From: Deltas, Viviana <abuchar@illinois.edu>
Sent: Friday, January 15, 2021 9:27 AM
To: HRSA Paperwork <paperwork@hrsa.gov>
Subject: Comment on: Information Collection Request Title: The Maternal, Infant, and Early Childhood Home Visiting Program Performance Measurement Information System, OMB No. 0906-0017, Rev

Below are some comments on the Information Collection Request Title above.

1) The necessity and utility of the proposed information collection for the proper performance of the agency's function is not explained. Currently the abundance of data is not fully utilized. The request for reporting on gender non-conforming and father and additional caregiver are extra burdens on the field that may be better left to an independent study about these subjects.
2) It is unclear if the estimated burden captures the time needed to establish a relationship with extra caregivers for then to be willing to share data.
3) The quality, utility and clarity of the information to be collected could be assessed doing a pilot in a site that has predominantly people of gender non-conforming or an abundance of fathers or other caregivers. Number of visits completed virtually could be estimated by site (only a few sites might be doing in-person visits during the covid period. However, I understand the need and practicality of figuring out how virtual visits compare with in-person visits and when one works better than the other.
4) If anything, the number of visits completed virtually would be one of the new elements that might be easily incorporated into data collection systems because it is known by the home visitors without needing to ask their participants.

Thanks for the opportunity for comment.
Viviana Deltas

From: McKelvey, Lorraine <McKelveyLorraine@uams.edu>
Sent: Wednesday, January 20, 2021 4:18 PM
To: HRSA Paperwork <paperwork@hrsa.gov>
Cc: Greenwood, Tyra M <GreenwoodTM@archildrens.org>
Subject: Document 85 FR 82490 (Pages 82490-82491)

To Whom It May Concern,

The state of Arkansas would like to submit a formal comment in regards to proposed changes to reporting requirements for HRSA's MIECHV program in regards to:
Information Collection Request Title: The Maternal, Infant, and Early Childhood Home Visiting Program Performance Measurement Information System, OMB No. 0906-0017, Revision.
https://www.federalregister.gov/documents/2020/12/18/2020-27919/agency-information-collection-activities-proposed-collection-public-comment-request-information#addresses

We would like to advise that the addition of two measures to Form 2 reporting, specifically the point "Form 2: Add two measures to collect information on substance use screening and referrals" may require a great deal of work for the state. Depending upon the allowed screening tools, the adoption of a new tool statewide would require the training of staff in a new tool, the rebuilding of offline data collection tools (used to conduct the screening), the reworking of online data collection tools (used to for track referrals), the recoding of monthly and quarterly data reports provided to LIAs to support the timely collection of data, as well as the recoding of performance reporting data and analysis. There will be additional staff costs for each of these elements as well as the need for additional contracting to build data collection tools and reports.

Thank you for your consideration,

Lorraine McKelvey, PhD (she/her)
Associate Professor
University of Arkansas for Medical Sciences
Department of Family & Preventive Medicine
4301 W. Markham St. #530, Little Rock, AR 72205-7199
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Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Maine Center for Disease Control and Prevention
11 State House Station
286 Water Street
Augusta, Maine 04333-0011
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TTY: Dial 711 (Maine Relay)

Ms. Cynthia Phillips
Director, Division of Home Visiting and Early Childhood Services
Maternal Child Health Bureau
Health Resources and Services Administration
Rockville, MD 20857

February 8, 2021

Dear Ms. Phillips,

RE: Document Citation: 85 FR 82490 Page: 82490-82491 (2 pages) Document Number: 2020-27919

This letter is in response to HRSA's notice of proposed changes to the MIECHV Program Performance Measurement Information System. The opportunity to offer feedback on the proposed changes is appreciated. The following response is broken out into sections focused on Form 1, Form 2, and general comments.

Form 1

The CQI and Evaluation team is encouraged and appreciative of the **addition of gender non-conforming/other and unknown categories to gender in Table 1,** and efforts to use gender neutral language such as "pregnant participants." This will help support the alignment of data collection tools with family experience and improve the accuracy of the performance measure reporting. However, there is concern about the impact the additional changes to subsequent tables will have on client privacy. As proposed, tables 4, 6, 7, 8, 9, 10, 11, and 18 would be broken out across the four gender categories. In the case of tables 4, 9, 10, and 18, also broken out by new and continuing participants. Given the small number of caregivers and children who may identify as other or non-binary or have an unknown gender at the time of reporting (for example, in previous years one or two caregivers identified as non-binary), these tables will make it impossible to protect the privacy of those individuals and as written will lead to the disclosure of multiple layers of personal information. It is suggested to either remove the gender breakouts from those tables or allow small numbers (less than 5 or 10) to be suppressed (e.g., allow states to report "less than 5" rather than the exact number).

Regarding the addition of **Table 16: Father and Additional Caregiver Engagement,** additional details will be helpful to adopt these changes. Questions that came up during discussion of the changes included:

- Does the table refer to *enrolled* caregivers who identify as father or other caregiver, or any other adult in a caregiving role who has attended at least one visit (not all caregivers enroll in home visiting, but they may attend a visit if they are home)?
- Would a family with both a father and other caregiver who have participated in visits (e.g., aunt/uncle, or grandfather/mother) be counted twice in the table?
- If the primary caregiver is not the mother, but that caregiver is the only adult participant in visit, would the household be counted here?

Form 2

To implement the proposed changes to **Measure 17, Continuity of Health Insurance**, additional information is requested to clarify the difference between the proposed changes and the current measure in terms of when the six months of health insurance can take place.

As currently proposed, the 30-day timeframe for **Measure 7, Substance Use Screening**, would disrupt the relationship building process and lead to fewer disclosures of substance use. A 90-day timeframe is more realistic and aligned with the other performance measures and model expectations of Parents as Teachers, the model used in Maine. Substance use screening and referral to substance use services has been a practice within Maine's MIECHV-funded home visiting program for several years. The current practice has been to align the timing of substance use screening with depression screening, which is currently required to occur within three months of enrollment (90 days). It has been found that a longer screening window allows home visitors time to build a relationship and trust with families, which are essential components for family engagement and education that is family-centered and conducted with cultural humility. The substance use screening is introduced through conversation with families which provides home visitors an opportunity to learn about caregiver's perceptions and values around alcohol and other substances, and the impact the caregiver's experiences have had their relationships and parenting. Whether or not there is current substance use in the home, caregivers often have a lot to share because of past history and childhood experiences, and that information can help deepen the visitor-family relationship and the support that visitors provide.

There are similar concerns regarding the timeframe outlined in the proposed **Measure 21, Completed Substance Use Referrals.** A fourteen-day timeframe for a parenting adult to connect with a behavioral health professional is not realistic in Maine due to the shortage of available providers. An alternative approach would be to measure the percent of caregivers who are referred to services, which is well within the scope of a home visitor's control and aligns with the intimate partner violence referral measure. However, HRSA might also consider including all referrals to substance use services, rather than only those as a result of a positive screening. As previously mentioned, the rate of positive screens will be lower than the actual incidence of substance use because screenings are to be conducted before relationship and trust has been built between caregiver and home visitor. As home visitors' work with families continues,

families share more about their use of alcohol and other substances, and home visitors refer to appropriate community resources. As currently written, Measure 21 truncates the true impact of home visiting practice. Finally, should the measure be implemented, it is recommended to permit caregivers who are already receiving services for substance use to be excluded from the measure.

General Comments

Should any of these changes be implemented, HRSA is encouraged to release additional information regarding any research from the field and the intention behind including them. Similarly, additional information on how the demographic information on continuing and new families in Form 1 will be used by HRSA would be helpful.

HRSA is encouraged to reconsider the Estimated Annualized Burden Hours for implementing these changes, particularly with the addition of two new measures to Form 2. In addition to the hours involved in updating Maine's family record system, reports, and performance measurement plan, all staff will need training in the new timeframes of the screening and the intention of screening. Implementing practice changes generally involves meeting with program managers (25 hours across 16 staff), planning and conducting a training webinar (120 hours across 105 staff), check-ins during staff meetings and supervision to discuss challenges and continue to practice new skills as necessary, and individual time spent by home visitors to plan visits following the new guidelines (approximately 75 hours across the system). Updates also may be needed to Core training for new staff. Therefore, the burden may be double what is estimated for Form 2. While Maine always seeks to identify efficiencies and will utilize resources developed by HRSA and subject matter experts, it is often found that the thoughtful integration of new practices is time intensive, and if there is the need to transition to a different validated tool than the one currently in use, training hours would likely be higher.

Thank you for the opportunity to submit these comments. Maine staff look forward to working with HRSA to implement any necessary changes to the Performance Measurement Information System.

Sincerely,

Maryann Harakall

Maryann Harakall
Maternal and Child Health Program Director

From: PW, PAHomeVisiting <RA-PWPAHOMEVISITING@pa.gov>
Sent: Wednesday, February 10, 2021 1:57 PM
To: HRSA Paperwork <paperwork@hrsa.gov>
Subject: RE: MIECHV Program Proposed Reporting Changes

February 10th, 2021

To Whom This May Concern,

The following feedback on the proposed MIECHV data collection changes is from the Pennsylvania Office of Child Development and Early Learning (OCDEL), Bureau of Early Intervention Services and Family Supports (BEIS&FFS). Within Pennsylvania OCDEL oversees the implementation of the MIECHV Program.

Proposed Performance Measures 7 and 21
On the proposed new screening and referral measures for substance use:
OCDEL believes that these proposed measures should not be implemented. It is OCDEL's opinion that the subject matter is more appropriate for a clinician and not appropriate for a home visitor due to the nature of the home visitor and caregiver relationship. From the family perspective it could potentially appear to be redundant since substance use is addressed in the medical community as an example Pennsylvania screens all newborns for substance exposure at the hospital. OCDEL also believes adding this Measure would deter families from enrolling or maintaining enrollment.

Recommendations on Proposed Performance Measures 7 and 21
If the proposed measures are implemented, we have the following suggestions:

Proposed Measure 7 - Substance Use Screening
The proposed 30-day time period is too early to complete this screening given the sensitive topic and nature. The proposed timeline does not allow enough time for a home visitor to build a relationship with the family they are serving prior to discussing sensitive topics conducting sensitive screenings. Other sensitive topics and screenings such as Depression (3 months) and Intimate Partner Violence (6 Months) allow the Home Visitor to build a relationship with the Caregiver prior to having these discussions.

The implementation of the proposed screening as is could deter caregivers from continuing with services if these are to be completed as early as required in the proposal. We recommend at least a minimum of 3 months to be the earliest data collection point for this Measure.

Some additional considerations are:

- Training for the Local Implementing Agencies (LIAs)
- The data collection is somewhat duplicative since tobacco use is already collected.
- How are Plans of Safe Care reflected in this Measure?
- Add options for caregivers who:
    - Were already receiving services; or
    - Were already screened; and
    - Are excluded from this Measure

Proposed Measure 21 - Completed Substance Use Referrals

The proposed 14-day post-screening is too early considering appointment availability and scheduling, even in normal conditions it will take much longer than 14-days in certain areas if the caregiver does not have an active addiction or is not pregnant, due to varying access to services and transportation. Consider including scheduled appointments or other steps to receiving services in the Numerator of this Measure.

Questions
Questions on this feedback can be directed to:
RA-PWPAHOMEVISITING@pa.gov

Thank you,

The Pennsylvania Family Support Program Team
Office of Child Development and Early Learning | Bureau of Early Intervention Services and Family Supports
333 Market Street, 6th Floor | Harrisburg, PA 17126-2210
www.pde.pa.gov | www.dhs.pa.gov

Providing families access to high quality services to prepare children for school and life success.

THE NATIONAL SERVICE OFFICE FOR
Nurse-Family Partnership
Helping First-Time Parents Succeed®
child first

February 11, 2021

Diana Espinosa
Acting Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane | Rockville, MD | 20857

Re: Agency Information Collection Activities: The Maternal, Infant, and Early Childhood Home Visiting Program Performance Measurement Information System

Dear Administrator Espinosa,

The National Service Office for Nurse-Family Partnership® (NFP) and Child First appreciates the opportunity to respond to the Health Resources and Services Administration's (the Department's) proposed changes to the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program's Information Collection Request (ICR) (85 FRN 82490, published 12/18/2020). The NSO, in general, supports the changes proposed. However, the NSO cautions that any proposed changes to the benchmarks imposes an increased burden on our Nurses, staff, and the families that we serve, and we recommend that the Department consider those burdens as it proceeds. Data collection and reporting are ongoing burdens for awardees, and the addition of even one new measure or assessment increases the time and resources for all awardees and staff. Requiring all the proposed changes by the 2022 reporting period may also need to be reconsidered. Pending more specific details (as explained below), the level of effort to implement these changes may be significant. The NSO offers the following specific comments.

- ***Form 1, Table 1:*** **Update table to include reporting for gender non-conforming participants and unknown/did not report participant gender.**

The NSO seeks further clarification regarding this proposed change. Does the Department intend to require specific language and categorization of gender options? Currently, the gender options for NFP include male, female, not answered, and transgender. It is unclear if this is sufficient given the update proposed.

Further, the NSO recommends that the word "other" be omitted as it sets apart people who do not identify as male or female. Instead, the NSO suggests that the Department consider using "Gender non-binary." This comment applies to all questions of gender throughout Form 1. The NSO also recommends that Form 1 ask for "sex assigned to birth of index child," as it may be difficult to ascertain a very young child's preferred gender expression. The Department may consider consultation with other experts about young children being assigned a sex other than male or female at birth.

- ***Form 1, Tables 3, 4, 6, 7, 8, 9, 10, 11, and 18:*** **Update tables to include reporting for gender non-conforming participants and unknown/did not report adult participant gender.**

The NSO has concerns over this proposed change, as the small cell size for this measure would be compromising to client confidentiality. In addition, updating the reporting and analysis on this measure would create an additional burden. The NSO recommends that the Department consider applying thresholds for suppressed data to ensure client confidentiality. For example, a cell size of less than ten would be suppressed, a standard used by the National Association for Public Health Statistics and Information Systems (NAPHSIS) when analyzing and sharing birth record data with external parties. Presumably, all children and caregivers in Table 1 should be accounted for in the subsequent tables, thus the "Unknown/Did Not Report" should be relabeled to "Unknown/Did Not Report/Suppressed due to small sample size."

- ***Form 1, Table 15:*** **Update table to collect the number of home visits completed virtually.**

Form 1 instructions refer to Models for the definition of virtual. Since these definitions vary, the NSO recommends that the table should include a "Notes" section to provide the Model definition of virtual.

- ***Form 1, Table 16:*** **Add new table to include reporting on father and additional caregiver engagement.**

The NSO seeks clarification on how father and additional caregiver engagement will be measured. Without a clear definition of what this will entail, it is hard for the NSO to evaluate our level of effort to make this change to our reporting. This proposed change will likely require a change to our data collection system, and depending on the ask, it may not be possible to make these changes in time for the 2022 reporting period.

Overall, the purpose of Table 16 is unclear. Throughout, we will be reporting on caregivers by their gender which will include male caregivers. Not only do we need clarity on how engagement will be measured, but we also need to understand the distinction of these caregivers from others that are already reported. As stated above, once we receive clarification, we would need time to evaluate the level of effort it would take to comply with that request.

- ***Form 2, Measure 16:*** **Update measure to reflect caregiver health insurance coverage status.**

The NSO seeks clarification on how the Department intends to measure caregiver health insurance coverage status. Additionally, the frequency of data collection for this measure is unclear. Without a clear definition of what this will entail, it is hard for the NSO to evaluate our level of effort to make

this change to our reporting. This proposed change may require a change to our data collection system, and depending on the ask, it may not be possible to make these changes in time for the 2022 reporting period. The NSO also recommends that the Department remove "the most recent data collection point within the reporting period" and replace it with a defined timeframe.

- ***Form 2:*** **Add two measures to collect information on substance use screening and referrals.**

The NSO has concerns over the required timing for the substance use screening. The language in the benchmark revision states that the tool must be conducted within thirty days from enrollment. We have concerns that this requirement goes against NFP Nursing/program implementation guidance. Establishing a relationship with the client in the first month is a key focus of the NFP program and requiring a substance use screen could impede a Nurse's ability to build a trusting relationship with their client. Home Visiting in general, and NFP and Child First in particular, uses strength-based practices to engage with the most vulnerable families. We are concerned that the proposed substance use screening tool focuses on risks of the family, and it is problematic to do so very early in the relationship. The NSO strongly recommends that the Department consider removing the timeframe requirement, or allow for more flexibility, such as within the first five to seven visits or aligned with the IPV assessment ("within six months"), but not based on days enrolled in the program.

Furthermore, as Registered Nurses and Licensed Mental Health Professionals/Developmental Clinicians, both NFP and Child First's models allow for clinical opinions and our families' needs and desires, to guide their assessments. A mandatory assessment within the first thirty days is counterproductive to the trusting relationships on which home visiting models are founded and infringes on the clinical knowledge and expertise of our home visitors.

