS ASSESSMENT PROCESS

TITLE V MCH BLOCK GRANT NEEDS ASSESSMENT FRAMEWORK

- Assess and summarize
  - MCH Population Needs
  - Program Capacity
  - Partnerships/Capacity
- Identify State Title V priority needs and consider national MCH priority areas

5 YEAR NEEDS ASSESSMENT

- Regional Stakeholder Meetings
- Focus Groups
- Analysis of State and National Data Sources
- Needs Assessment Webinars
- Needs Assessment Survey & NPM Alignment

HEALTH CARE COVERAGE AND ACCESS

Priorities Identified	OPDS	OTVFH & CSHCN	Stakeholder Qualitative Input	Stakeholder Webinar	NPM	Life Course Indicator
Health Care Coverage and Access						
Percent of Children < 6 Without Health Insurance	√	√	√	√	15	
Percent of Females 18-44 Years Without Health Insurance	√	√	√	√	1 15	
Ratio of Primary Care Physicians to Population	√	√	√	√	15	
Primary Care Health Professional Shortage Area	√	√	√	√	15	
Ratio of Children to School Psychologists	√				15	
Ratio of Population to Psychiatrists	√				15	
Education of Providers Regarding Available Services			√	√	15	
Access to Health Care			√	√	15	LC-35 LC-36A LC-36B LC-38 LC-39
Coordination of Care			√	√	15	

PRE-PREGNANCY HEALTH

Priorities Identified	OPDS	OTVFH & CSHCN	Stakeholder Qualitative Input	Stakeholder Webinar	NPM	Life Course Indicator
Pre-Pregnancy Health						
Obesity and Chronic Disease	√	√	√	√	1 2	
Smoking	√	√	√		14	
Alcohol	√	√				
Illicit Drugs & Nonmedical Use of Prescription Drugs	√	√	√			
Mental Health	√	√				
Routine Checkup In Last Year		√		√	1	
Asthma		√				
Flu Shot in the Last Year		√			1	
Diet and Exercise		√		√		
Sexually Transmitted Diseases		√		√		

PREGNANCY AND BIRTH

Priorities Identified	OPDS	OTVFH & CSHCN	Stakeholder Qualitative Input	Stakeholder Webinar	NPM	Life Course Indicator
Pregnancy and Birth						
Prenatal Care	√	√		√	15	
Diabetes and Hypertension	√	√	√	√		LC-49
Oral Health Care Utilization	√	√	√	√	13	
Smoking During Pregnancy	√	√	√	√	14 5	LC-28
Stress and Maternal Risk During Pregnancy	√					LC-44 LC-56
Intimate Partner Violence	√	√		√		
Labor Inductions	√	√				
Cesarean Section	√	√		√	2	
Severe Maternal Morbidity	√	√				
Maternal Mortality	√	√		√		

BIRTH AND INFANCY

Priorities Identified	OPDS	OTVFH & CSHCN	Stakeholder Qualitative Input	Stakeholder Webinar	NPM	Life Course Indicator
Birth and Infancy						
Preterm Birth Rate	√	√			3	LC-55
Low Birth Weight	√	√		√		
Breastfeeding	√	√		√	4 5	LC-4 LC-27
Birth Defects	√					
Congenital Abnormalities	√					
Cerebral Palsy	√					
Infant Mortality including Sleep Related Deaths	√	√		√	5	
Feto-infant Mortality Rate	√					
Percent of Infants Placed on Back to Sleep	√	√		√	5	
Homicide	√					

CHILDHOOD

Priorities Identified	OPDS	OTVFH & CSHCN	Stakeholder Qualitative Input	Stakeholder Webinar	NPM	Life Course Indicator
Childhood						
Child Abuse and Neglect Fatalities	√	√		√	7	
Poverty	√	√	√	√		
Drowning	√	√		√	7	
Asthma	√	√		√		
Obesity	√	√	√	√	8	LC-32A
Oral Health	√	√		√	13	LC-41
Adverse Childhood Events		√			7	LC-1, LC-2, LC-3
Early Childhood School Readiness		√		√		LC-17
Cancer		√		√		
Behavioral Issues: ADD and ADHD			√	√		
Accidental Injuries			√	√	7	
Household Smoking	√	√		√	14	LC-28

