From: Laura Cordeira <lcordeira@rvnahealth.org>
Sent: Monday, June 3, 2024 9:08 PM
To: HRSA Paperwork <paperwork@hrsa.gov>
Subject: [EXTERNAL] Comments on: Information Collection Request Title: The Maternal, Infant, and Early Childhood Home Visiting Program Performance Measurement Information System

Good Afternoon,

My name is Laura Shulman Cordeira, and I am the program administrator for Nurse-Family Partnership at RVNAhealth, a home visiting program that is funded in part by Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funds. In my role, I oversee all data collection, budgeting and programmatic operations of our program.

In response to your request for public comment regarding performance measurement for entities receiving MIECHV funds, my comments fall into three major buckets: (1) concerns around breastfeeding as a benchmark construct, (2) suggestions to improve racial and ethnic demographic categories; and (3) the lack of nuance in binary measures. They are described in detail below for your consideration.

1. **Benchmark Construct: Breastfeeding**

   While breastfeeding has long been shown to have positive effects on both the mother and child, an emerging body of evidence has emphasized the importance of context as it relates to breastfeeding success. According to Postpartum Support International, "a long-term feeding relationship requires all kinds of support: educational, familial, financial, and workplace support, to name a few."

   Current policies in the United States are not conducive to these types of support. Policies such as a lack of national paid leave, a fragmented healthcare system that leaves many without insurance coverage, no protections of breastfeeding mothers in the workplace (until recently), and for those who are lucky enough to take parental leave (paid or unpaid), an expectation to return to work within three months of giving birth. Most postpartum visits to a person's obstetrician occur 6 weeks after the birth of a child, which is a critical time for new parents to learn how to breastfeed successfully. These policies and practices do not create the supportive environment needed for parents to succeed in this metric, regardless of wants and desires of the parents, many of whom do not choose to breastfeed.

   Additionally, the high prevalence of perinatal mood disorders (both during pregnancy and after birth) influences a person's ability to breastfeed. The pressure to breastfeed successfully has been shown to increase the chances of developing these disorders, especially if difficulties arose in achieving this. On the flip side of this, perinatal mood disorders can also make it difficult for a person to breastfeed.

   For these reasons and more, I advocate for removing breastfeeding as a metric on which home visiting is evaluated, as it largely ignores the context in which these decisions are being made, for those lucky enough to have a choice.

2. **Participant Demographics: Participants by Ethnicity and Participants by Race**

Racial and ethnic identity is complex and does not easily fit into the buckets that are presented on the current data collection form. Many of our clients, particularly those who are born outside of the United States, do not identify with one of the pre-prescribed categories that are given for race. Because of this limitation, our home visitors are often left to check off "unknown/did not report". Allowing a write-in option and/or an opportunity for nationality would more accurately collect the details of the racial and ethnic break down of our home visiting population and provide HRSA with a more accurate picture of the populations that are being served.

3. **Qualitative Measures: More Needed**

Lastly, many of the data collection measures lack the opportunity to expand on items qualitatively. For instance, when asking about pre-term births, there is no opportunity to distinguish between medically necessary pre-term births and others, or births of multiples and others. For breastfeeding measures, many of the moms we visit return to work, which often leads to the cessation of breastfeeding. As mentioned earlier, the lack of supportive environments and policies often lead to this change and should not be used as a metric of success.

Another example of this is with safe sleep. Many of our families culturally share the family bed. In the current data collection process, there is no way to distinguish between those who receive education and choose to sleep in ways that we deem "unsafe" versus those who don't receive the education at all.

Without an opportunity to elaborate on these items, it can create a skewed picture of what is happening in these homes, and it does not necessarily indicate a success – or failure – of a home visiting program. That said, capturing qualitative date places an extra burden on the home visitors, so this would only be worthwhile if it would be analyzed regularly by HRSA.

I thank you for the opportunity to provide my comments and hope you will consider them in the next iteration of data collection and program evaluation tools.

Best,

Laura Shulman Cordeira, MPH
Director of Community Health and Wellness
She/her/hers

(o) 203.438.5555 x 1102
(f) 203.431.6583

Nurse-Family Partnership
RVNAhealth.org/nfp

rVnaHEALTH™
For Lifelong Care & Wellness

TOP WORK PLACES 2023
HEARST CONNECTICUT MEDIA GROUP

27 Governor Street
Ridgefield, CT 06877

68 Park Lane Road
New Milford, CT 06776

RVNAhealth.org