The NSO also strongly encourages the Department to consider more than one validated tool to screen for substance use. The NSO encourages the Department to consider the use of modified, validated tools or consider accepting other methods of screening for substance use as defined by the evidence-based model. In this case, Form 2 could include a statement on which specific methods have been used.

The proposed changes to Measure 7 (page 11) states that an awardee can list the "validated tool(s) utilized." We seek further clarity on whether the Department will provide awardees with a preapproved list, or if tools will be approved on a case-by-case basis. In addition, we have concerns that new tools will require a change to Nursing practice, education, and data collection that may not be feasible by the start of the 2022 reporting period. Again, this change creates an additional burden for our home visitors and staff. The NSO recommends that the Department consider these implications when determining the timeline for this change.

Finally, the NSO suggests that the Department reconsider the timing requirements for referrals to substance a behavioral health specialist. Proposing that a caregiver meet with "a behavioral health specialist within 14 days of a positive screen for unhealthy alcohol use or drug use" (Measure 21) is an unrealistic expectation, given the availability of substance use/mental health services. The availability of these services varies across the country and does not even take into consideration the long wait times many of these service providers currently have. In addition, Child First Clinicians may work directly with caregivers on substance use or abuse. Thus, we would recommend an option to indicate that the identified substance use issues are being addressed by a clinician (or behavioral health specialist) within the model.

This requirement only increases the burden to our families and highlights the existing structural racism and oppression in access to care. The NSO has serious concerns that this change may only exacerbate this problem. Additionally, Home Visitors do all that they can to ensure that families are connected to resources, but they cannot control if a referral partner has availability or if that resource even exists in their communities. Measuring Home Visiting's effectiveness on this time-bound measurement, is in our opinion, not a strong measure. Again, if a timeframe is to be included in the measure, we propose more flexibility, recognizing the realities of access to substance use/behavioral health services.

Thank you for your consideration of these comments and your continued work to bring quality programs to families in need.

Regards,

Frank Daidone
President and CEO
National Service Office for Nurse-Family Partnership and Child First
1900 Grant St. | 4th Floor | Denver, CO | 80203

Parents as Teachers®

All children will develop, learn and grow to realize their full potential.

February 16, 2021

Lisa Wright-Solomon,
Information Collection Clearance Officer, 14N136B,
HRSA
5600 Fishers Lane,
Rockville, MD 20857

Dear Lisa Wright-Solomon:

On behalf of Parents as Teachers National Center (PATNC), thank you for the opportunity to provide feedback on the proposed revisions to the Maternal, Infant, and Early Childhood Home Visiting Program Performance Measurement Information System (PMIS), OMB No. 0906–0017, Revision posted on Friday, December 18, 2020.

Parents as Teachers (PAT) is an evidence-based Maternal, Infant, and Early Childhood Home Visiting model that offers culturally competent care with a focus on families during pregnancy and the early years. PAT provides parents and other adults in the home with tools to help whole families thrive, with an emphasis on maternal and infant health and development. Our home visiting model operates in all 50 states and more than 110 tribal communities. Half our programs are in rural areas. As members of the communities they serve, PAT home visitors bring a critical understanding of how a family's culture and values impact parenting and health practices. As you know, PAT has met Health and Human Services criteria for evidence of effectiveness and is thus an approved model for implementation of the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV).

The implementation, training, and evaluation teams at Parents as Teachers National Center have reviewed the proposed changes to the PMIS as part of our collective goal to better serve families enrolled in MIECHV, and respectfully offer the following comments, questions, and concerns:

Form 1, Table 1: We appreciate the expanded options within the gender question to be more inclusive.

Form 2: We recommend adding two measures collecting information on substance use screening and referrals.

Proposed performance measure 7: "Percent of primary caregivers enrolled in home visiting who were screened for unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use using a validated tool within 30 days of enrollment" requires further clarification and has some potentially negative impacts on a home visitor's ability to be successful with families:

1. Administering the substance use screening tool within 30 days of enrollment poses significant challenges to the home visitor's ability to build trust and develop and maintain relationships with families. There are serious fears associated with

admitting to substance abuse that are not associated with intimate partner violence and depressions screening. Concerns include the threat of the removal of child(ren) from the home, and potential legal consequences that could result in job loss, economic impacts, and possible incarceration. Conducting such sensitive screens at the onset of building relationships for supportive services threatens a home visitor's ability to build therapeutic and supportive relationships and could also hamper recruitment efforts. As a result, families may choose not to begin or continue receiving services. We recommend allowing more time for the tool (administered annually) to be initially administered with any new family to allow the home visitor and family to first establish a trusting relationship.

2. Would HRSA consider allowing non-reliable and valid tools that might be already incorporated into data collection for home visiting models? Many evidence-based home visiting models already do informal screenings on substance abuse as part of their model's approach to supporting families and connecting to community resources.
3. How many tools are intended to be utilized for the screening? The measure states that primary caregivers are screened for "unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use" which suggests that states may need to use multiple tools to be able to assess all substances as most tools are only designed to assess for one substance (e.g., AUDIT assesses for alcohol use).
4. Additional clarification is needed on the following questions: Will a list of validated and approved tools be provided? Will states need to measure all substances listed (e.g., unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use)?

PAT recommends that proposed performance measure 21 "Percent of primary caregivers enrolled in home visiting with positive screens for unhealthy alcohol use or drug use (measured using a validated tool) who receive services in a timely manner" be refined to align with performance measure 18 by measuring the percent of primary caregivers referred to services for a positive screen for unhealthy alcohol or drug use who receive one or more service contacts: Screening for unhealthy alcohol or drug use are intended to identify concerns that warrant further assessment by a professional in the field of alcohol and substance use disorders. This measure seems to skip the step of having a further assessment with a substance abuse professional to determine whether and what services are appropriate.

1. This proposed measure is inconsistent with other measures involving adult screening. For example, performance measure 18 states: Percent of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts. This allows for the mental health service provider to determine if services are indeed appropriate.
2. The numerator for this measures states, "Number of primary caregivers enrolled in home visiting who met with a behavioral health specialist within 14 days of a positive screen for unhealthy alcohol use or drug use." The 14 day measure for a family to enroll in services with a behavioral health specialist will be unrealistic for many/most families. The definition of behavioral health specialist is very restrictive and families may not have access to behavioral health specialists, money to afford a behavioral health specialist, flexibility to quickly arrange for an appointment during a specialist's hours of operation, access to transportation, or child care to attend services.
3. Additional clarification is needed on the following questions: Is telehealth an acceptable form of services received? What if the caregiver is put on a waitlist?

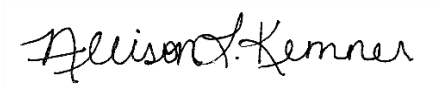
Finally, there are several cost implications of the proposed changes and it is unclear how they will be funded, including:

- As a model that offers a data system to our affiliates to use, there will be significant costs associated with changing our system to include the proposed updates.
- States would have to integrate another training for home visitor staff to be able to conduct the substance use screening tool and be prepared to follow up based on the findings. Additionally, states would need a period of time to identify substance use tools and train home visitors before implementing the screening.
- The 25% cap on administrative support may have implications as data systems may need to add additional variables and fields based on the changes, and data systems would need to alter reports to accommodate the

changes. The addition of two new Performance Measures, new fatherhood items looking at visit attendance, changes to Form 1 tables, and adjustment to insurance measures will require revisions to our reports. Awardees may incur substantial costs associated with the changes, which could impact the 25% cap on administrative support.

Thank you for providing the opportunity to provide input on the proposed changes to the PMIS. We look forward to further clarity and revisions to this proposal. Please feel free to contact me directly at Allison.kemner@parentsasteachers.org with any questions.

Sincerely,



Allison Kemner, MPH
Vice President, Research and Quality

February 15, 2021

To: Department of Health and Human Services
Health Resources and Services Administration (HRSA)
HRSA Information Collection Clearance Officer, 14N136B
5600 Fishers Lane
Rockville, MD 20857

Re: Notice for public comment
The Maternal, Infant, and Early Childhood Home Visiting Program Performance Measurement Information System
OMB No. 0906-0017 Revision

Dear Ms. Wright-Solomon:

Thank you for the opportunity to provide feedback to HRSA on the Maternal, Infant, and Early Childhood (MIECHV) Home Visiting Program Performance Measurement Information System. Wisconsin hopes that these comments will be useful as HRSA finalizes the changes to the MIECHV data collection forms.

The following comments are submitted by the State of Wisconsin's MIECHV program, the Wisconsin Family Foundations Home Visiting Program. This program is co-administered by the Wisconsin Department of Children and Families and the Wisconsin Department of Health Services.

General Comments

The proposed timeline of the changes to Form 1 and Form 2 to take effect with the FY 2022 reporting period (October 2021-September 2022) is not feasible. A number of the proposed additions or changes to the data Wisconsin reports for MIECHV would require extensive changes or additions to the State's data system, DAISEY, where all of the MIECHV local implementing agencies (LIAs) enter their data. In addition to the time it would take to make these changes to the data system, LIAs would require training and technical assistance on the new data elements to assure good data quality. This training could be delivered by the Wisconsin state team, evaluation partner, and/or professional development system. Additional time will be needed to update Wisconsin's data dictionary and data collection support resources for LIAs. Wisconsin believes these tasks would take more time than what is currently estimated in the burden statement. Additionally, the longer it takes for HRSA to release the final version of the required changes to Form 1 and Form 2, the more challenging it will be for Wisconsin to add or change data elements and complete these other necessary activities ahead of the proposed timeline of October 1, 2021.

Comments on Participant Demographics, Service Utilization, and Clinical Indicator Data (Form 1)

Form 1, Table 1: Update table to include reporting for gender non-conforming participants and unknown/did not report participant gender

- Wisconsin does not currently collect information on gender non-conforming participants and would need to add a new data element to the existing data system.
- To enhance clarity, HRSA could provide information on whether there is a difference between "unknown" and "did not report" for federal reporting purposes. This clarification will impact the potential changes Wisconsin would need to make to the existing data system in order to meet this updated requirement.
- To further enhance clarity, HRSA could provide more information on how this proposed change may or may not impact the denominator for Form 2, Measure 1 (% of infants (among mothers who enrolled prenatally before 37 weeks) who are born preterm following program enrollment), Form 2, Measure 2 (% of infants (among mothers who enrolled prenatally) who were breastfed any amount at 6 months of age) and Form 2, Measure 5 (% of mothers enrolled prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks of delivery). Wisconsin's existing DAISEY data system identifies "mothers" by the gender in the caregiver profile (female). If Wisconsin were required to add a data element for gender non-conforming participants, it would be helpful to have some guidance on how to potentially incorporate caregivers that identify as gender non-conforming into the above-mentioned federal performance measures.
- To enhance the quality of the information collected, it would be helpful for HRSA to specify that participant gender is to be based on participant self-report.
- In response to these proposed changes, Wisconsin would appreciate additional clarification from HRSA regarding participant gender data collection, including the meaning of the term "gender non-conforming" to incorporate this clarification into training and technical assistance to LIAs.
- In response to these proposed changes, Wisconsin would need to make updates to existing automated collection reports in the State's data system, DAISEY, which currently support annual data reporting and data quality.

Form 1, Tables 3, 4, 6, 7, 8, 9, 10, 11, and 18: Updated tables to include reporting for gender non-conforming participants and unknown/did not report adult participant gender.

- See comments under proposed changes to Form 1, Table 1

Form 1, Tables 3, 5, 6, 7, 18, 19, and 20: Update tables to remove index child gender reporting

- Wisconsin has no concerns about this change. In response to these proposed changes, Wisconsin would need to make updates to existing automated collection reports in the State's data system, DAISEY, which currently support annual data reporting and data quality.

Form 1, Table 15: change table title to "home visits"

- Wisconsin has no concerns about this change.

Form 1, Table 15: Update table to collect the number of home visits completed virtually

- Wisconsin currently requires LIAs to enter any completed home visit that meets the definition of a home visit according to their evidence-based model into the State's data system, DAISEY. Wisconsin does not currently collect information about which of those home visits are completed virtually and which are completed in person. If this were a required change, Wisconsin would need to add this data element to the State's data system. In response to this proposed change, Wisconsin would need to make updates to existing automated collection reports in the State's data system, DAISEY, which currently support annual data reporting and data quality.
- To enhance clarity, HRSA could provide information on whether collecting the number of home visits completed virtually will replace the total number of home visits or will be in addition to the total number of home visits completed in this table.
- Providing a definition of "home visits completed virtually" would further enhance the clarity of this proposed change.

Form 1, Tables 4, 9, 10, and 18: Update tables to include reporting for new and continuing adult participants

- Wisconsin has no concerns about this change. In response to these proposed changes, Wisconsin would need to make updates to existing automated collection reports in the State's data system, DAISEY, which currently support annual data reporting and data quality.

Form 1, Tables 5, 19, and 20: Update tables to include reporting for new and continuing index children

- Wisconsin has no concerns about this change. In response to these proposed changes, Wisconsin would need to make updates to existing automated collection reports in the State's data system, DAISEY, which currently support annual data reporting and data quality.

Form 1, Table 16: Add new table to include reporting on father and additional caregiver engagement

- To enhance clarity, it would be helpful to provide the definition of "father and additional caregiver engagement".
- To further enhance the clarity of this proposed change, HRSA could provide information on whether this measure will request reporting fathers and additional caregivers as separate groups or as one group. In the existing data system, Wisconsin currently collects information on primary caregivers and secondary caregivers. However, Wisconsin does not collect information on the relationship between any type of caregiver and the index child except in the case where information is collected on whether the caregiver is currently pregnant. If this were to be added as a new table and the information requested was specifically about fathers, Wisconsin would need to add

new data elements to the existing data system to capture this information, which would increase the amount of time estimated to meet these changes.
- In response to this proposed change, Wisconsin would need to make updates to existing automated collection reports in the State's data system, DAISEY, which currently support annual data reporting and data quality.

Form 1, Tables 16, 17, 18, 19, 20, and 21: Update table numbers to reflect the addition of Table 16

- Wisconsin has no concerns about this change.

Comments on Performance and Outcome Benchmark Data (Form 2)

Form 2, Measure 13: Change measure name to "Behavioral Concern Inquiries"

- Wisconsin has no concerns about this change.

Form 2, Measure 16: Update measure to reflect caregiver health insurance coverage status

- Providing a definition of "reflect caregiver health insurance coverage status" would enhance the clarity of this proposed change. Wisconsin currently collects information on caregiver health insurance at several different time points, including at enrollment, 6 months post-enrollment, and annually at the anniversary of the caregiver's enrollment. If this measure is updated, Wisconsin might need to change the time points at which this information is collected, which would mean that Wisconsin would need time to train the LIAs on the updated collection timeline. Additionally, it is possible that Wisconsin might need to change the current questions regarding caregiver health insurance coverage or add new questions, which would also require additional training for LIAs.
- In response to this proposed change, Wisconsin would need to make updates to existing automated collection reports in the State's data system, DAISEY, which currently support annual data reporting and data quality.

Form 2: add two measures to collect information on substance use screening and referrals

- Wisconsin does not currently collect information about substance use screening and referrals. If this were to become a requirement, Wisconsin would need to add data elements to the State's existing data system.
- To enhance clarity, it would be helpful to provide additional information on the components of these measures and what screening tools are being considered for use to collect these measures. Wisconsin's evaluation team and some of the LIAs are familiar with the CAGE AID 4 question screener; if this was an approved tool, it might take less time to provide training and technical assistance to the LIAs on using this tool.
- In response to these proposed changes, Wisconsin would need to make updates to existing automated collection reports in the State's data system, DAISEY, which currently support annual data reporting and data quality.

Summary

Wisconsin wishes to express appreciation for the opportunity to provide feedback on the proposed changes to the Maternal, Infant, and Early Childhood Home Visiting Program Performance Measurement Information System.

Please feel free to contact Abby Eskenazi, Home Visiting Evaluation Coordinator, at 608-422-6902 or via email at abigail.eskenazi@wisconsin.gov with any questions regarding these comments.

Sincerely,

Abby Eskenazi

Home Visiting Evaluation Coordinator
Wisconsin Department of Children and Families

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 14, 2021

Ms. Cynthia Phillips
Director, Division of Home Visiting and Early Childhood Services
Maternal Child Health Bureau
Health Resources and Services Administration
Rockville, MD 20857

Dear Ms. Phillips,

Thank you for the opportunity to comment on the proposed revisions to Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Forms 1 and 2, as described in the Federal Register Notice dated 12/18/2020. We appreciate HRSA's efforts to refine changes to the MIECHV performance measurement system by incorporating feedback from grantees.

Minnesota's comments related to specific changes in MIECHV Forms 1 and 2 are attached to this letter. HRSA also specifically requested comments on 1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions, 2) the accuracy of the estimated burden, 3) ways to enhance the quality, utility, and clarity of the information to be collected, and 4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden. Our comments on these topics follow.