CSHCN

Priorities Identified	OPDS	OTVFH & CSHCN	Stakeholder Qualitative Input	Stakeholder Webinar	NPM	Life Course Indicator
CSHCN						
CSHCN Medical Home	√	√		√	11	LC-25 LC-37
CSHCN Transition to Adult Health Care	√	√	√	√	12	
Families of CYSHCN have adequate private and/or public insurance to pay for the needed services		√		√	11 15	
Children are screened early and continuously for special health care needs		√		√		
Community-based services are organized so families can use them easily		√		√		
More day care			√	√		
More accessible parks and adaptive playgrounds.			√	√		
Access to qualified, trustworthy respite care providers			√	√	15	
After-school and sports programs			√	√		
Therapies in all modalities			√	√	15	
More sensitivity training about special healthcare needs for the community at large			√	√		

ADOLESCENTS

Priorities Identified	OPDS	OTVFH & CSHCN	Stakeholder Qualitative Input	Stakeholder Webinar	NPM	Life Course Indicator
Adolescents						
Mortality Rate by Manner of Death	√	√		√		
Motor Vehicle Crashes	√	√		√	7	
Suicides	√	√	√	√	9	LC-42
Tobacco	√	√	√	√	14	LC-23
Alcohol	√	√		√		LC-24
Illicit Drugs and Nonmedical Use of Prescription Drugs	√	√	√	√		
Unprotected Sex	√	√				LC-50
Sexually Transmitted Infections	√	√				
Dating and Intimate Partner Violence	√	√		√	9	
Obesity	√	√	√	√	8	LC-33
Positive Youth Development	√	√				
Teen Pregnancy	√	√	√			LC-50 LC-53 LC-54
Cancer		√				
Sex Education			√	√		
Bullying		√		√	9	LC-12 LC-42
Teen Contraceptive use		√		√		

CROSSCUTTING

Priorities Identified	OPDS	OTVFH & CSHCN	Stakeholder Qualitative Input	Stakeholder Webinar	NPM	Life Course Indicator
Crosscutting						
Parental Education			√	√		
Mental Health			√	√		
Substance Abuse			√	√		LC-30
Medicaid Reimbursement Rates Result in Lack of Providers			√	√	15	
Neighborhood Safety			√	√		
Contraception Services			√	√		
Obesity (Mothers, Fathers, Children)			√	√		LC-32B

PRIORITY NEEDS DRAFT LANGUAGE

- Medical Home –final language pending
- Transition – final language pending
- Advance Community Integration efforts.
- Reduce health disparities for maternal and child health populations
- Promote collaborations including family professional partnerships (to enhance Maternal and Child Health programming).
- Bolster access to quality statewide data, screening, and surveillance (to inform Maternal and Child Health programming).
- Improve coordination of care for Maternal and Child Health populations
- Improve access to and quality of primary care, reproductive health, and specialty clinical services.
- Ensure use of culturally and linguistically appropriate Maternal and Child Health education and outreach efforts.
- Increase Maternal and Child Health safety programming for birth to 19 year olds.

SELECTION OF NATIONAL PERFORMANCE MEASURES

TITLE V MCH BLOCK GRANT
NEEDS ASSESSMENT FRAMEWORK

- Select national performance measures
  - Develop interim strategies to address
    - priority needs and
    - selected national measures

PROCESS

- Stakeholder Input
  - Webinar Polls
  - Survey on DSHS MCH Website
- Other Factors
  - Existing Partners for Programming
  - Political Climate
- Recommendation to the Commissioner
- Approval by the Commissioner