Necessity and utility of the proposed information collection for the proper performance of the agency's functions

In general, we would appreciate additional information about how HRSA uses the data reported in Form 1, particularly tables where there are two-way and proposed three-way crosstabulations. We wonder if all these granular breakouts of MIECHV participant counts are necessary for HRSA's performance of its functions. We have a responsibility to protect the privacy of MIECHV participant data, and the small cell sizes produced by some crosstabulations increase risk of identifiability.

Accuracy of the estimated burden

The Federal Register Notice stated an average burden per response of 560 hours per year for Form 1 and 221 hours per year for Form 2. Based on our experience, that estimate is high for Form 1 and low for Form 2, if these estimates are limited to the hours needed by MN Department of Health staff to analyze data and produce these reports and do not include time required for Local Implementing Agencies to collect and enter data into our system. Calculation of the performance measures in Form 2 is considerably more complex than reporting counts of participants in Form 1. We estimate approximately 160-200 hours of effort needed for Form 1, and approximately 500 hours needed for Form 2.

Ways to Enhance the Quality, Utility and Clarity of the Information Collected

Some performance measures on Form 2 are of limited use for our state's evaluation and quality improvement needs because of how they are specified. Measures such as the developmental screening measure and the primary caregiver education measure require additional explanation when we share measure results with Local Implementing Agencies because of complex numerator criteria. We are finding it necessary to create our own state evaluation measures that are easier for our stakeholders to understand. We encourage HRSA to consider simplifying some performance measures to enhance their utility and clarity.

Use of automated collection techniques or other forms of information technology to minimize the information collection burden

The information collection burden required to complete Forms 1 and 2 occurs at two levels: the Local Implementing Agency (LIA) level and the MIECHV grantee level. To reduce the LIA burden, Minnesota implemented a new home visiting data system in early 2020 that integrates data collection forms within the electronic health record systems used by LIAs for charting and case management. We have found this system to be a good investment. However, when system changes are needed to align with MIECHV reporting changes, modifications need to occur within each source system as well as within the state data system. The complexity of the change process means that the addition of new questions or modules takes more time and effort than it would if our system were not interoperable with local systems. We ask HRSA to consider delaying the effective date of the proposed changes to Federal Fiscal Year 2023 to allow more time for any required data system changes and associated training of LIA staff.

Regarding the use of automated collection techniques to minimize our information collection burden at the MIECHV grantee level, at this time we do not believe the national landscape of home visiting data systems is standardized or mature enough to support an automated data collection system for performance measure data. We look forward to collaborating with HRSA on future efforts to establish home visiting data standards that might lay a foundation for automated reporting.

Thank you for the opportunity to provide feedback. Please contact me if I can provide additional information or clarification.

Sincerely,

Virginia Zawistowski, MPH
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Minnesota Response to FRN 2020-27919:
Proposed Changes to MIECHV Forms 1 and 2, OMB 0906-0017

Table or Measure	Proposed Revision	MN Comments

Form 1 – Overall Comments		▪ **Updated reporting categories for Adult Participant Gender:**
		  ▪ The addition of categories for Gender Non-Conforming Caregivers and Children is welcome, as it includes participants who do not identify as exclusively male or female. We suggest that HRSA avoid the term "Other" in this category and explore whether there are additional terms that people in this category typically use for themselves or find most acceptable, such as non-binary.
		  ▪ The addition of an "Unknown/Did Not Report" caregiver gender category makes data collection consistent with other variables reported on these forms and would allow us to report all MIECHV-funded participants on the forms.
		▪ **Cross-tabulation of Adult Participants by Gender with other variables (e.g., age, race, Hispanic ethnicity, etc.):**
		  ▪ Several tables crosstablulate Adult Participants by gender/pregnancy status with another variable (for example race, Hispanic ethnicity, marital status). Because of the relatively small number of participants in the gender non-conforming and unknown/did not report groups, these cross-tabulations will result in small cell sizes. Small cell sizes may risk the confidentiality of MIECHV participants in this report. **We recommend that cross-tabulations by Adult Participant gender be removed from all tables except Table 1 to protect the privacy of MIECHV participants.**
		  ▪ Other tables go further with a three-way cross-tabulation of participants by gender/pregnancy status, newly-enrolled vs. continuing, and a third variable (for example age group, educational attainment, employment status). In addition to the confidentiality concern, these tables would be complex and burdensome to complete, with little discernable benefit. **We strongly recommend that all tables in Form 1 be limited to two-way cross-tabulations at most.**

Form 1, Table 1: Unduplicated Count of New and Continuing Program Participants Served by MIECHV	Change "Pregnant Women" to "Pregnant Participants"; Updated to include reporting for gender non-conforming and unknown/did not report participant gender for both adult participants and index children.	▪ We support and appreciate the change in wording from "Pregnant Women" to "Pregnant Participants." ▪ The categories for adult participants mix 2 constructs: 1) whether the participant is pregnant and 2) the participant's gender. We suggest separating these constructs (e.g., participants by pregnancy status and participants by gender in separate tables). ▪ We suggest removing the gender breakout for index children. It is unclear to us how this data is useful.

Table or Measure	Proposed Revision	MN Comments
Form 1, Table 8: Adult Participants by Marital Status	Change "Pregnant Women" to "Pregnant Participants"; Updated to include reporting for gender non-conforming and unknown/did not report participant gender for adult participants.	▪ The marital status categories mix 2 constructs: 1) marital status and 2) whether the participant is living together with their partner. The categories are therefore somewhat confusing: what if a participant is legally married, but not living with their partner (for many possible reasons, such as employment, military deployment, incarceration)? What if a participant is married and separated from their spouse (pending a divorce)?
Form 1, Table 15: Home Visits	Added Service Modality categories (In-Person, Virtual, Unknown/Did Not Report)	▪ This change will require us to update our data collection system to include the service modality for each home visit. We support this change because we think this will be useful information for our evaluation purposes. However, making this change will involve some time and cost (IT expenses and training of LIA staff) and we may not be able to make this change in time for the beginning of FFY 2022.
Form 1, Table 16: Father and Additional Caregiver Engagement by Household	New table	▪ It is unclear from the table and definitions of terms whether this table is meant to include Adult Participants in MIECHV, or other persons who are not Adult Participants in MIECHV. For example, in the row "Father participation in at least one home visit" do you want 1) fathers who are Adult Participants in MIECHV (who may or may not be Primary Caregivers), 2) fathers who are Adult Participants in MIECHV (who are NOT Primary Caregivers), or 3) fathers who are NOT Participants in MIECHV (but who have "participated in at least one home visit")? ▪ It is also unclear what "participation in at least one home visit" means. Does it mean that the father/additional caregiver was physically present for the home visit? Does it mean that they talked with the home visitor? ▪ Our data system only collects data on caregivers and children who are participating in (signed up and actively enrolled in) home visiting programs, including MIECHV. If this table is asking for information on persons who are not signed up to participate in the home visiting program, then our data system does not collect this data and we would need to make system changes to begin collecting data on these fathers/additional caregivers. The time and cost needed for these system changes would depend on what "participation in at least one home visit" means (and therefore how we would need to structure our data collection). ▪ Would "additional caregivers" need to live in the household, or can they live outside of the MIECHV household (that is, a relative that lives in their own household but frequently cares for the index child)?

Table or Measure	Proposed Revision	MN Comments
Form 2 – Overall Comments		▪ We concur with the ASTHVI Data Committee that all measures in Form 2 should be limited to actively enrolled MIECHV participants (which in MN we define as participants who have had at least one home visit during the reporting period). Because most data are collected during home visits, including participants in Form 2 that have not had a home visit during the reporting period inflates the amount of missing data.
Form 2, Measure 7: Substance Use Screening and	New measure	▪ **We surveyed our LIAs to gather information on their current substance use screening and referral practices, as well as their questions and concerns about the proposed measures. The majority of our LIAs responded, with representative distribution between urban and rural LIAs. We describe the survey results below.** ▪ Although nearly all our LIAs routinely screen MIECHV participants for substance use disorder, only about half usually or always complete this screen during the 1st 30 days of home visiting. Several LIAs reported concerns about conducting this type of screening within the 1st few visits, because the client may not trust the home visitor enough during this early stage in their relationship to provide honest/complete answers about their substance use. LIAs are also concerned that asking about this topic too early may lead the client to discontinue their participation in the home visiting program. ▪ About half of our LIAs are using a validated tool for substance use disorder screening. Most of the remaining LIAs are using model-specific questionnaires about substance use (primarily the Nurse-Family Partnership Health Habits form). **We recommend that if these measures are implemented, HRSA work with home visiting model developers to incorporate validated screening tools into their procedures, training, and data collection, to minimize the amount of additional screening and data collection that home visitors need to do for this measure on top of their model requirements.** ▪ **Based on this feedback from MN LIAs, we suggest expanding the timeframe for substance use screening in this measure to the first 60-90 days of enrollment in home visiting.** This would allow more time for the home visitor to build rapport with the client before conducting this screening, and therefore greater likelihood that the client is willing to disclose their substance use to the home visitor (more accurate screening results).

Table or Measure	Proposed Revision	MN Comments
Form 2, Measure 21: Completed Substance Use Referrals	New measure	▪ About 2/3 of our LIAs make referrals to behavioral health clinics/providers, and/or to the county's substance use assessment program. A few LIAs refer clients to primary care providers because of a lack of behavioral health specialists in their areas. ▪ **The majority of LIAs reported that substance use disorder assessment/treatment referrals are rarely or never completed within 14 days of the screening.** LIAs described the following barriers: ▫ Lack of providers, particularly in rural areas. Often behavioral health providers are far away/outside of the area. ▫ Lack of transportation to see providers. One respondent said, "transportation is a huge barrier in our county with no public transportation available." ▫ Clients refuse the referrals or do not follow through on appointments; often multiple referral attempts from the home visitor are needed before the client accepts. As stated by one LIA staff, "it may take several visits to continue working on a relationship to help the client decide they should seek help." ▪ **Based on this information, we think that a 14-day timeline between positive screening and receipt of services is an unrealistically high standard to meet. We acknowledge that this is (appropriately) proposed as a systems outcome rather than a performance indicator, as it would be difficult for our state home visiting program to influence or change our state's performance on this measure because of the barriers described above.**
Form 2, Measure 17: Continuity of Insurance Coverage	Updated numerator to "Number of primary caregivers enrolled in home visiting who reported having continuous health insurance coverage for at least 6 consecutive months at the most recent data collection time point in the reporting period	▪ We support this change because it ties the measurement of continuous insurance coverage to the current reporting period, making this a more useful measure for annual reporting.

Lisa Wright-Solomon,

Information Collection Clearance Officer, 14N136B,

HRSA

5600 Fishers Lane,

Rockville, MD 20857

Dear Lisa Wright-Solomon:

In its role as the non-profit grantee for the state of Wyoming's Maternal, Infant, and Early Childhood Home Visiting program (MIECHV), thanks you for the opportunity to provide feedback on proposed revisions to the MEICHV Performance Measurement Information System, OMB No. 0906–0017, Revision posted on Friday, December 18, 2020.

As you know, Parents as Teachers (PAT) is an evidence-based Maternal, Infant, and Early Childhood Home Visiting model that offers culturally competent care with a focus on families during pregnancy and the early years. PAT provides parents and other adults in the home with tools to help whole families thrive, with an emphasis on maternal and infant health and development. Our home visiting model operates in all 50 states and more than 110 tribal communities. Half our programs are in rural areas. As members of the communities they serve, PAT home visitors bring a critical understanding of how a family's culture and values impact parenting and health practices. PAT has met Health and Human Services criteria for evidence of effectiveness and is thus an approved model for implementation of the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV).

In our role as MIECHV grantee for the state of Wyoming, we offer the following comments based on how the proposed changes could impact implementation in the state:

The change to the insurance measure: **"**Percent of primary caregivers enrolled in home visiting for at least 6 months who had continuous health insurance coverage for at least 6 consecutive months at the most recent data collection time point in the reporting period" will make it more difficult to meet the numerator criteria. Since the 6 months of coverage must occur during the reporting period, this will likely lower awardees' percentages on this measure when compared to the current criteria, which includes insurance coverage during a prior program year. While we understand the reasoning for this change, this could make demonstrating improvement more difficult for the next cycle if 2020-2021 is used as a baseline year (using the current criteria) and the year awardee's need to demonstrate improvement uses the narrower criteria. If making this change, we ask that change over time implications be taken into consideration when developing the demonstrating improvement criteria.

The addition of performance measure 7: "Percent of primary caregivers enrolled in home visiting who were screened for unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use using a validated tool within 30 days of enrollment" requires further clarification.

1. Administering the substance use screening tool within 30 days of a family enrolling poses significant implications on the home visitor's ability to build trust and develop and maintain relationships with families. There are serious fears associated with admitting to substance abuse that are not associated with intimate partner violence and depressions screening. One concern is that the child(ren) will be removed from the home, and another is facing legal consequences that result in job loss, economic impacts and possible incarceration. Conducting such an invasive screen, or multiple screens at the onset of building relationship for supportive services will be damaging to building therapeutic and supportive relationships and limiting to recruitment efforts. As a result, families may choose not to begin or continue receiving services. We recommend allowing more time for the tool (administered annually) to be administered to try to avoid impacts to the home visitor and family relationship. It also adds a new data collection timeframe for home visitors.
2. The measures states that primary caregivers are screened for "unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use" which suggests that states may need to use multiple tools to be able to assess all substances as most tools are only designed to assess for one substance (e.g., AUDIT assesses for alcohol use).
3. Additional clarification is needed on the following questions: Will a list of validated and approved tools be provided? Will states need to measure all substances listed (e.g., unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use)? Would HRSA consider allowing non-reliable and valid tools that might be already incorporated into data collection for home visiting models?

The addition of performance measure 21 "Percent of primary caregivers enrolled in home visiting with positive screens for unhealthy alcohol use or drug use (measured using a validated tool) who receive services in a timely manner" will pose significant challenges in Wyoming. The numerator for this measures states, "Number of primary caregivers enrolled in home visiting who met with a behavioral health specialist within 14 days of a positive screen for unhealthy alcohol use or drug use." The timing to expect a family to enroll in services with a behavioral health specialist would be unrealistic in Wyoming. Within the state, behavioral health specialists are sparse- the MIECHV Needs Assessment states that there are 15 state funded community substance abuse treatment providers for 23 counties, so not even one for every county. Furthermore, according to Mental Health America, Wyoming ranks 48 overall in access to care and prevalence of mental illness. This ranking is based on 15 measures including data on adults, children, and the mental health workforce. Rankings 39-51 indicate a higher overall prevalence of mental illness and lower rates of access to care. Much of this can be explained by the fact that Wyoming is more geographically rural with a population below 550,000. Rural areas are more likely to be medically underserved, especially in the behavioral health specialty, and Wyoming is no exception, with 28 mental health shortage areas, community care centers are lacking the number of clinicians needed to meet demand (https://data.hrsa.gov/topics/health-workforce/shortage-areas).

There are several cost implications of the proposed changes that would impact implementation in Wyoming. For example, states would have to integrate a new training for home visitor staff to be able to conduct the substance use screening tool and follow up based on the findings. Additionally, states would need time to identify substance use tools and train home visitors before implementing the screening. Data systems may need to add additional variables and fields based on the changes, and data systems would need to alter reports to accommodate the changes. The addition of two new Performance Measures, new fatherhood items looking at visit attendance, changes to Form 1 tables, and adjustments to the insurance measure will require revisions to our reports. Awardees may incur substantial costs associated with the changes, which could impact the 25% cap

on administrative support. When proposing changes that will come at a cost, please also consider how programs can pay for these changes.

We share a common goal to best support families enrolled in MIECHV, including those facing hardships such as substance abuse. As you collect and analyze comments and draft final revisions to the MEICHV Performance Measurement Information System, please take into consideration the challenges to implementation laid out in these comments. If you have any questions, please feel free to contact me at [insert Angela's email address].

Sincerely,

Angela Ward

Wyoming MIECHV, Project Director

Ms. Cynthia Phillips
Director, Division of Home Visiting and Early Childhood Services
Maternal Child Health Bureau
Health Resources and Services Administration
Rockville, MD 20857

February 16, 2021

Dear Ms. Phillips,

Thank you for the opportunity to provide HRSA with feedback on the proposed changes to the *Maternal, Infant and Early Childhood Home Visiting Program Performance Measurement Information System (OMB No. 0906-0017*), published in the Federal Register on December 18, 2020. The Massachusetts MIECHV program appreciates the opportunity to offer detailed feedback. The following tables include our response to the suggested revisions. In addition, we have offered additional feedback for your consideration on measures that were not noted in the Federal Register Notice.