TEXAS CURRENT NATIONAL PERFORMANCE MEASURES

- 1 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.
- 2 Percent of CSHCN (0-18 yrs) whose families partner in decision making at all levels and are satisfied with services they receive.
- 3 Percent of CSHCN age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home.
- 4 Percent of CSHCN age 0-18 whose families have adequate private and/or public insurance to pay for the services they need.
- 5 Percent of CSHCN age 0-18 whose families report the community-based systems are organized so they can use them easily.
- 6 Percentage of youth with SHCN who received the services necessary to make transition to all aspects of adult life.
- 7 Percent of 19-35 mo. olds who have received full schedule of age appropriate immunizations against MMR, Polio, Diphtheria, Tetanus, Pertussis, HIB and Hep B.
- 8 Rate of birth (per 1,000) for teenagers aged 15 through 17 years.
- 9 Percent of 3rd grade children who have received protective sealants on at least one permanent molar tooth.
- 10 Rate of deaths to children aged 14 yrs and younger caused by motor vehicle crashes per 100,000 children.
- 11 Percentage of mothers who breastfeed their infants at six months of age.
- 12 Percentage of newborns who have been screened for hearing before hospital discharge.
- 13 Percent of children without health insurance.
- 14 Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
- 15 Percentage of women who smoke in the last three months of pregnancy.
- 16 The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
- 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
- 18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

CURRENT STATE PERFORMANCE MEASURES

- 1 Change in percentage of CSHCN living in congregate care settings as a percent of base year 2003.
- 2 Rate of excess feto-infant mortality in Texas.
- 3 The extent to which programs enhance statewide capacity for public health approaches to mental and behavioral health for MCH populations.
- 4 The proportion of women between the ages of 18 and 44 who are current cigarette smokers.
- 5 The percent of obesity among school-aged children (grades 3-12).
- 6 Rate of preventable child deaths (0-17 year olds) in Texas.
- 7 The extent to which research findings and/or evidence-based practices are used to develop and improve DSHS programs serving MCH populations.

NEW NPM BY 6 POPULATION DOMAINS

Maternal & Women's Health
- Well woman care
- Low risk cesarean deliveries

Perinatal Health
- Perinatal regionalization
- Safe sleep
- Breastfeeding

Child Health
- Developmental screening
- Child safety/Injury
- Physical activity

CSHCN
- Medical home
- Transition

Adolescent Health
- Safety/Injury
- Bullying
- Adolescent well visit
- Physical activity

Crosscutting or Life Course
- Adequate insurance coverage
- Physical activity
- Household Smoking

MATERNAL AND WOMEN'S HEALTH

Performance Measure	Goal	Definition	Significance
1. Percent of women with a past year preventive visit	To increase the number of women who have a preventive visit.	Numerator: Women who reported having a routine check-up in the last year Denominator: Women, ages 18-44	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.
2. Percent of cesarean deliveries among low-risk first births	To reduce the number of cesarean deliveries among low-risk first births.	Numerator: Cesarean delivery among term (37+ weeks), singleton, vertex births to nulliparous women Denominator: All term (37+ weeks), singleton, vertex births to nulliparous women	Cesarean delivery can be a life-saving procedure for certain medical indications. However, for most low-risk pregnancies, cesarean delivery poses avoidable maternal risks of morbidity and mortality, including hemorrhage, infection, and blood clots—risks that compound with subsequent cesarean deliveries. Much of the temporal increase in cesarean delivery (over 50% in the past decade), and wide variation across states, hospitals, and practitioners, can be attributed to first-birth cesareans. Moreover, cesarean delivery in low-risk first births may be most amenable to intervention through quality improvement efforts. This low-risk cesarean measure, also known as nulliparous term singleton vertex (NTSV) cesarean, is endorsed by the ACOG, The Joint Commission (PC-02), National Quality Forum (#0471), Center for Medicaid and Medicare Services (CMS) – CHIPRA Child Core Set of Maternity Measures, and the American Medical Association-Physician Consortium for Patient Improvement.