Form 1: Demographic, Service Utilization, and Select Critical Indicators

Section	Proposed Revision	MA MIECHV Response
Tables 1, 3, 4, 6, 7, 8, 9, 10, 11, and 18	Updated to include reporting for gender non-conforming and unknown/did not report participant gender for adult participants.	We appreciate HRSA's interest in expanding gender categories to be more inclusive of gender non-binary participants. However, the complexity of the cross tabulations of this data point increases data collection and reporting burden without being self-evident what this addition can be used for at the federal level. We agree with capturing participant gender using the more inclusive categories, and suggest including one table for gender rather than multiple cross tabulations. We also would like to note that the complexity of the cross-tabulations raises concerns about identifiable data due to small numbers. The need to suppress data has the potential to limit our ability to tell the full story of MA MIECHV services. Additionally, we will need to modify data collection systems in order to track this data point and prevent missing data. This will require additional financial resources, staff time, and training to educate local implementing agency (LIA) staff regarding correct interpretation, understanding, and implementation of these changes. The need for training extends beyond data collection and reporting to ensure that all LIA staff are comfortable with the concept of gender non-conforming and gender non-binary.
Tables 3, 5,	Update tables to remove index	We have no concerns regarding this proposed

Section	Proposed Revision	MA MIECHV Response
6, 7, 18, 19, and 20	child gender reporting	revision.
Table 15	Change table title to ‘‘Home Visits’ Update table to collect the number of home visits completed virtually	We have no concerns regarding this proposed revision.
Tables 4, 9, 10, and 18	Update tables to include reporting for new and continuing adult participants.	The complexity of the cross tabulations of this data point increases data collection and reporting burden without being self-evident what this addition can be used for at the federal level. The complexity of the cross-tabulations raises concerns about identifiable data due to small numbers. The need to suppress data has the potential to limit our ability to tell the full story of MA MIECHV services.
Tables 5, 19, and 20	Update tables to include reporting for new and continuing index children	We have no concerns regarding this proposed revision.
Table 16	Add new table to include reporting on father and additional caregiver engagement	We appreciate HRSA’s interest in learning more about father and other caregiver engagement in home visiting services. However, a focus on co-parent would be more inclusive. This table assumes that women are primary participants in home visiting and makes heteronormative assumptions that do not reflect the various co-parenting relationships seen in families participating in home visiting services. Additionally, we will need to modify data collection systems in order to ensure accurate and reliable reporting for this measure. This will require additional financial resources and staff time to educate local implementing agency (LIA) staff regarding correct interpretation, understanding, and implementation of these changes.

Form 2: Performance and Systems Outcome Measures

Section	Proposed Revision	MA MIECHV Response
Measure 13	Change measure name to ‘‘Behavioral Concern Inquiries’’	We have no concerns regarding this proposed revision.
Measure 16	Update measure to reflect caregiver health insurance coverage status.	It is unclear if this measure is designed to assess six consecutive months of insurance coverage at any time during the enrollment or the most recent six consecutive months during the enrollment.
Form 2	Add two measures to	We appreciate that assessing substance misuse and

Section	Proposed Revision	MA MIECHV Response
	collect information on substance use screening and referrals.	facilitating connections to services is a priority for HRSA. However, we have a number of concerns about the addition of these measures. Overall concerns with the addition of the two measures are noted below. 1. LIA staff already feel overburdened by the extensive data collection requirements for compliance with the MIECHV Performance Measurement System. The addition of two new measures will increase the data collection burden for home visitors and families, which could have detrimental effects on a variety of implementation factors, including time available to deliver services, data documentation quality overall, staff retention, and family retention. 2. Many evidence-based home visiting models are not clinical models. We are concerned about HRSA's expectation for home visitors across models to have the clinical expertise required to assess substance misuse and determine the appropriate service. 3. We will need to modify data collection systems in order to ensure accurate and reliable reporting for these measures. This will require additional financial resources and staff time to educate LIA staff regarding correct interpretation, understanding, and implementation of these changes. 4. The addition of two new measures will require additional training and professional development related to substance use to ensure that LIA staff are supported in offering screening and referrals. This will also require additional financial resources and staff time to develop and/or access the appropriate training. 5. We are concerned about the potential impact of stigma and/or bias related to substance use on family retention in home visiting services. Screening for substance use would require revisiting LIA policies and protocols to ensure that families receive ongoing support in home visiting services following a positive screen. Agency policies to protect home visitor safety in situations where participants may screen positive and/or be experiencing active substance use may have unintended consequences for participants who disclose (e.g., discontinuation

Section	Proposed Revision	MA MIECHV Response
		of services). 6. If the two new performance measures are not implemented in parallel with necessary policy changes and comprehensive training, screening may fundamentally change the home visitor/participant relationship. Specifically, programs would risk identifying substance use without the supports needed to respond to positive screens in a way that centers the participant and the home visitor/participant relationship, and that supports the physical and emotional safety of both the participant and home visitor.
Measure 7	New measure "Substance Use Screening"	Although we recognize that early identification of substance use is best practice, adding a substance use screen within 30 days presents a number of challenges – particularly in the context of virtual service delivery. It is possible that the home visitor will only have one or two interactions with the participant during the first 30 days of enrollment. There is concern that screening for substance use within this short window--in many instances before home visitors have had an opportunity to establish trusting relationships with their participants --may negatively impact families' early engagement in services. Relatedly, home visitors in the field have expressed that answers to this question will often change once a relationship has been built, suggesting that the results of a screen administered so early in the relationship may not yield accurate responses. Additionally, home visitors are mandated reporters which will likely impact how participants respond to screening questions. We recognize that these considerations also apply to other screens (e.g., depression, IPV). In Massachusetts, a large proportion of participants are under the age of 21. There is concern that all participants who report alcohol or marijuana use will screen positive due to their age, rather than misuse beyond using under the legal age. Please note that we are not suggesting that age is a reason to not screen for substance use. However, we want to acknowledge the potential impact screening may on

Section	Proposed Revision	MA MIECHV Response
		engagement in services for the younger (i.e., less than 21 years of age) population. The 30-day screening window does not align with other performance measures such as depression or IPV screening. Giving home visitor choice and flexibility to screen within a wide window of time would be important for building the relationship and responding to the needs of participants. Our recommendation is that HRSA consider aligning with 3-month screening window allotted for the depression screen performance measure. We are concerned that there is no clear guidance, both within and across states, on what constitutes substance use. For example, most substance use screens would include marijuana on the list of substances. However, it is unclear how marijuana legalization will factor in to assessment of substance use or misuse. Similarly, there is concern that it may not be reasonable for a home visitor to make a referral for marijuana use. Given the strain on the behavioral health and substance use treatment systems from the opioid epidemic, accessing supports for marijuana use is often a challenge. Lastly, it would be helpful to see a list of substance use screening tools that are validated for use in a home-based setting. It is important to note that tools must be validated in the diverse populations (e.g., language, age) served by home visiting programs. In addition, we would appreciate additional guidance on how legal, adult marijuana use should be considered.
Measure 21	New measure "Completed Substance Use Referrals"	Once options for validated tools are established, we would appreciate clarity on how a positive screen is defined. As noted above, assessing substance misuse is often a clinical decision. It is unclear how severity, frequency of use, type of substance will be factored in. We want to emphasize that screening for substance is not as clear as a yes/no response to screening questions. In addition, measuring receipt of services within 14 days seems like an unrealistic timeline. There are a number of factors (e.g., insurance status, substance used, availability of services and geographic

Section	Proposed Revision	MA MIECHV Response
		distribution) that we know impact how quickly participants are able to access services. As a systems measure, a more realistic timeframe will likely offer a more accurate picture of the availability and accessibility of substance use treatment supports and services. Even if framed as a systems measure rather than a performance measure, home visitors may feel pressure to meet this unrealistic benchmark, and see an inability to do so as a failure. With respect to the definition of missing data, we suggest that participants who are missing the screening should be excluded from the referral measure. In addition, we request clarity on whether participants who are already receiving substance use treatment should be excluded from the denominator. We suggest this performance measure align with depression referrals measure – once a participant screens positive for substance use, they should remain in the denominator until they receive services. We are concerned that the definition of behavioral health specialist does not recognize the value of additional recovery supports for participants who screen positive for substance use. For many people, a recovery coach will help them eventually engage in treatment if needed. The current definition does not allow participants to determine what is appropriate for them. Lastly, similar to the feedback on the other referral measures, those who do not screen positive should be excluded rather than added to missing.

Additional Feedback on MIECHV Form 1 and Form 2

Section	Suggested Revision	MA MIECHV Rationale
Form 1, Table 5	Expand child age categories	We suggest another age category of ">6 years" as Parents as Teachers is able to serve children through kindergarten completion.
Form 1, Table 7	Expand race categories	The overwhelming majority of participants who self-identify as ethnically Hispanic decline to choose any of the race options provided, and are therefore coded as being of

Section	Suggested Revision	MA MIECHV Rationale
		"Unknown/Did not Report" race. We suggest adding an "Other" or "Chose not to identify" option to Table 7 to respect how participants choose to self-identify. This would also provide a more accurate depiction of missing data.
Form 1, Table 13	Expand income categories	Participants often decline to report income. We suggest adding a "Chose not to report" option to Table 13 to provide a more accurate depiction of missing data.
Form 2, all constructs	Consistency across constructs	One consideration is to limit all measures in Form 2 to "actively-enrolled", or participants who had at least one home visit during the reporting period.
Form 2, all constructs	Clarify time frames	Varying timelines and enrollment status requirements add a layer of complexity that may not be necessary for performance measurement and may cause confusion.
Form 2, all constructs	Clarify definitions of missing	There are inconsistencies in how missing data are defined across measures. Clear and consistent guidance would be helpful.
Measure 2	Clarify exclusion criteria	Per the Toolkit, children are excluded if they are not asked about breastfeeding between 6-12 months of age. For example, the 6th month visit conducted during the 5th month or the 12th month visit conducted during the 13th month would be excluded. For other screening measures (substance use, intimate partner violence), when the screening is completed outside of the window they are counted as Missing not Excluded.
Measure 4	Consider revising	The intent of this measure seems to be ensuring children are seen routinely by providers. However, following the AAP guidelines on windows for well child visits is restrictive. The guidelines are for pediatricians, yet often the timeline of visits is adjusted by the provider and not the home visitor or family. Adjustments to schedules are especially true for premature infants and children with special healthcare needs. Intent of measure should be to ensure that children are being seen routinely by providers. In addition, if a child is late for one well-child visit for reasons outside the family's control, insurance billing cycles creates a barrier to completing subsequent visits within the expected window. One consideration is to revise this performance measure to assess how many children receive a

Section	Suggested Revision	MA MIECHV Rationale
		minimum number of visits during the first year and the second year of life.
Measure 8	Difficult to meet all three parts of the measure.	It may be more useful to report responses to each individual requirement plus the combined performance. This will allow for more focused support around each of the three components of safe sleep.
Measure 13	Consider revising and clarify exclusion criteria	The requirement to meet the three specific screens in the narrow windows is difficult for programs and adds a layer of coding difficulty. If the intent is to screen during a 9-30-month window, a potential revision could be to count any development screens completed within the window. The current guidance for exceptions on when/if to screen based on prior screening results and/or diagnosed delays is confusing. Currently, a positive ASQ with no later screen is excluded, but if screened again it is then included in the measure, making it difficult to track who to include and when. We suggest always excluding a child after any diagnosis or any positive ASQ screening, regardless of any subsequent screenings completed.
Measure 16	Consider revising.	The complexity of this measure adds significant data collection, analysis, and reporting burden and limits the ability to use this measure for continuous quality improvement activities. We suggest simplifying to include only the percent of primary caregivers who enrolled in home visiting without a high school degree or equivalent who subsequently enrolled in, or completed, high school or equivalent during their participation in home visiting.
Measure 18	Clarify missing data and exclusion criteria	Including those who miss a screening as missing a referral conflates the two. Administrators should not try to assess completeness of the screening measure when evaluating the referral measure. Those missing the screening should be excluded from the referral measure
Measure 19	Consider revising and clarify missing data and exclusion criteria	Including those who miss a screening as missing a referral conflates the two. Administrators should not try to assess completeness of the screening measure when evaluating the referral measure. Those missing the screening should be excluded from the referral measure.
Measure 20	Clarify missing data and exclusion criteria	Including those who miss a screening as missing a referral conflates the two. Administrators should try

Section	Suggested Revision	MA MIECHV Rationale
		to assess completeness of the screening measure when evaluating the referral measure. Those missing the screening should be excluded from the referral measure.

In addition to the specific comments provided above, we would like to note that each change requires time and resources to educate staff regarding correct interpretation, understanding, and implementation of the changes. Changes to Form 1 and Form 2 are particularly challenging when the rationale for the proposed change is unclear. Although the rationale for many of the proposed changes is self-evident, in some instances, it would be helpful to understand why HRSA is proposing to change the existing requirements, or what HRSA aims to learn from the suggested amendments. We respectfully request additional information about the rationale for the proposed changes to Form 1 and Form 2. Additional context would help grantees understand the objectives, and more consistently interpret and implement the revisions.

We would like to thank you for the opportunity to submit comments and acknowledge your efforts to reduce the reporting burden for grantees, select indicators that can be used to monitor program performance and inform continuous quality improvement efforts, and increase accountability. If you have any questions, please feel free to contact Christine Silva at christine.silva@state.ma.us.

Sincerely,

On Behalf of the Massachusetts MIECHV Team
Karin Downs, RN MPH
MCH Director, PI of MIECHV
Director, Division of Pregnancy, Infancy and Early Childhood
Bureau of Family Health and Nutrition
Massachusetts Department of Public Health

cc. Elaine Fitzgerald Lewis, Christine Silva, Susan Manning, Emma Posner, Jessica Goldberg

Virginia Department of Health
Office of Family Health Services
MIECHV Program
109 Governor Street
Richmond VA 23219

February 16, 2021

To Whom It May Concern,

Thank you for offering the opportunity for our organization to provide public comment on the proposed changes to the MIECHV benchmarks. The Virginia Department of Health has been a MIECHV funding recipient since 2012 and funds 18 sites statewide who implement Parents as Teachers, Nurse Family Partnership and Healthy Families America evidence based models.

After review with our home visiting professionals, we would like to provide the following feedback.

Form 1, Table 16: Add new table to include reporting on father and additional caregiver engagement.

- ***We are not in favor of this change.***
- Rationale: Although several models/sites collect who participated in home visits, there were questions about which value MIECHV was intending to promote by adding this to the benchmark. For instance, could this be used to fuel negative stereotypes about the types of families we serve and fatherhood? The group did not feel that the proposed categories (i.e., father was involved in at least one home visit) convey important information. For example, if a father is the primary source of income, participating in home visits may not be feasible, but would also not be indicative of an uninvolved father. Further, the definition of "participating in at least one home visit" is not clear. What constitutes participation is subjective, and also does not indicate fatherhood involvement in the child's life. Alternatives could include looking at relationships between target children and primary caregivers plus caregiving status (single parent, co-parenting, etc.).

Form 2: Add two measures to collect information on substance use screening and referrals.

- ***While we are in strong agreement with the value of home visitors conducting primary caregiver substance use screening tailored to family needs and the specific implementation context, we have concerns about the proposed additions of two federally required performance measures (#7 and #21) and the implications of these changes for practice and policy.***
- Rationale: With all of the competing demands and current screening requirements at the beginning of home visiting, 30 days is not nearly enough time to screen for something that requires such high levels or trust and rapport. The quality of

data would be questionable due to the rushed screening on such a sensitive topic. In addition, after a positive screen, home visitors may not have appropriate services to refer clients to. Another issue is that Virginia does not currently have a validated tool widely used among sites – extensive training would be required. The legalization and decriminalization of marijuana in various states would also cause lack of clarity and homogeneity in the measures across the US. One alternative would be to model substance use performance measures (PM) like the tobacco cessation PM, to include more time, self-report, and resources/referrals provided.

In addition to our comments about the additional performance measures, we include a comment on changes in guidance regarding IPV screening during virtual service delivery for home visiting and on the suggested change to the Behavioral Concerns construct area name.

Change in PM for IPV Screening

- Rationale: Based on guidance from Futures Without Violence, and work they are doing with the HV CoIIN, our state is interested in shifting our approach, and therefore training, for how home visitors address IPV through universal education and referral as opposed to screening. This is in line with information shared on the HRSA website page Important Information During COVID-19. As stated in the HVCoIIN memo posted on that same page, "At the moment there is no research indicating that virtual screenings are safe." While we appreciate the ability to add notes to our APR and other MIECHV reports, we would like to know more about how HRSA is planning to accommodate this change in programmatic activities as more states and programs begin to adopt this approach.

Change in Behavioral Concerns Construct Name Comments:

- ***We recommend the construct name reflect the breadth of the construct as well as the intent, using the name "Child Development, Behavior, or Learning Concern Inquiries"***
- Rationale: Instead of the proposed change to "behavioral concern inquiries," we suggest the construct name be broadened to reflect the breadth of the performance measure. This change would also underline the field's belief in the importance of areas beyond just child behavior and would more clearly tie to parent concerns in areas such as social and emotional development,

Sincerely,
Staysi Blunt, MPH
MIECHV Program Evaluator

From: Davy Fearon <dfearon@rappahannockareacsb.org>
Sent: Tuesday, February 16, 2021 3:05 PM
To: HRSA Paperwork <paperwork@hrsa.gov>
Subject: Healthy Families Rappahannock Area's public comment on proposed changes to MIECHV benchmarks

Thank you for offering the opportunity for our organization to provide public comment on the proposed changes to the MIECHV benchmarks.

Healthy Families Rappahannock Area serves as that needed living, breathing manual for families at risk for adverse childhood experiences. Through an evidence-based home visiting program, HFRA Family Support Workers enable families to identify their strengths, to feel supported, and to access additional community resources.

After review with our home visiting professionals, we would like to provide the following feedback.

Form 1, Table 16: Add new table to include reporting on father and additional caregiver engagement.

- ***We are not in favor of this change.***
- Rationale: Although several models/sites collect who participated in home visits, there were questions about which value MIECHV was intending to promote by adding this to the benchmark. For instance, could this be used to fuel negative stereotypes about the types of families we serve and fatherhood? The group did not feel that the proposed categories (i.e., father was involved in at least one home visit) convey important information. For example, if a father is the primary source of income, participating in home visits may not be feasible, but would also not be indicative of an uninvolved father. Further, the definition of "participating in at least one home visit" is not clear. What constitutes participation is subjective, and also does not indicate fatherhood involvement in the child's life. Alternatives could include looking at relationships between target children and primary caregivers plus caregiving status (single parent, co-parenting, etc.).

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- ***While we are in strong agreement with the value of home visitors conducting primary caregiver substance use screening tailored to family needs and the specific implementation context, we have concerns about the proposed additions of two federally required performance measures (#7 and #21) and the implications of these changes for practice and policy.***
- Rationale: With all of the competing demands and current screening requirements at the beginning of home visiting, 30 days is not nearly enough time to screen for something that requires such high levels or trust and rapport. The quality of data would be questionable due to the rushed screening on such a sensitive topic. In addition, after a positive screen, home visitors may not have appropriate services to refer clients to. Another issue is that Virginia does not currently have a validated tool widely used among sites – extensive training would be required. The legalization and decriminalization of marijuana in various states would also cause lack of clarity and homogeneity in the measures across the US. One alternative would be to model substance use performance measures (PM) like the tobacco cessation PM, to include more time, self-report, and resources/referrals provided.

In addition to our comments about the additional performance measures, we include a comment on changes in guidance regarding IPV screening during virtual service delivery for home visiting and on the suggested change to the Behavioral Concerns construct area name.

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- Rationale: Based on guidance from Futures Without Violence, and work they are doing with the HV CoIIN, our state is interested in shifting our approach, and therefore training, for how home visitors address IPV through universal education and referral as opposed to screening. This is in line with information shared on the HRSA website page Important Information During COVID-19. As stated in the HVCoIIN memo posted on that same page, "At the moment there is no research indicating that virtual screenings are safe." While we appreciate the ability to add notes to our APR and other MIECHV reports, we would like to know more about how HRSA is planning to accommodate this change in programmatic activities as more states and programs begin to adopt this approach.

Change in Behavioral Concerns Construct Name Comments:

- ***We recommend the construct name reflect the breadth of the construct as well as the intent, using the name "Child Development, Behavior, or Learning Concern Inquiries"***
- Rationale: Instead of the proposed change to "behavioral concern inquiries," we suggest the construct name be broadened to reflect the breadth of the performance measure. This change would also underline the field's belief in the importance of areas beyond just child behavior and would more clearly tie to parent concerns in areas such as social and emotional development,

Sincerely,

Davy Fearon Jr.
Healthy Families Rappahannock Area
4815 Carr Drive, Fredericksburg VA 22408
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National Alliance of Home Visiting Models: Shared Comments- MIECHV Benchmark FRN Comments

The National Alliance of Home Visiting Models welcomes the opportunity to provide feedback and respond to HRSA's notice, The Maternal, Infant and Early Childhood Home Visiting Program Performance Measurement Information System (OMB No. 0906-0017), published on December 18, 2020, which would modify several of the current data collection practices for demographic performance measures (Form 1) and benchmark performance measures (Form 2).

The Alliance recognizes the importance of review and revisions to ensure integrity and quality of the performance measurement process. However, with each proposed change, there is an increased burden on awardees. The Alliance advises that any proposed changes to the benchmarks imposes an increased burden on staff and families, and it is recommended these burdens are considered before any changes are made. Data collection and reporting structures are extremely time intensive, and the addition of even one measure or assessment increases the time and resources for staff and awardees. In addition, the Alliance asks to consider the burden and cost of these additional changes to data systems both at the model level and the state level.

The Alliance acknowledges that while there were some differing opinions among the Alliance members about the addition of new benchmarks, there is consensus that if these are added, the proposed timing expectations of the two new performance measures is unrealistic and will be an issue for the field, as well as the requirements about the tool used.

Measure 7: The Alliance recommends aligning the timeline for substance abuse screening with the depression or IPV screening timelines. Adding this type of measurement within 30 days of enrollment is counterintuitive to the relationship-based nature of home visiting.

- Screening should be conducted with consideration of the need to build trusting relationships with families and individualize services building on family strengths and needs. Substance abuse screening is sensitive in nature; therefore, time to build trust is imperative.

Measure 21: The Alliance recommends that the Department reconsider the timing requirements pertaining to receipt of services within 14 days. The Alliance believes this is an unrealistic expectation, as the suggested timeframe does not consider the reality of the availability of behavioral health resources in communities.

- This requirement only increases the burden to our families and highlights the existing structural racism and oppression in access to care. Behavioral health resources are scarce, with long waiting lists to receive the needed services, especially in communities of color.

The Alliance also recommends the Department to consider more than one validated tool to screen for substance use. The Alliance encourages the Department to consider the use of modified,

validated tools or consider accepting other methods of screening for substance use as defined by the evidence-based model.

- Models should be able to use modified, validated, multi-purpose tools that measure the complex needs of families, including substance abuse issues. This approach embraces the nature of working with families in a trusting relationship-based context.

February 16, 2021

Dear HRSA Information Collection Clearance Officer:

Prevent Child Abuse America is the oldest national nonprofit organization focused on the prevention of child abuse and neglect. Our success is founded on a nationwide network of state chapters and nearly 600 community-based Healthy Families America (HFA) home visiting sites in 38 states, DC, and all five U.S. territories. HFA has been shown to improve school readiness, reduce child maltreatment and intimate partner violence, and improve family economic stability, among other positive outcomes. Our approach is relationship-based, culturally informed, family-centered, and grounded in the parallel process: the relationships we build with parents and families serve as a model for the supportive, positive relationships we help them cultivate with their children. HFA is one of the most widely implemented home visiting programs in the country, delivering approximately one million home visits every year, and directly impacting more than 70,000 families (93,000+ children). The HFA national team supports these sites with training, accreditation, technical assistance, and other critical supports.

HFA welcomes the opportunity to provide feedback and respond to HRSA's notice (OMB No. 0906-0017), published on December 18, 2020, which would modify several of the current data collection practices for MIECHV Form 1 and Form 2. While we are in strong agreement with the value of HFA sites' conducting primary caregiver substance use screening tailored to family needs and the specific implementation context, we have concerns about the proposed additions of two federally required performance measures and the implications of these changes for practice and policy. Our comments on the two added substance abuse screening measures are guided by these key points:

- Data burden is an ongoing challenge for implementing sites and changes to existing protocols increases the time and financial burden for sites and home visitors. The addition of performance measures requires that data collection systems be modified to ensure accurate and reliable reporting, as well as new staff training, quality assurance, and quality improvement processes. These modifications require financial and staff resources, potentially resulting in fewer resources focused on direct service to families.
- Building a trusting relationship with parents is key to successful outcomes for home visiting and a critical part of Healthy Families America's Best Practice Standards. In addition, many of the families served by HFA have experienced adverse childhood events, trauma, and ruptures in their relationships, along with historical racism and systemic oppression. Adding required screenings focused on risk and challenges and not framed in a strengths-based way or tailored to family needs could interfere with the development of the home visitor-parent relationship.
- Work with infants, children and families should be guided by the Diversity-Informed Tenets (https://diversityinformedtenets.org) and evaluation should be guided by principles of equity.
- Any new performance measures should be assessed within the context of existing MIECHV performance measurement requirements and consistency with existing measurement approaches should apply wherever possible. In addition, adding a seventh measure to the area of maternal and newborn health would result in one third of the measures falling in that benchmark area. Adding another measure to that area also makes it increasingly high stakes and potentially more difficult for states to show improvement in the maternal and newborn health construct, and therefore overall.

We therefore recommend that the two proposed substance use screening measures not be added to the list of required performance measures.

Proposed Measure 7 Comments:

Timing: Should a new performance measure on substance use screening be added, we recommend that the timing for substance use screening be adjusted to be aligned with the IPV screening with a timing of "within 6 months of enrollment." Requiring universal substance use screening within 30 days of enrollment can result in parents not being comfortable sharing sensitive information and therefore inaccurate screens.

> *Rationale*: Within HFA, we require home visitors to build relationships based on mutual respect and partnership, which includes delivering screenings. Establishing a trusting relationship with a parent increases the likelihood of an accurate screen. Screening should be conducted with consideration of the need to build trusting relationships with families and individualize services building on family strengths and resources and the needs of families with varied life histories and circumstances.

Requirement to Use a Validated Tool: We are concerned about the availability of tools that have been validated with both adolescent and adult parents with diverse cultural and language backgrounds and designed for administration and scoring by home visitors.

> *Rationale*: Many HFA sites currently use a more comprehensive and well-tested multi-purpose tool that would not be considered a validated substance abuse screening tool but that addresses family needs in a respectful and parent-centered conversation. Being sensitive to the community context and the development of a trusting home visitor-parent relationship is critical to gathering accurate information about substance use and for making referrals. In addition, using separate screening tools with adolescent parents and adult parents, determining a definition of a "positive" screen, and ensuring that the screening tools are valid all pose challenges.

Measurement: The performance measure uses the wording "unhealthy alcohol use, nonmedical prescriptions drug use, and illicit drug use." Requiring that all three be assessed for all families could mean an additional 3 screening tools that are not based on family needs and would also add to the existing data burden of home visitors. To complicate interpretation further, the draft revised form does not align with the performance measurement language and specifies only "unhealthy alcohol use and drug use" for the numerator. We suggest using the broader term of "unhealthy alcohol and drug use" throughout.

> *Rationale*: Initial conversations with families during the intake process and completion of the intake process typically guide HFA home visitors as to which full screening tools they might use (e.g., if a parent shares information that suggests they don't have addiction issues with other drugs but do with alcohol, then the prioritized follow-up screen would focus on alcohol, not on nonmedical prescription drug use or illicit drug use). Requiring screening in all three areas regardless of parent need could appear tone-deaf and insensitive when building a trusting relationship.

Proposed Measure 21 Comments:

The expectation that parents would meet with a behavioral health specialist within 14 days does not consider the reality of the availability of behavioral health specialist providers and the length of time to appointments in our country. If a new performance measure on substance use referrals is added, we believe that the language around substance use referrals ought to be aligned with the IPV screening referral language "Number of primary caregivers enrolled in home visiting who received referral information to substance use resources (and met the conditions specified in the denominator)."

Rationale:

- Availability of and access to needed resources is unevenly distributed in the United States including substance use treatment and behavioral health treatment; existing inequities in resources such as transportation and availability of behavioral health providers unfortunately limit access to care for many of our families, particularly those in rural areas and high poverty communities.
- It is a challenge in many communities to find high quality behavioral health specialists who will treat parents with respect, understand the role of trauma and the impact of systematic oppression and historical racism, and who follow principles of cultural humility and rely on diversity-informed tenets. Access does not equal quality care, and we should be cautious about putting home visitors in a place of pressuring families to access care that may not be supportive.

- Home visitors do not have control over when a family can be seen by an outside referral or whether the service provider has availability or maintains a waitlist.
- HFA home visitors empower families to access needed services, including referrals to behavioral health. Home visitors work diligently to reduce barriers and support parents, but parents choose whether they are ready for change and how they prioritize this with their other needs. Home visitors aim to build a long-term relationship that will result in positive outcomes for families and this requires attending to the family in a holistic and comprehensive way depending on families' resilience and opportunities for growth in addition to their risk characteristics.
- The timing requirement seems to prioritize receipt of substance abuse services over other mental health services and support for IPV.
- The performance measure has a restrictive definition of a "behavioral health specialist. A parent with comorbid conditions such as depression might be well-served by an experienced psychiatrist who does not have formal specialization in addiction medicine, and research suggests integrated treatment can be ideal for comorbid mental health and substance use issues. Availability of psychiatric care is challenging enough for most parents without adding federal expectations that could make it even more difficult for them to receive needed services. Parent choice should not be restricted by such a specific and exclusive definition (e.g., some PhD level clinicians).

Change in Behavioral Concerns Construct Name Comments:
In addition to our comments about the additional performance measures, we suggest a change to the Behavioral Concerns construct area name. We recommend the construct name reflect the breadth of the construct as well as the intent, using the name "Child Development, Behavior, or Learning Concern Inquiries"

Rationale:

- Instead of the proposed change to "behavioral concern inquiries," we suggest the construct name be broadened to reflect the breadth of the performance measure. This change would also underline the field's belief in the importance of areas beyond just child behavior and would more clearly tie to parent concerns in areas such as social and emotional development, attachment, attention, etc. – all critical areas to young children's healthy development.

Thank you for your attention to our comments.

Sincerely,

Kathleen Strader, MSW, IMH-E® (IV)
Chief Program Officer, Prevent Child Abuse America and National Director, Healthy Families America®

Karen Guskin, PhD
Managing Director of Healthy Families America® Research

Melissa Merrick, PhD
President and CEO, Prevent Child Abuse America

EARLY IMPACT VIRGINIA
ALLIANCE FOR EARLY CHILDHOOD HOME VISITING

February 16, 2021

To Whom It May Concern,

Thank you for offering the opportunity for our organization to provide public comment on the proposed changes to the MIECHV benchmarks.

As the Alliance for Early Childhood Home Visiting, Early Impact Virginia is not only responsible for statewide reporting across the seven program models providing services to Virginia families, but also convenes a workgroup specifically tasked with addressing data related issues and driving data, research and evaluation activities. This group met to review the proposed changes and develop a collective response.

The following comments represent the collective response from the group which includes the Early Impact Virginia Applied Research Coordinator and the following organizations and/or individuals:

- Virginia MIECHV Program Evaluator
- Healthy Families Virginia
- Nurse Family Partnership
- Parents as Teachers
- Resource Mothers
- Healthy Start
- CHIP of Virginia

Form 1, Table 16: Add new table to include reporting on father and additional caregiver engagement.

- ***We are not in favor of this change.***
- Rationale: Although several models/sites collect who participated in home visits, there were questions about which value MIECHV was intending to promote by adding this to the benchmark. For instance, could this be used to fuel negative stereotypes about the types of families we serve and fatherhood? The group did not feel that the proposed categories (i.e., father was involved in at least one home visit) convey important information. For example, if a father is the primary source of income, participating in home visits may not be feasible, but would also not be indicative of an uninvolved father. Further, the definition of "participating in at least one home visit" is not clear. What constitutes participation is subjective, and also does not indicate fatherhood involvement in the child's life. Alternatives could include looking at relationships between target children and primary caregivers plus caregiving status (single parent, co-parenting, etc.).

Form 2: Add two measures to collect information on substance use screening and referrals.

- ***While we are in strong agreement with the value of home visitors conducting primary caregiver substance use screening tailored to family needs and the specific implementation context, we have concerns about the proposed additions of two***

federally required performance measures (#7 and #21) and the implications of these changes for practice and policy.

- Rationale: With all of the competing demands and current screening requirements at the beginning of home visiting, 30 days is not nearly enough time to screen for something that requires such high levels or trust and rapport. The quality of data would be questionable due to the rushed screening on such a sensitive topic. In addition, after a positive screen, home visitors may not have appropriate services to refer clients to. Another issue is that Virginia does not currently have a validated tool widely used among sites – extensive training would be required. The legalization and decriminalization of marijuana in various states would also cause lack of clarity and homogeneity in the measures across the US. One alternative would be to model substance use performance measures (PM) like the tobacco cessation PM, to include more time, self-report, and resources/referrals provided.

In addition to our comments about the additional performance measures, we include a comment on changes in guidance regarding IPV screening during virtual service delivery for home visiting and on the suggested change to the Behavioral Concerns construct area name.

Change in PM for IPV Screening

- Rationale: Based on guidance from Futures Without Violence, and work they are doing with the HV CoIIN, our state is interested in shifting our approach, and therefore training, for how home visitors address IPV through universal education and referral as opposed to screening. This is in line with information shared on the HRSA website page Important Information During COVID-19. As stated in the HVCoIIN memo posted on that same page, "At the moment there is no research indicating that virtual screenings are safe." While we appreciate the ability to add notes to our APR and other MIECHV reports, we would like to know more about how HRSA is planning to accommodate this change in programmatic activities as more states and programs begin to adopt this approach.

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Thank you for this opportunity to share our feedback. Please feel free to contact me if you have any questions or need additional clarification.

Sincerely,

Laurel Aparicio
Executive Director

February 16, 2021

To whom it may concern,

As an awardee, The Florida Maternal, Infant and Early Childhood Home Visiting Program would like to thank you for the opportunity to provide feedback while considering the announced changes to the demographic performance measures (Form 1) and benchmark performance measures (Form 2) (OMB No. 0906-0017), published on December 18, 2020.