INFANT/PERINATAL HEALTH

Performance Measure	Goal	Definition	Significance
3. Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	To ensure that higher risk mothers and newborns deliver at appropriate level hospitals.	Numerator: VLBW infants born in a hospital with a level III or higher NICU Denominator: VLBW infants (< 1500 grams)	Very low birth weight infants (<1,500 grams or 3.25 pounds) are the most fragile newborns. Although they represented less than 2% of all births in 2010, VLBW infants accounted for 53% of all infant deaths, with a risk of death over 100 times higher than that of normal birth weight infants (≥2,500 grams or 5.5 pounds). VLBW infants are significantly more likely to survive and thrive when born in a facility with a level-III Neonatal Intensive Care Unit (NICU), a subspecialty facility equipped to handle high-risk neonates. In 2012, the AAP provided updated guidelines on the definitions of neonatal levels of care to include Level I (basic care), Level II (specialty care), and Levels III and IV (subspecialty intensive care) based on the availability of appropriate personnel, physical space, equipment, and organization. Given overwhelming evidence of improved outcomes, the AAP recommends that VLBW and/or very preterm infants (<32 weeks' gestation) be born in only level III or IV facilities. This measure is endorsed by the National Quality Forum (#0477).
4. A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months.	To increase the proportion of infants who are breastfed and who are breastfed at six months	Numerator: A) Number of infants who were ever breastfed B) Number of infants breastfed exclusively through 6 months Denominator: A) All infants born in a calendar year B) All infants born in a calendar year	Advantages of breastfeeding are indisputable. The American Academy of Pediatrics recommends all infants (including premature and sick newborns) exclusively breastfeed for about six months as human milk supports optimal growth and development by providing all required nutrients during that time. Breastfeeding strengthens the immune system, improves normal immune response to certain vaccines, offers possible protection from allergies, and reduces probability of SIDS. Research demonstrates breastfed children may be less likely to develop juvenile diabetes; and may have a lower risk of developing childhood obesity, and asthma; and tend to have fewer dental cavities throughout life. The bond of a nursing mother and child is stronger than any other human contact. A woman's ability to meet her child's nutritional needs improves confidence and bonding with the baby and reduces feelings of anxiety and postnatal depression. Increased release of oxytocin while breastfeeding, leads to a reduction in post-partum hemorrhage and quicker return to a normal sized uterus over time, mothers who breastfeed may be less likely to develop breast, uterine and ovarian cancer and have a reduced risk of developing osteoporosis.
5. Percent of infants placed to sleep on their back	To increase the number of infants placed to sleep on their backs	Numerator: Mothers reporting that they most often place their baby to sleep on their back (Excludes multiple responses of back and combination with side or stomach sleep positions) Denominator: Live births	Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the AAP has long recommended the back (supine) sleep position. However, in 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. Among others, additional higher-level recommendations include breastfeeding and avoiding smoke exposure during pregnancy and after birth. These expanded recommendations have formed the basis of the National Institute of Child Health and Development (NICHD) Safe to Sleep Campaign.

CHILD HEALTH

Performance Measure	Goal	Definition	Significance
6. Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool	To increase the number of children who receive a developmental screening.	Numerator: Parent reporting they have filled out a questionnaire provided by a health care provider concerning child's development, communication or social behaviors for a child ages 9 through 71 months Denominator: All children ages 9 through 71 months	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.
7. Rate of injury-related hospital admissions per population ages 0 through 19 years	To decrease the number of injury-related hospital admissions among children ages 0 through 19 years.	Numerator: Number of hospital admissions among children ages 0 through 19 years with a diagnosis of unintentional or intentional injury. (first admission for an injury event, excludes readmissions for same event) Denominator: Number of children and adolescents 0 through 19 years	Injury is the leading cause of child mortality. For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.
8. Percent of children ages 6 through 11 years and adolescents ages 12 through 17 years who are physically active at least 60 minutes per day	To increase the number of children and adolescents who are physically active.	Numerator: Parent report of children (in NSCH), ages 6 through 11 years, and adolescents (in NSCH), ages 12 through 17 years, who are physically active at least 60 minutes per day. (YRBSS is also available and provides self-report by adolescents) Denominator: All children ages 6 through 11 years and adolescents ages 12 through 17 years	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.

ADOLESCENT HEALTH

Performance Measure	Goal	Definition	Significance
7. Rate of injury-related hospital admissions per population ages 0 through 19 years	To decrease the number of injury-related hospital admissions among children ages 0 through 19 years.	Numerator: Number of hospital admissions among children ages 0 through 19 years with a diagnosis of unintentional or intentional injury. (first admission for an injury event, excludes readmissions for same event) Denominator: Number of children and adolescents 0 through 19 years	Injury is the leading cause of child mortality. For those who suffer non-fatal severe injuries, many will become children with special health care needs. Effective interventions to reduce injury exist but are not fully implemented in systems of care that serve children and their families. Reducing the burden of nonfatal injury can greatly improve the life course trajectory of infants, children, and adolescents resulting in improved quality of life and cost savings.
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ADOLESCENT HEALTH (2)