The announcement of the proposed Form 1 and Form 2 changes initiated a series of in-depth discussions about the advantages and challenges such revisions would have on our state and local implementing agencies (LIA). In this document, the Florida MIECHV administrative team included a table where you may find comments on various areas where changes are proposed. While some of the proposed changes identified are self-explanatory, additional details on some changes would help us better understand the expectation and goals HRSA hopes to achieve.

Similarly, the changes proposed by HRSA will impose considerable burden on data collection/analysis and application at the state level, as well as LIAs. These changes will require time to train staff on proper procedures and tools, correct interpretation of changes, and contractual and financial cost. Data collection and analysis changes will also require adaptations to data collection and analysis systems and software, and carry cost related to updates. Further clarification will help all affected execute the changes in the most consistent way possible.

Area/Section	Revision/Burden	FL MIECHV Comment
Demographic Performance Measures (Form 1)		
Table 1, 3, 4, 6, 7, 8, 9, 10, 11, and 18	Update tables to include reporting for gender non-conforming participants and unknown/did not report participant's gender.	FL MIECHV recognizes HRSA's interest to expand gender categories as an admirable step towards inclusion but must highlight the additional burden this change places upon the state. Models who do not collect this data will need to update their data collection procedures to accurate capture this new data point. Additionally, the added complexity of the table tabulation increases the reporting burden and potential for data quality inconsistencies, which should be taken into consideration in the context of all proposed changes.
Tables 3, 5, 6, 7, 18, 19, and 20	Update tables to remove index child gender reporting.	FL MIECHV recognizes HRSA's interest to expand gender categories as an admirable step towards inclusion. LIAs expressed concern over removing gender categories for index children because the breakdown is often requested for funding opportunities and other reporting purposes.
Tables 4, 9, 10, and 18	Update tables to include reporting for new and continuing adult participants.	The added complexity of the table tabulation increases the reporting burden and potential for data quality inconsistencies.
Tables 5, 19, and 20	Update tables to include reporting for new and continuing index children.	The added complexity of the table tabulation increases the reporting burden and potential for data quality inconsistencies.

Table 16	Addition of Father and Additional Caregiver Engagement by Household table.	HRSA's interest in capturing father and additional caregiver engagement is lauded by Florida MIECHV. However, a more detailed definition of "father/additional caregiver" and "participation" is necessary for the consistent capturing of this demographic. Also, data collection and completeness requirements for this new data point will be difficult to implement across the varying models.
Benchmark Performance Measure (Form 2)		
Performance Measure 16	Update measure to reflect caregiver health insurance coverage status.	Clarification on the 6 consecutive months of insurance is necessary to determine if 6 consecutive months of coverage at any point during the reporting period apply, or if it now means the most recent 6 consecutive months during the reporting period.
Performance Measure 6, 18, 19, and 20	Missing Data.	Screen completion measure should not be assessed in the referral measure. Missing screens should be excluded from the referral measure.
Performance Measure 7	Addition of substance use screening.	Collecting this measure within 30 days of enrollment would be a heavy undertaking for home visiting staff. Requiring the sensitive assessment to be completed shortly after enrollment could negatively impact engagement during the first 30 days. Additionally, the likelihood of obtaining a meaningful assessment increases once a relationship has been built.

		Florida MIECHV recommends aligning this measure with the timeline of the IPV screen. Allowing up to 6 months for screening completion better promotes accurate screening and relationship building.
Performance Measure 21	Addition of substance use referral.	Fourteen days to measure receipt of service would be a nearly impossible undertaking. LIAs expressed concern over the capabilities of their communities to access substance use services. Existing obstacles compound when considering that approximately half of Florida's counties don't have treatment programs for pregnant or postpartum women. Even counties with programs lack in capacity to serve patients, and admissions depend on the substance and severity of use. We are concerned that the efficacy of home visiting services will be evaluated by lack of received services, when, it more closely reflects the systemic lack of substance treatment facilities. Additional information on how the time frame was determined would help us better understand and adopt this new measure.

Texas Department of
Family and Protective Services
Prevention & Early Intervention

Ms. Cynthia Phillips
Director, Division of Home Visiting and Early Childhood Services
Maternal Child Health Bureau
Health Resources and Services Administration
Rockville, MD 20857

February 16, 2021

Dear Ms. Phillips:

The Prevention and Early Intervention Division of the Texas Department of Family and Protective Services (PEI) is the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Grantee for the state of Texas. As such, we are writing to respond to HRSA's Federal Register Notice Public Comment Request; Information Collection Request Title: *The Maternal, Infant, and Early Childhood Home Visiting Program Performance Measurement Information System.* The notice provides information about how HRSA is planning to measure MIECHV program performance through the performance measurement information system starting in Fiscal Year 2022.

PEI's research and evaluation team is strongly committed to valid and reliable performance measurement and continuous quality improvement. We appreciate HRSA's release of proposed changes and the efforts they have already undertaken to ensure the concerns and suggestions of states and local implementing agencies are incorporated into the guidance.

Based upon the draft guidance and information we have received through our membership in the *Association of State and Tribal home Visiting Initiatives*, we are providing the feedback below.

Overall Comments

PEI appreciates the MIECHV program's commitment to data-driven programming and tracking performance measures. There are significant challenges and concerns related to the implementation of the MIECHV performance measures. In several cases, the performance measures are not aligned with data collection policies and procedures of evidence-based models. In cases where models are not in alignment, MIECHV grantees become intermediaries between models and the federal government, with little ability to influence the way data is collected but accountability for the collection of that data. To reduce discrepancies and minimize duplicative data collection, PEI would like to request that HRSA consult with evidence-based models on the measures and proposed changes to ensure that the models are willing and able to implement them as designed. Where there are discrepancies, PEI would like to request best practices and guidance on reconciling the differences between HRSA and the evidence-based models.

While some changes can increase the validity and reliability of outcomes measurement for the MIECHV program, each change must be weighed with the burden of data collection and reporting changes in mind. Most changes to measures require updates to information technology (IT) systems to allow for changes to data entry and reporting. PEI would therefore like to request the ability to phase in these

changes over the course of fiscal year 2022 and would like HRSA to weigh the benefit of changes to data collection with the burden that a change may impose on grantees.

Further, the proposed changes to Form 1 and Form 2 increase the data collection burden for states and local implementing agencies (LIAs) without reducing the burden elsewhere. PEI would like HRSA to consider the trade-offs of increased data collection and its effect on program implementation, particularly as related to the concerns below:

- Client experience and retention – While collection of performance data is important for the measurement of outcomes, the collection of 21 performance measures, along with demographic data to populate 22 descriptive tables can be burdensome to home visitors and affect the client's experience in the program. This is especially true where model and HRSA data collection do not align, leading to duplicative data collection.

For these reasons, PEI would like to request that HRSA not add new measures without reducing or simplifying the existing measures. Further, provision of a logic model for how MIECHV is expected to influence each of the performance measures would help PEI explain the data collection requirements to LIAs.

Form 1

- Addition of gender non-conforming and unknown/did not report gender categories (Tables 1, 3, 4, 6, 7, 8, 9, 10, 11, and 18):

  This change does not align with Texas state government reporting and data quality standards.

- Increased reporting on new and continuing adult participants (Tables 4, 9, 10, and 18):

  PEI would like more information about the reason for this change. While the data needed to report this information is available in PEI's data system of record, a change to reporting will need to be made. This will impose some burden on PEI.

- Removal of index child gender reporting (Tables 3, 5, 6, 7, 18, 19, and 20)

  PEI would like clarification as to why index child gender will still be required for table 1, but is not reported for other tables.

- Increased reporting on new and continuing index children (5, 19, and 20)

  PEI would like more information about the reason for this change. PEI would also like to request additional guidance on how to classify index children as new or continuing when a new index child is added as a client. For example, if the family is participating with an older sibling and the younger sibling would like to participate, and the model allows for more than one index child, would one child be continuing and one new, even though the associated caregivers are continuing? While the data needed to report this information is available in PEI's data system of record, a change to reporting will need to be made. This will impose some burden on PEI.

- Reporting on virtual home visits (Table 15)

PEI believes that it is currently capturing all data needed to report on this table. We would like additional clarification on counting a virtual visit, and whether there are any restrictions or limitations to something counting as a virtual visit versus another type of service. While the data needed to report this information is available in PEI's data system of record, a change to reporting will need to be made. This will impose some burden on PEI.

- Reporting on father and additional caregiver engagement (Table 16)

  PEI would like clarification of who HRSA considers a father. Specifically, is it only the biological father or any male caregiver? Additionally, we would like to know how to capture participation of other caregivers. PEI is currently reporting participation of both primary and secondary caregivers in Form 1, but can add other participants who may also be caregivers if needed. We would like to request further clarification on how to define other caregivers. While the data needed to report this information is available in PEI's data system of record, a change to reporting will need to be made. This will impose some burden on PEI.

Form 2

- Update to health insurance coverage measure (Measure 16)

  PEI does not support this change to the measure and would prefer to keep the measure as it is currently defined. As a non-expansion state, PEI and its LIAs have very little influence on the ability of adult caregivers who are not expectant women to gain and keep insurance coverage. Currently, models are able to meet this measure in Texas when they serve prenatal clients and youth clients by helping them obtain public insurance such as Medicaid. By changing this measure to the last point of measurement during the fiscal year, many families who might have qualified for this measure at some point during the fiscal year may not be included if they age out or give birth before the end of the fiscal year.

  Additionally, families who do not exit during the fiscal year but continue to the next fiscal year will all be measured by PEI at the time of their last home visit before the end of the fiscal year. This makes the measure more subject to economic trends influencing families' ability to retain health insurance.

  PEI would like to further request that non-expansion states only be compared to other non-expansion states for the purposes of setting national thresholds and determining performance on this measure.

  While the data needed to report this information is available in PEI's data system of record, a change to reporting will need to be made. This will impose some burden on PEI.

- Addition of two measures to collect information on substance use screening and referral

  PEI understands and supports the need to measure the role of home visitors in screening and referral for substance misuse. PEI has some questions and concerns about the proposed measures, as detailed below:

  - Universality of screening – The American Academy for Family Physicians currently recommends against universal screening for substance misuse among adults. PEI would

like more information about whether HRSA is proposing universal screening for all participants, or only where there is indication that a screening is needed.

- Timing of screening – PEI would like to propose that HRSA use the same timeline currently in place for Intimate Partner Violence (IPV) screening. Substance misuse is a sensitive topic, subject to social desirability bias. Allowing for six months to screen a caregiver, gives the home visitor the discretion to screen immediately or screen once the relationship with the family is more established. This is likely to lead to more valid screening results and increased ability to successfully retain and refer families in need.
- Validated tools – PEI would like more information about what tools HRSA is including on its list of validated tools. PEI would prefer to implement tools that
  - screen for substance misuse as an overall health check;
  - can be used for adults, adolescents, and expecting women;
  - and that would not automatically trigger a mandatory report while home visitors are in the process of building a relationship with a family.
- Referral timeframe – PEI would like more information about how HRSA determined the timeframe for referral to behavioral health services. While 14 days is an appropriate timeframe for formal screening from the Local Mental Health Authorities (LMHA)/Local Behavioral Health Authorities (LBHA), it will likely be a challenge for other behavioral health services to meet this timeframe.
- Acceptable referrals – PEI would like additional information about which behavioral health services are considered acceptable referrals for a positive substance use screen. Is it HRSA's intention that all referrals will be to LMHAs or LBHAs? If not, will the models determine acceptable referrals, as they do for other measures?
- Missing data – PEI would like to request that those who do not receive a screening that qualifies for the new measure 7 screening measure are not counted as missing in the referral measure. By considering the universality of the screening measure as part of the referral measure, HRSA ensures that there will always be more missing data than the 10 percent cut-off on all referral measures. This also obscures other missing data that may have more interesting implications for referral measures. For example, when families are missing follow-up data collection points.

Neither of these measures are currently captured in PEI's data collection system. Their inclusion will impose a data collection, data entry, and reporting burden for PEI. PEI will have to build functionality into its system of record to accurately capture this data on the correct timeline.

- Other measures

  PEI would also like to take the opportunity to comment on a few of the other performance measures that HRSA has not proposed for changes.

  - Measure 1 – Preterm birth:

PEI appreciates that reducing preterm birth through increased prenatal care is an important outcome for evidence-based home visiting. We are somewhat concerned that this measure's inclusion as a performance measure may discourage enrollment of higher risk expectant women, particularly those expecting multiples, who may be those most in need of home visiting services. Further, the implementation of the measure to include women who enroll all the way up to 37 weeks, means that the LIA is held accountable for pre-term births that occur shortly after enrollment. Additionally, the inclusion of subsequent pregnancies is difficult to implement, due to questions about who should be included, and is outside the scope of many evidence-based models.

- Measure 4 – Well-child visit:

  PEI agrees that increasing attendance at well-child visits is a key outcome of evidence-based home visiting programs. PEI believes that the specification of this measure does not accurately capture home visiting models' work towards this goal. By looking only at the well-child visit due at the last home visit before the end of the fiscal year, HRSA does not include any visits that occur earlier in the year to count for performance. This makes continuous quality improvement efforts to improve this measure difficult, if not impossible. It also increases the likelihood of missing data for models like Home Instruction for Parents of Preschool Youngsters (HIPPY), which serve older children and operate on the same schedule as the school year. Many of those children will have received their well child visit over the summer, but not restarted home visiting services by the end of the fiscal year. Further, it subjects the measure to undue influence of situations like the current COVID-19 pandemic, which reduce well-child visit attendance for all families, whether or not they participate in home visiting.

  PEI would like to propose that HRSA implement this measure to either track receipt of at least one well-child visit at any point during the fiscal year while the family is enrolled in services or receipt of a set percentage of well-child visits due during the fiscal year, while the family is enrolled in services. This will ensure that LIAs performance is based upon work throughout the fiscal year and allow for continuous quality improvement projects around this measure.

- Measure 9 – Child injury

  PEI would like to propose renaming this measure to reflect the inclusion of accidental ingestions in this measure. Further, we would like to note that the measurement of this construct may be biased in the state of Texas due to the presence of stand-alone emergency rooms. Families may not know when they are visiting an ER and when they are visiting urgent care.

- Measure 10 – Child maltreatment

  PEI would like to encourage HRSA to measure confirmed cases of maltreatment, rather than investigations. Investigations are more heavily influenced by disproportionalities

and bias in reporting. PEI is currently measuring confirmed cases of abuse and neglect while receiving services and would like to propose that as a more valid performance measure.

- Measures 18 through 21 – Referral measures

  Home visiting plays an important role in connecting families to needed services. PEI supports the inclusion of these measures. However, we would like to recommend that those who are not screened for depression, substance use, developmental delays, and IPV in the recommended timeframe for measures 3, 7, 13, and 15 should not be included as missing for the referral measures.

Once again, PEI appreciates the opportunity to comment on the proposed changes to the MIECHV performance measures. We further appreciate our ongoing partnership with HRSA as we work to provide needed home visiting services to Texans

Sincerely,

Kathryn Sibley Horton

Director of Research and Safety
Prevention and Early Intervention Division
Texas Department of Family and Protective Services
Kathryn.sibley@dfps.texas.gov

From: Robinson, Hannah <Hannah.Robinson@dcs.IN.gov>
Sent: Tuesday, February 16, 2021 5:52 PM
To: HRSA Paperwork <paperwork@hrsa.gov>
Cc: Higgins, Carrie <Carrie.Higgins@dcs.IN.gov>; Kinderman, Cassondra <CKinderman@isdh.IN.gov>; Herring, Heather R <HHerring@isdh.IN.gov>
Subject: OMB No 0906-0017 – MIECHV Performance Measurement

To Whom It May Concern:

The Indiana Department of Child Services (DCS), Prevention Team appreciates the opportunity to provide comment on The Maternal, Infant and Early Childhood Home Visiting Program Performance Measurement Information System (OMB No. 0906-0017), published on December 18, 2020.

The Indiana DCS Prevention Team – as the central administration for a state-wide implementation of Healthy Families America (HFA) model, known as Healthy Families Indiana (HFI) – supports comments provided by HFA in response to proposed changes to the MIECHV performance measures.

In addition, the Indiana DCS Prevention Team would like to note concern for proposed changes regarding the following items:

1. adding additional performance measures – the addition of performance measures increases the data collection burden for home visitors at a time when home visitors are not only already over-burdened with data collection requirements for typical practices but are also balancing expectations to provide support above and beyond typical home visiting practice as a result of the current pandemic.
2. substance use screening – should current HFA multi-purpose screening tool not be accepted as a validated substance abuse screening tool, these changes would require researching and selecting an appropriate tool, training staff to conduct the tool, and revising the data collection/database to accommodate the tool data entry and related reports. The aforementioned activities would require additional resources beyond currently budgeted expenses and would take approximately 6-9 months to implement.
3. substance use referral – while we anticipate that several responses to this notice may include concern over the time frame for referral and receipt of service for substance abuse, we would like to reinforce that referring families to appropriate mental health and/or substance use services is not a guarantee that the services will be available, timely, and/or accessible to families. Given the challenges we already see with the referral measure for depression screening, we would anticipate similar challenges for substance use services.
4. referral measures in general – for those measures that incorporate not only a screen and referral, but measure receipt of service, we would like to offer that illustrating improvement in these measures that are measuring activity beyond the control of the home visiting environment does not reflect home visiting practice, outcome, or improvement.