Performance Measure	Goal	Definition	Significance
9. Percent of adolescents, ages 12 through 17 years, who are bullied	To reduce the number of adolescents who are bullied.	Numerator: Parent report on adolescents (in NSCH), and adolescent report (in YRBSS), for adolescents ages 12 through 17 years, who were bullied Denominator: Number of adolescents, ages 12 through 17 years	Bullying, particularly among school-age children, is a major public health problem. Current estimates suggest nearly 30% of American adolescents reported at least moderate bullying experiences as the bully, the victim, or both. Specifically, of a nationally representative sample of adolescents, 13% reported being a bully, 11% reported being a victim of bullying, and 6% reported being both a bully and a victim Studies indicate bullying experiences are associated with a number of behavioral, emotional, and physical adjustment problems. Adolescents who bully others tend t exhibit other defiant and delinquent behaviors, have poor school performance, be more likely to drop-out of school, and are more likely to bring weapons to school. Victims of bullying tend to report feelings of depression, anxiety, low self-esteem, and isolation; poor school performance; suicidal ideation; and suicide attempts. Evidence further suggests that people who are the victims of bullying and who also perpetrate bullying (i.e., bully-victims) may exhibit the poorest functioning, in comparison with either victims or bullies. Emotional and behavioral problems experienced by victims, bullies, and bully-victims may continue into adulthood and produce long-term negative outcomes, including low self-esteem and self-worth, depression, antisocial behavior, vandalism, drug use and abuse, criminal behavior, gang membership, and suicidal ideation.
10. Percent of adolescents with a preventive services visit in the last year	To increase the number of adolescents who have a preventive services visit.	Numerator: Parent report of adolescents, ages 12 through 17, with a preventive services visit in the past year from the survey Denominator: Number of adolescents, ages 12 through 17 years	Adolescence is a period of major physical, psychological, and social development. As adolescents move from childhood to adulthood, they assume individual responsibility for health habits, and those who have chronic health problems take on a greater role in managing those conditions. Initiation of risky behaviors is a critical health issue during adolescence, as adolescents try on adult roles and behaviors. Risky behaviors often initiated in adolescence include unsafe sexual activity, unsafe driving, and use of substances, including tobacco, alcohol, and illegal drugs. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease. Receipt of services can help prepare adolescents to manage their health and health care as adults. The Bright Futures guidelines recommends that adolescents have an annual checkup starting at age 11. The visit should cover a comprehensive set of preventive services, such as a physical examination, discussion of health-related behaviors, and immunizations. It recommends that the annual checkup include discussion of several health-related topics, including healthy eating, physical activity, substance use, sexual behavior, violence, and motor vehicle safety.

CSHCN

Performance Measure	Goal	Definition	Significance
11. Percent of children with and without special health care needs having a medical home	To increase the number of children with and without special health care needs who have a medical home	Numerator: Parent report for all children with and without special health care needs, ages 0 to 18 years, who meet the criteria for having a medical home, with subset analyses for children with special health care needs Denominator: All children and adolescents, ages 0 to 18 years	The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care: accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. 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 familiar with the child and family and the child's health history. Providing comprehensive care to children in a medical home is the standard of pediatric 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 Maternal and Child Health Bureau uses the AAP definition of medical home.
12. Percent of children with and without special health care needs who received services necessary to make transitions to adult health care	To increase the percent of youth with and without special health care needs who have received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.	Numerator: Parent report of youth with and without special health care needs, ages 12 through 17, whose families report that they received the services necessary to transition to adult health care, with subset analyses for children with special health care needs Denominator: All adolescents, ages 12 through 17 years	The transition of youth to adulthood has become a priority issue nationwide as evidenced by the clinical report and algorithm developed jointly by the AAP, American Academy of Family Physicians and American College of Physicians to improve healthcare transitions for all youth and families. 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.

CROSSCUTTING/LIFECOURSE

Performance Measure	Goal	Definition	Significance
13. A) Percent of women who had a dental visit during pregnancy and B) Percent of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year	A) To increase the number of pregnant women who have a dental visit and B) To increase the number of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year.	Numerator: A) Report of a dental visit during pregnancy B) Parent report of infant or child, ages 1 through 17 years, who had a preventive dental visit in the last year Denominator: A) All live births B) All infants and children, ages 1 through 17 years	Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases. Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits.
14. A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes	**A) To decrease the number of women who smoke during pregnancy and B) To decrease the number of households where someone smokes**.	**Numerator: A) Women who report smoking during pregnancy B) Parent report of cigar, cigarette, or pipe tobacco use by household members Denominator: A) All women who delivered a live birth in a calendar year B) All children, ages 0 to 18 years**	**Women who smoke during pregnancy are more likely to experience a fetal death or deliver a low birth weight baby. Further, secondhand smoke (SHS) is a mixture of mainstream smoke (exhaled by smoker) and the more toxic side stream smoke (from lit end of nicotine product) which is classified as a "known human carcinogen" by the US Environmental Protection Agency, the US National Toxicology Program, and the International Agency for Research on Cancer. Adverse effects of parental smoking on children have been a clinical and public health concern for decades and were documented in the 1986 U.S. Surgeon General Report. The only way to fully protect non-smokers from indoor exposure to SHS is to prevent all smoking in the space; separating smokers from non-smokers, cleaning the air, and ventilating buildings do not eliminate exposure. Unfortunately, millions (more than 60%) of children are exposed to SHS in their homes. These children have an increased frequency of ear infections; acute respiratory illnesses and related hospital admissions during infancy; severe asthma and asthma-related problems; lower respiratory tract infections leading to 7,500 to 15,000 hospitalizations annually in children under 18 months; and sudden infant death syndrome (SIDS). Higher intensity medical services are also required by children of parents who smoke including an increased need for intensive care unit services when admitted for flu, longer hospital stays; and more frequent use of breathing tubes during admissions.**

CROSSCUTTING/LIFECOURSE(2)

Performance Measure	Goal	Definition	Significance
15. Percent of children 0 through 17 years who are adequately insured	To increase the number of children who are adequately insured	Numerator: Parent report of children, ages 0 through 17 years, who were reported to be adequately insured, based on 3 criteria: whether their children's insurance covers needed services and providers, and reasonably covers costs. If a parent answered "always" or "usually" to all three dimensions of adequacy, then the child was considered to have adequate insurance coverage. (No out-of-pocket costs were considered to be "always" reasonable.) Denominator: All children, 0 through 17 years	Almost one-quarter of American children with continuous insurance coverage are not adequately insured. Inadequately insured children are more likely to have delayed or forgone care, lack a medical home, be less likely to receive needed referrals and care coordination, and receive family-centered care. The American Academy of Pediatrics highlighted the importance of this issue with a policy statement. The major problems cited were cost-sharing requirements that are too high, benefit limitations, and inadequate coverage of needed services.

NEXT STEPS

FIVE YEAR ACTION PLAN TABLE

- Texas is in the process of writing our plan to present how the state will move forward in addressing each of the measures.

DRAFT ACTIVITY PLAN TABLE
CHILD INJURY

- Objective: Increase activities that that help to prevent child injury and death.
- Possible Strategies:
  - Safe Riders car seats to reduce motor vehicle injuries.
  - Periods of Purple Crying to reduce shaken baby syndrome
  - Drowning RFP to reduce children being injured in bodies of water.
  - Healthy Child Care Texas Child Care Consultant Training Program that provides guidance on how child care providers keep children in their care safe and healthy.
  - Parent Guide to Healthy, Happy Children provided to Medicaid parents on how to keep their kids healthy, highlighting normal behaviors and developmental delays as well as doctor visit schedules.
  - Encourage MEDCARES providers to provide increased prevention activities.

DRAFT ACTIVITY PLAN TABLE CSHCN

- Objective: By 2020, increase the percentage of **CYSHCN and their families** who are provided education and support about receiving care within a medical home.
- **Strategy 1:**
  Assess level of CYSHCN and family members' understanding of medical home.
  - **Activities**
    1a. Partner with Texas' Family Voice affiliate to ensure family input.
  - 1b. Develop a survey for families of CYSHCN.
  - 1c. Distribute survey through GovDelivery, community-based contractors, regional staff, CSHCN SP website, MHWG, TTVTW, health care benefit program and other partners.
    1d. Analyze survey results.
    1e. Utilize findings to guide programming and activities.
    1f. Reassess level of family understanding of medical home.

STATE PERFORMANCE MEASURES

- Texas will submit in 2017

QUESTIONS & COMMENTS