Thank you for the opportunity to provide comment. We look forward to the ongoing efforts to improve data collection and reporting for MIECHV funded services.

Hannah Robinson
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765-265-6797 cell
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STATE OF WASHINGTON

DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

P.O. Box 40970, Olympia, Washington 98504-0970
(360) 725-4665 • FAX (360) 413-3482

February 16, 2021

Ms. Cynthia Phillips
Director, Division of Home Visiting and Early Childhood Services
Maternal and Child Health Bureau
Health Resources and Services Administration
Rockville, MD 20857

Re: The Maternal, Infant, and Early Childhood Home Visiting Program Performance Measurement Information System, OMB No. 0906–0017, Revision

Dear Ms. Phillips,

The Washington State Department of Children, Youth, and Families (DCYF) thanks you for the opportunity to provide feedback on the proposed revisions to HRSA's notice, *The Maternal, Infant and Early Childhood Home Visiting Program Performance Measurement Information System* (OMB No. 0906-0017), which would modify several of the current data collection practices for Form 1 and Form 2 performance measures.

Form 1 Comments

General Comments:
Overall, the reporting of data by multiple dis-aggregations for several tables has increased the complexity of data production multi-fold. This in turn will lead to data collection, reporting and production errors due to increased missing data and/or inconsistent classification of data elements across Grantees. We strongly encourage HRSA to streamline the demographic reporting, focusing only on the essential data elements for routine reporting with 2-way tables only.

Table Comments:

- **Table 1: Update table to include reporting for gender nonconforming participants and unknown/did not report participant gender; AND**
- **Tables 3, 4, 6, 7, 8, 9, 10, 11, and 18: Update table to include reporting for gender nonconforming participants and unknown/did not report adult participant gender; AND**

Tables 3, 5, 6, 7, 18, 19, and 20: Update table to remove index child gender reporting.

- Washington agrees with decision to add Unknown/Did not Report Gender. This will allow for a more complete accounting of all participants (for all tables cited).
- It is recommended that gender, non-conforming gender, and unknown gender are included in Table 1 for adults and children but no dis-aggregations by gender in remaining tables, per comments below.
- The Washington MIECHV program has concerns about the request to include gender non-conforming dis-aggregations throughout Form 1. The necessity and utility of this additional data for HRSA's use has not been demonstrated adequately to support overcoming or accommodating the barriers noted, as follows:
    - For several tables, the cell counts for gender non-conforming will not meet standard criteria for reporting out small numbers, particularly true with the 3-way tables that look at Gender, New/Continuing Enrollment, and a specific demographic variable. These small reporting numbers fail to adequately protect family confidentiality. For example, if you only have one reported non-conforming adult, you could then identify all of that individual's other demographic characteristics.
    - Reporting on gender non-conforming participants will require updates to national model data systems. HRSA would need to require these modifications from the national models so that awardees could comply.
    - Extensive effort will be required to update data collection forms, training for data collectors, data entry screens, coding to process data, and quality control for each step in the process. This includes the need for HRSA or each individual state to advocate to models to update their data collection systems.

Tables 4, 9, 10, and 18: Update table to include reporting for new and continuing adult participants; AND
Tables 5, 19, and 20: Update table to include reporting for new and continuing index children.

- For some of these tables, the interest in dis-aggregation by new and continuing participants makes sense; however, additional guidance is needed from HRSA. Often a family enrolls and exits as a full unit, such that new or continuing enrollment for adult participants matches that for the family and for the children. However, if over the course of service, children are added to the family, then in one family we will have differing reporting on new vs continuing. And it will only be possible to report out separately if enrollment/exit dates are tracked by individual. This challenge will be more visible in the data when we are required to report by Child status and age (Table 5).
- As noted above, 3-way tables will require more complex coding and quality review.

Table 14: Priority Populations

- Washington encourages HRSA to require national MIECHV-approved models to collect data on Priority Populations and report on it uniformly and as specified in Table 14 in their respective model data systems.

Table 15: Change table title to "Home Visits" and update table to collect the number of home visits completed virtually.

- While Washington agrees with the intent, the implementation will require model-specific training on differentiation of a true home visit completed via different methods. It will also require updates to the national model data systems and local data systems.

Table 16: Add new table to include reporting on father and additional caregiver engagement.

- While Washington believes this is an interesting data collection point, data collection and completeness will be extremely difficult for this change. This will require home visitors to ask about this at every visit. Data on additional adults participating is currently not collected by NFP, although possible for PAT (it is part of the Personal Visit Record - PVR) but we believe reporting is incomplete.
- Washington strongly recommends against this data collection for routine reporting and instead encourages HRSA to alternatively pursue this with a special study.

Form 2 Comments

General Comments:

- Washington recommends limiting all measures in Form 2 to "actively-enrolled." For many models, data is not collected on any measures unless there is a visit. Allowing data to be collected without a visit in some measures could create comparison challenges when looking at Form 1 and 2 data. Currently only four measures require active enrollment during the report year (i.e. at least one home visit in report year). For most models, data is not collected on any measures unless there is a visit. However, by allowing for those without a visit to be counted in some measures means that data between Forms 1 and 2 are out of sync. If this guidance does not change, then it is imperative that national models follow the same standard. For example, *NFP only includes "actively-enrolled" for all measures in Form 2 regardless of HRSA intent
  **per the report built to pull this data in their Power BI, data warehouse.*
- In general Washington is interested in learning more about how the time frames for certain measures, namely 7 and 21, were derived, particularly if they remain unchanged. Home visitors might be interested in this information, and it could help them adopt new practices.

Measure 2: Breastfeeding

- The data collection period and the cadence of model home visiting data collection do not align, which results in the exclusion of many infants from the measure. Per the Toolkit, children are excluded if they are not asked about breastfeeding between 6-12 months of age; however, models collect at the 6-month visit (which often occurs during the 5th month) or at the 12-month visit (often occurs during 13th month). For other screening measures (Measure 3, Measure 14) if the screening is completed outside of the window they are counted as Missing, Not Excluded. Data would be more complete if data collection period is extended to 15 months of age or MIECHV works with models to collect this data more frequently.

Measure 4: Well Child Visits (WCV)

- Following the American Academy of Pediatrics, the MIECHV guidelines on windows for WCV is unnecessarily restrictive. The guidelines are for pediatricians, yet often the timeline of visits is adjusted by the provider not the home visitor or family. Adjustments to schedules are especially true for premature infants and children with special healthcare needs. Intent of measure should be to ensure that children are being seen routinely by providers. Consider alternative measures for WCV, such as National Survey of Children's Health or Medicaid measures.

Measure 7: Substance Use Screening

- Washington recommends aligning the timeline for the substance use screening with the depression or IPV screening timelines. A 3-6-month window is more ideal for accurate reporting and relationship building. Without that strong relationship, the validity of the screening may be concerning. The ideal would be a 6-month screening window in alignment with the IPV screening.
- Additional exploration would need to happen with the Washington State Child Welfare program to determine if home visitors collecting this data would mean mandatory reporting to Child Protective Services if the screening was positive.
- HRSA must provide a list of HRSA-approved screening tools, including those validated for virtual use, otherwise each Grantee and Model must sort this out resulting in lack of uniformity across MIECHV.

Measure 12: Child Developmental Screens

- A requirement to meet the 3 specific screens in their narrow windows is difficult for programs and adds a layer of coding difficulty. If intent is to screen during 9-30-month window, then count any screens completed. Recommend considering NSCH or Medicaid measures.
- Guidance for exceptions on when/if to screen based on prior screening results and/or diagnosed delays is confusing. Currently a positive ASQ with no later screen is excluded but if screened again, then included in measure, making it difficult to track who to include and when. Recommend always excluding a child after <u>any</u> diagnosis or <u>any</u> positive ASQ screening, regardless of any subsequent screenings completed.

Measure 16: Update measure to reflect caregiver health insurance coverage status.

- HRSA would need to provide clear guidance on how to report on caregivers who remain enrolled but were not asked for updated insurance status during report year. Currently, we require annual updated data collection but we use any insurance data reported to respond to this measure. If new data updates have not been collected during the report year, would this be considered missing data?

Measure 17 – Depression Referral Completed:

- Recommend universal guidance on what constitutes a "positive screen" requiring a referral. Some models (e.g., NFP) count referrals provided to those with Mild Depression (PHQ9 score 5-9) whereas the state program only tracks referrals for those with Moderate to Severe Depression.

Measure 19: IPV Referral

- The restriction to limit counting of Referrals to only those with a prior positive IPV screen gives a very limited picture of the IPV referral work completed by LIAs. In our state, over three times as many referrals were provided during FFY20 for IPV services than what the measure counts.

Measures 17, 18, and 19: (referral measures)

- Including those missing a screening as missing a referral conflates the two, we should not be trying to assess completeness of the screening measure when evaluating the referral measure. Recommend excluding from these referral measures those who missed the screenings.

Measure 21: Substance Use Completed Referral

- For most of the families we serve, substance use/abuse is a chronic health problem, one requiring ongoing support to help participants take that step to care. A crisis response (14-day turnaround for completed referral) is unrealistic and not reflective of the commitment needed to do this work well. This also relies on overburdened and spotty services being available in the comminutes we serve within that 14-day window.
- If this new measure is added, Washington recommends a Referral Only requirement (not completed referral) which also aligns with IPV screening and referrals.
- To effectively implement a new screening and referral system, extensive training would need to be provided to home visitors; major data system updates would be required for local data systems as well as requirements for national model data systems; and ongoing data quality and review would be necessary.

If you need additional information or have any questions, do not hesitate to call me at 360.999.0894 or email Courtney.Jiles@dcyf.wa.gov.

Sincerely,

Courtney Jiles
MIECHV Lead Administrator
Department of Children, Youth, and Families

cc: Laura Alfani, Strengthening Families Administrator, Dept. of Children, Youth, and Families
Judy King, Director of Family Support, Dept. of Children, Youth, and Families
Teresa Vollan, Surveillance & Evaluation Section Manager, Dept. of Health
Martha Skiles, Home Visiting Supervisor and Sr. Epidemiologist, Dept. of Health

COLORADO
Department of Public Health & Environment

To: Health Resources and Services Administration

Re: The Maternal, Infant, and Early Childhood Home Visiting Program Performance Measurement Information System

OMB Control Number: 0906-0017, Revision

Date: February 16th, 2021

To Whom It May Concern:

Thank you for the opportunity to provide feedback based on our experiences collecting and reporting data under MIECHV with the following evidenced-based models: Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT). We appreciate your commitment to maintaining a transparent and collaborative process; however, we have concerns regarding the feasibility and utility of some of the proposed revisions to data collection and have suggestions to enhance the value and clarity of information collected.

While the revisions set forth in the Federal Register Notice (FRN) are described for all grantees of the MIECHV Program, this letter will address how the changes to data collection and reporting will directly affect the Colorado MIECHV program, program staff, clients and families. We hope the information below will be helpful as you consider the potential changes to the MIECHV Performance Measurement System.

We would like to acknowledge that any changes to data collection activities require additional time and funding to implement, increasing burden at the state and local levels for data managers, supervisors, home visitors and the families they serve. We urge decision-makers to consider which data are needed and how it will be utilized at the national level, as programs and enrollees take on the burden of implemented changes.

Form 1: Demographic, Service Utilization, and Select Clinical Indicators

Table 1: Including reporting for gender non-conforming/unknown/did not report

I. We applaud the inclusion of non-binary genders, but categories are not exclusive and conflate terms referring to gender identity, gender expression, biological sex and prenatal services/pregnancy status. A caregiver could express themselves and/or identify as gender non-conforming, identify as female and/or be assigned female at birth (biological sex) and be pregnant/receiving services. While "non-conforming" may refer to someone's gender identity, it is a blanket term that can also refer to gender expression. Adding "non-binary" may be more inclusive to gender identities not falling into the woman/man gender binary. The GLAAD Media Reference Guide on Transgender terminology provides helpful guidance surrounding inclusive language. Language is constantly changing and while a category to encompass participants who do not identify with the provided options is important, "Other" on its own can marginalize identities. We recommend adding

a separate table for prenatal services/pregnancy and offer the following selections for caregiver gender for consideration:

- Woman
- Man
- Transgender
- Non-binary/Nonconforming
- All other genders

II. If HRSA moves forward with the proposed categories, additional guidance on how transgender participants should be categorized would be helpful as programs may utilize terminology that is more inclusive and gender affirming for their communities.

III. Gender is fluid and participants may transition (socially and/or medically) during or throughout their participation in the program. While we understand, for reporting purposes, data reporting at enrollment and annually thereafter is a helpful snapshot, programs do not necessarily collect all data in this way. If a caregiver becomes pregnant or transitions, it is important for the program to update their data system to best reflect and serve their clients. It may be difficult to recall data from a specific time point and when data are pulled at the end of the year, it may reflect the most up-to-date information rather than data at enrollment or at annual data collection.

Tables 4, 5, 6, 7, 8, 9, 10, 11, 18, 19 and 20: Disaggregation by gender and new/continuing enrollment

I. Our team is curious on the utility of disaggregating these tables by gender and new/continuing status at the national level. While it is not difficult to adjust data reporting at the state-level, data systems will have to build new reports to pull these data at the site-level, which will take additional time and funding across multiple data systems without corresponding usefulness for programs.

Form 2: Performance and Systems Outcome Measures

While Colorado takes great pride in demonstrating improvement using the MIECHV benchmarks, data burden continues to be a significant challenge for our home visitors. The proposed changes make reporting more complex and thus, data quality and reliability may suffer at the aggregate level. More significantly, an increased data burden can impact staff retention and the relationship with program participants, take away time from service delivery and pose a threat to model fidelity.

Proposed Measure 7: Substance Use Screening

I. Introducing substance use screenings creates substantial additional workload for home visitors, will require additional training and may impact the relationship between home visitors and clients.

II. Requiring screening within 30 days of enrollment does not provide enough time for relationship and trust building between home visitors and clients and may result in high levels of refusals to complete the screening and/or inaccurate information. We suggest expanding the data collection timeframe to six months post enrollment to match the IPV screening requirements.

III. While home visitors currently discuss substance use in the home with clients and provide resources/referrals as needed for substance use, reducing substance use is

not a goal for any MIECHV-funded home visiting models currently implemented in Colorado.

Proposed Measure 21: Completed Substance Use Referrals

I. This construct can be well outside the purview of home visiting programs. Access to substance use services are limited across the state according to geography and behavioral health specialists' caseload. Additionally, there are many reasons individuals may not seek treatment for substance use, such as skepticism of treatment, tolerance of substance use risks and stigma. Results from the 2018 National Survey on Drug Use and Health found that 95% of people aged 12 and older who were defined as needing substance use treatment, did not believe they needed treatment. Of those participants who perceived needing services, but did not receive them, less than half made an effort to get treatment.[1]

II. The design of this measure misses clients who screened positive and were *not referred* to any substance use services (the denominator looks at those with a positive screen *and* a referral to services). This measure misses the first and most important step in completing the referral loop: making sure the referral has been given.

With these proposed revisions, we urge you to please also consider the time required for redesigning forms and databases, as well as training home visiting staff in data collection practices. We have concerns about the impact these changes may have on home visitor job satisfaction, job stress and staff retention. Any changes to measures and reporting directly impacts the work of home visitors and the quality of data collected. Trainings for implementing these revisions and maintaining data quality will take time, and we will continue to strive for the highest levels of data quality, accuracy and integrity.

We hope HRSA will continue to hold MIECHV clients and home visiting staff at the forefront of decision-making. Thank you for allowing us this opportunity to express our concerns. We look forward to future opportunities to provide input on potential changes to the MIECHV program. If there are any questions regarding our comments, please do not hesitate to let us know.

Sincerely,

Carsten Baumann
Manager

Jessica Stoker
Evaluation Lead

Early Childhood Evaluation Unit
Health Surveys and Evaluation Branch
Center for Health & Environmental Data
Colorado Department of Public Health and Environment

[1] Substance Abuse and Mental Health Services Administration [SAMHSA]. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: SAMHSA.

The Indiana MIECHV Team appreciates the opportunity to provide comment on The Maternal, Infant and Early Childhood Home Visiting Program Performance Measurement Information System (OMB No. 0906-0017), published on December 18, 2020.

Indiana would like to specifically support comments provided by Association of State and Tribal Home Visiting Initiatives (ASTHVI) in response to proposed changes to the MIECHV performance measures. Indiana consistently participates in the ASTHVI data committee and feels the ASTHVI response accurately reflects the comments of a wide representation of MIECHV administrators.

In addition, Indiana would like to emphasize and comment on the following:

1. Additional performance measures – including an additional screen requiring a validated tool – may require researching and selecting an appropriate tool, training staff to conduct the tool, revising data collection/database(s) to accommodate the tool data entry and related reports, as well as revising coding to calculate and report performance measure across home visiting models. The aforementioned activities would require additional resources beyond currently budgeted expenses and would take several months to implement.
2. Safe Sleep – Indiana routinely looks at each of the 3 measures within this Performance Measure and would not incur additional burden to measure each – back to sleep, bed-sharing, soft bedding – as a way to better understand and address safe sleep practices.
3. Referral measures that require receipt of service – Indiana would like to offer that this type of measurement on activity beyond the control of the home visiting environment does not accurately reflect home visiting practice outcomes.

We look forward to the continued improvement of performance measurement.

Carrie Higgins
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MIECHV Grant Coordinator
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302 West Washington Street, Room E306
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ASTHVI
ASSOCIATION OF STATE AND TRIBAL HOME VISITING INITIATIVES

Ms. Cynthia Phillips
Director, Division of Home Visiting and Early Childhood Services
Maternal Child Health Bureau
Health Resources and Services Administration
Rockville, MD 20857

February 16, 2021

Dear Ms. Phillips,

The Association of State and Tribal Home Visiting Initiatives (ASTHVI) is a collaboration of administrators of home visiting funds dedicated to supporting the effective implementation and continuous quality improvement of home visiting programs. We are writing to respond to HRSA's notice, *The Maternal, Infant and Early Childhood Home Visiting Program Performance Measurement Information System* (OMB No. 0906-0017), published on December 18, 2020, which would modify several of the current data collection practices for demographic performance measures (Form 1) and benchmark performance measures (Form 2). We appreciate the opportunity to provide feedback and look forward to future collaboration.

Before addressing the proposed changes, ASTHVI would like to express its gratitude to HRSA for consistently engaging state and Tribal administrators in conversations about the changes to the MIECHV data collection and performance measures. The ASTHVI Data Committee was given several opportunities to provide feedback on possible updates and additions to the forms, and it is gratifying to see our members' concerns and suggestions reflected in many of the proposed changes. Our administrators appreciate the collaboration that has developed with HRSA and are grateful for the opportunity to collaborate and offer feedback in preparation for significant programmatic changes.

Over 40 members from around the country joined the ASTHVI Data Committee on a call to review the proposed changes. During that conversation, administrators expressed an interest in both responding to the proposed changes and offering additional feedback on existing language that is problematic or challenging. Alongside the specific comments provided below, ASTHVI members would like to offer the following global observations for your consideration:

In certain cases, the need for the proposed revisions is fairly self-evident, particularly those that ASTHVI and HRSA have previously discussed. However, in other instances, it is not clear to us why HRSA is proposing to change the existing requirements, or what HRSA is hoping to achieve from the suggested amendments. Additional context, background, and guidance explaining the rationale for the changes would help administrators understand the objectives, and more consistently interpret and implement the revisions nationwide. This would improve data quality and comparability, and help administrators more effectively achieve HRSA's goals.

The need for additional context is amplified by the burden imposed by each change to the measures. Understanding the importance of adjustments to "get it right" and reflect continuous quality improvement, each change imposes a burden on data collection teams, at state agencies as well as local implementing agencies. It also imposes a burden on home visiting models, with states and LIAs sometimes being unable to move forward and implement any changes until model data systems reflect the necessary alterations. Each time a measure is changed or definitions are revised, the likelihood of inconsistent or incorrect interpretation increases. Time is required to educate staff regarding correct interpretation, understanding, and implementation of changes, and data quality and consistency suffers in the meantime. Some changes require adaptations to data collection and analysis systems and software and carry financial cost and time delays related to updates. For both financial and data quality reasons, minimizing the number of changes and setting indicators that can remain constant for a number of years should be a primary goal.

Members of the Data Committee are also concerned that the anticipated burden underestimates the time required to implement the proposed changes, particularly for Form 2. The estimated 221 burden hours might cover the time to train staff across the system in those changes, but is not enough to cover the changes to data systems, reports, and performance measurement plans. Administrators emphasized the significant time required when proposed changes necessitate a change in practice in addition to data system alterations, as at least one awardee would need to do in order to implement the proposed change to the substance use screening measure.

As you know, varying data collection and reporting structures for home visiting models can sometimes make it difficult or impossible for administrators to consistently report on all measures. The variations across evidence-based home visiting models enables states and Tribes to choose those that best meet the needs of their individual communities, and these distinctive model approaches understandably result in unique data systems. ASTHVI recognizes the challenge of coordinating with models that have varied goals but is concerned about the possibility of having important missing or inaccurate data as a result of the unique data systems. To the extent possible, we encourage HRSA to continue engaging with home visiting models when considering or making changes to data collection to limit this concern and to provide sufficient advance notice before changes need to be implemented for data systems to be updated and tested, and for troubleshooting to occur.

With these high-level comments in mind, we are pleased to offer the following specific responses to the changes proposed:

Form 1: Demographic, Service Utilization, and Select Critical Indicators

Section	Revision/Challenge	ASTHVI Response
All Tables	Updated to include reporting for gender non-conforming and unknown/did not report participant gender for adult participants.	Members appreciate HRSA's laudable interest in expanding gender categories but are concerned that it could result in small numbers and identifiable data for certain tables in some areas. Several states mentioned that they are already limited in telling the full story of MIECHV because of their inability to share small number data with that concern in mind. Additionally, some models will need to update their data collection systems in order to track this data point and prevent missing data. Finally, members raised questions about the cross tabulation of this data point. This added complexity increases data collection and reporting burden without being self-evident what this addition can be used for at the federal level.
Table 7	Update all tables to include specific guidance to account for and report missing data. Some model data systems do not allow for the identification of more than one race.	At present, some model data systems do not allow for the identification of more than one race, making it difficult to compare and consistently report racial identification data across models. ASTHVI members encourage HRSA to continue engaging with home visiting models to ensure we can collect and report this data consistently and accurately.

Table 14	For Each Household Indicate the Priority Population Characteristics	The data in the priority populations table is not currently collected by all national models. As mentioned, this creates significant challenges for administrators. ASTHVI members recommend either requiring national models to collect the data required in Table 14, eliminating the table, or limiting the table to the first two questions, which all models collect.
Table 16	Addition of Father and Additional Caregiver Engagement by Household table	As with Table 14, administrators expressed concerns about the ability of certain models to collect this information. Will this cause confusion when implemented at the same time as the creation of a gender-neutral/unidentified category as discussed above? Data collection and completeness will be extremely difficult. This will require home visitors to ask about this at every visit. At least one national model does not collect this information, and reporting for others is often incomplete. This information may be more accurately collected through a separate study.
Definition of Key Terms	Virtual Home Visits	While several administrators initially expressed the desire for a more detailed definition of virtual home visits, members ultimately came to the consensus that the challenges of creating a national definition, combined with the flexibility of leaving it to the models, is the best approach.

Form 2: Performance and Systems Outcome Measures

Section	Revision/Challenge	ASTHVI Response
All Tables	Consistency across constructs	The inconsistency across constructs adds a layer of complexity that may not be necessary, with varying timelines and enrollment status requirements potentially causing confusion. ASTHVI members recommend limiting all measures in Form 2 to "actively-enrolled." For many models, data is not collected on any measures unless there is a visit. Allowing data to be collected without a visit in some measures could create comparison challenges when looking at Form 1 and 2 data.
All Tables	Time frames	Members are interested in learning more about how the time frames for certain measures, namely 7 and 21, were derived, particularly if they remain unchanged. Home visitors are interested in this information, and it could help them adopt new practices.
All Tables	Performance measure numbering	The addition of two new measures would offset seven measures and create a little work to edit across systems and documentation. Administrators also often refer to the numbers when discussing the measures. We request that performance measure numbering be kept the same.
Measure 2	The data collection period and the cadence of model home visit data collection do not align, which means a lot of infants end up excluded from the measure. Per the Toolkit, children are excluded if they are not asked about breastfeeding between 6-12 months of age; however, models collect at the 6 month	Administrators feel data would be more complete if the data collection period were extended to 15 months of age or if the MIECHV program worked with models to collect this data more frequently.

	visit (which often occurs during the 5th month) or at the 12 month visit (often occurs during 13th month). For other screening measures (C3, C14), when the screening is completed outside of the window they are counted as Missing not Excluded.	
Measure 4	Following the AAP guidelines on windows for well child visits is restrictive. The guidelines are for pediatricians yet often the timeline of visits is adjusted by the provider not the home visitor or family. Adjustments to schedules are especially true for premature infants and children with special healthcare needs. Intent of measure should be to ensure that children are being seen routinely by providers.	Members see the intent of this measure as ensuring that children are being seen routinely by providers. In order to better fulfill that goal, members recommend alternative measures, such as NSCH or Medicaid measures, for well child visits. ASTHVI recommends that MIECHV align with other federal measures of well-child frequency such as (1) Medicaid Children's Health Care Quality Measures: Well-Child Visits in the First 30 Months of Life and Child and Adolescence Well-Care Visits and (2) CMS form 416. Both of these measure whether children received an appropriate number of well-child visits within a year, based on the child's age. The measures align with recommended periodicity schedules, but are not as restrictive on the timeframe during which each visit must take place.
Measure 7	Adding this type of assessment and measuring within 14 days would be a heavy lift for home visiting staff. The compressed timeframe could also potentially negatively impact engagement during the first 30 days of service. Home visitors in the field have expressed that answers to this question will often change once a relationship has been built.	ASTHVI recommends aligning the timeline for the substance use screening with the depression or IPV screening timelines. A 3-6-month window is more ideal for accurate reporting and relationship building.

	Additionally, several members expressed concerns about home visitors being mandatory reporters in their state and the possible complications that could arise as a result.	
Measure 8	Difficult to meet all three parts of the measure.	It may be more useful to report responses to each individual requirement plus the combined performance.
Measure 11	Guidance on the unit of analysis (parent, child, or dyad) is confusing and conflicting.	Administrators recommend making the primary caregiver the unit of analysis, resulting in one observation per caregiver per year.
Measure 13	The requirement to meet the three specific screens in the narrow windows is difficult for programs and adds a layer of coding difficulty. Guidance for exceptions on when/if to screen based on prior screening results and/or diagnosed delays is confusing. Currently, a positive ASQ with no later screen is excluded, but if screened again it is then included in the measure, making it difficult to track who to include and when.	If the intent is to screen during a 9-30-month window, members recommend counting any screens completed. Members recommend always excluding a child after any diagnosis or any positive ASQ screening, regardless of any subsequent screenings completed.
Measure 16	Primary caregiver education needs clarity.	Member request additional information.
Measure 17	Unclear if this means 6 consecutive months coverage could still be at any time during the enrollment or if they now mean the most recent 6 consecutive months during the enrollment.	Additional information needed.

Measure 18	Without universal guidance on what constitutes a "positive screen" results produced by states vs by models may differ. This means the referral denominators will never match. Including those who miss a screening as missing a referral conflates the two. We should not be trying to assess completeness of the screening measure when evaluating the referral measure.	It would be helpful if HRSA determined what a "positive" screen is (e.g., score on PHQ9). Those missing the screening should be excluded from the referral measure. Administrators should not be trying to assess completeness of the screening measure when evaluating the referral measure
Measure 19, 20	As with measure 18, including those who miss a screening as missing a referral conflates the two.	Again, members recommend that those who miss the screening should be excluded from the referral measure.
Measure 21	Measuring receipt of services within 14 days seems like an unrealistic timeline. Administrators expect this timeline is research driven, and anything that can shared with home visitors on that front would be helpful if it remains unchanged. The other concern is that this will serve as a measure of what's available in a community rather than a reflection of how effective home visiting programs are at connecting families with helpful resources.	Three options for meeting ASQ referrals is a level of complexity that doesn't necessarily contribute to the understanding of referrals; the more this can be simplified, the better. Additionally, administrators think it would be more useful to ask about the results of all referrals for substance use related services that happen during the course of enrollment, not just those following a positive screening. For all the referral/completed referral measures, those who do not screen positive should be excluded rather than added to missing.

Thank you for your attention to these comments. We look forward to working with you to improve health, child welfare, and early education outcomes for even more children across the country.

Sincerely,

Kasondra Kugler, Washington
ASTHVI Data Committee Co-Chair

Ginny Zawistowski, Minnesota
ASTHVI Data Committee Co-Chair

From:	Kim Thomas
To:	HRSA Paperwork
Subject:	MIECHV OMB 0906-0017 public comment
Date:	Tuesday, February 16, 2021 8:49:36 PM

Hello,

I have a public comment on the Maternal, Infant, and Early Childhood Home Visiting Program Performance Measurement Information System, OMB No. 0906-0017, Revision. I have concerns about the proposed additions of two federally required performance measures (#7 and #21) on primary caregiver substance use. I've worked in evidence-based home visiting program since 2013. Many of the families served by home visiting programs have experienced adverse childhood events, trauma, and ruptures in their relationships. At times, this trauma is caused by the very institutions that seek to serve families. I fear that implementing a substance abuse screening into home visiting will alienate families and feed feelings of guilt among participant families. Our society is not yet accepting of substance abuse as a response to trauma. Too often, people that use substances are labeled and stigmatized. Asking parents and parents-to-be about substance use or abuse is a delicate conversation. We must acknowledge that as mandated reporters, we hold power over families and are a potential threat to their family stability. I predict most families will deny the use of substances because they fear their children being taken away. This seems a misuse of resources to collect data when we expect the data to be of poor quality

Best,
Kim Thomas

From: Garry Pritchett
To: HRSA Paperwork
Subject: Public comment on proposed changes to MIECHV benchmarks
Date: Tuesday, February 16, 2021 7:50:24 PM

Thank you for offering the opportunity for our organization to provide public comment on the proposed changes to the MIECHV benchmarks. Healthy Families Virginia Danville – Pittsylvania County

After review with our home visiting professionals, we would like to provide the following feedback.

Form 1, Table 16: Add new table to include reporting on father and additional caregiver engagement.

- ***We are not in favor of this change.***
- Rationale: Although several models/sites collect who participated in home visits, there were questions about which value MIECHV was intending to promote by adding this to the benchmark. For instance, could this be used to fuel negative stereotypes about the types of families we serve and fatherhood? The group did not feel that the proposed categories (i.e., father was involved in at least one home visit) convey important information. For example, if a father is the primary source of income, participating in home visits may not be feasible, but would also not be indicative of an uninvolved father. Further, the definition of "participating in at least one home visit" is not clear. What constitutes participation is subjective, and also does not indicate fatherhood involvement in the child's life. Alternatives could include looking at relationships between target children and primary caregivers plus caregiving status (single parent, co-parenting, etc.).

Form 2: Add two measures to collect information on substance use screening and referrals.

- ***While we are in strong agreement with the value of home visitors conducting primary caregiver substance use screening tailored to family needs and the specific implementation context, we have concerns about the proposed additions of two federally required performance measures (#7 and #21) and the implications of these changes for practice and policy.***
- Rationale: With all of the competing demands and current screening requirements at the beginning of home visiting, 30 days is not nearly enough time to screen for something that requires such high levels or trust and rapport. The quality of data would be questionable due to the rushed screening on such a sensitive topic. In addition, after a positive screen, home visitors may not have appropriate services to refer clients to. Another issue is that Virginia does not currently have a validated tool widely used among sites – extensive training would be required. The legalization and decriminalization of marijuana in various states would also cause lack of clarity and homogeneity in the measures across the US. One alternative would be to model substance use performance measures (PM) like the tobacco cessation PM, to include more time, self-report, and resources/referrals provided.

In addition to our comments about the additional performance measures, we include a comment on changes in guidance regarding IPV screening during virtual service delivery for home visiting and on the suggested change to the Behavioral Concerns construct area name.

Change in PM for IPV Screening

- Rationale: Based on guidance from Futures Without Violence, and work they are doing with the HV CoIIN, our state is interested in shifting our approach, and therefore training, for how home visitors address IPV through universal education and referral as opposed to screening.

This is in line with information shared on the HRSA website page Important Information During COVID-19. As stated in the HVCoIIN memo posted on that same page, "At the moment there is no research indicating that virtual screenings are safe." While we appreciate the ability to add notes to our APR and other MIECHV reports, we would like to know more about how HRSA is planning to accommodate this change in programmatic activities as more states and programs begin to adopt this approach.

Change in Behavioral Concerns Construct Name Comments:

- ***We recommend the construct name reflect the breadth of the construct as well as the intent, using the name "Child Development, Behavior, or Learning Concern Inquiries"***
- Rationale: Instead of the proposed change to "behavioral concern inquiries," we suggest the construct name be broadened to reflect the breadth of the performance measure. This change would also underline the field's belief in the importance of areas beyond just child behavior and would more clearly tie to parent concerns in areas such as social and emotional development,

Sincerely,

Garry Pritchett
Prevention Program Manager
Director of Healthy Families
Danville-Pittsylvania Community Services
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