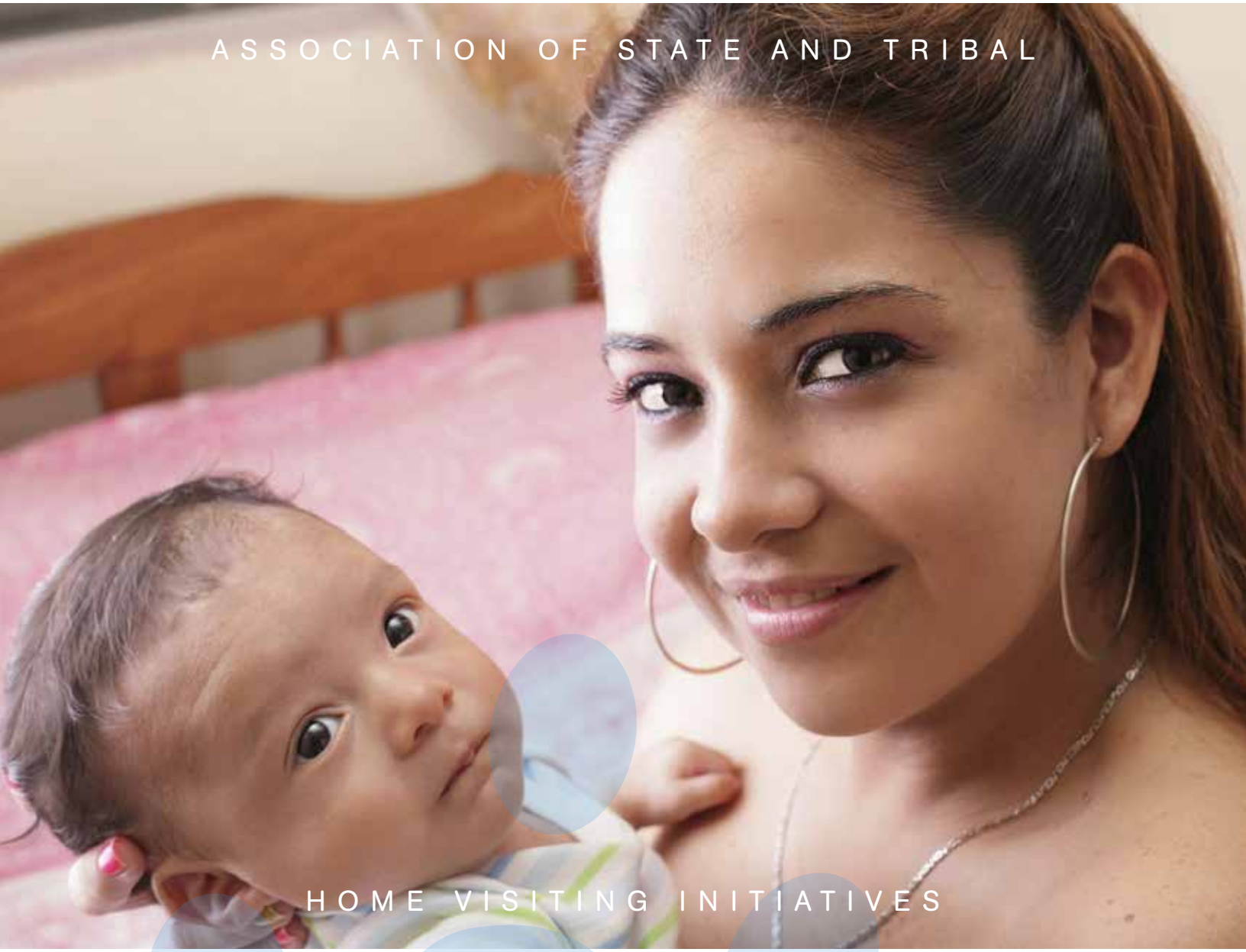


2014-2015 ANNUAL REPORT

ASTHVI

ASSOCIATION OF STATE AND TRIBAL HOME VISITING INITIATIVES

EXECUTIVE SUMMARY

The Association of State and Tribal Home Visiting Initiatives (ASTHVI) was founded in September 2014 to support state and tribal administrators of home visiting programs. Prior to the creation of ASTHVI, there was no organization to facilitate the sharing of best practices, development of consensus, and communication of administrators' priorities and perspectives to policymakers and other stakeholders. Administrators welcomed this forum to exchange information and have input into federal policies affecting home visiting programs in their states and communities. Currently, at least one person from each of 48 states, 5 tribes and one territory is registered as an ASTHVI participant; nearly 200 individuals representing states and tribes have participated in at least one ASTHVI meeting or call or have requested to be included on the ASTHVI mailing list for weekly updates.

The timing of ASTHVI's creation proved to be fortuitous, immediately positioning the administrators as a valued resource as decision makers in the Administration and on Capitol Hill considered potential changes to the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Over the course of its first sixteen months, ASTHVI "built the plane while flying it," simultaneously establishing goals, membership, benefits and bylaws, while providing a valuable state and tribal point of view as significant policy shifts were considered by Congress and the Administration.

Funded by the Richard W. Goldman Family Foundation and hosted by the New Venture Fund, ASTHVI is a non-partisan, non-profit, member-driven organization. Committees of state and tribal administrators of home visiting programs lead and oversee all of the organization's activities. As it enters 2016, ASTHVI is positioned to transition to a fully independent organization in order to continue its work of communicating administrator perspectives on the implementation of home visiting programs in communities around the country.

ASTHVI

Prior to the creation of ASTHVI, there was no organization to facilitate the sharing of best practices, development of consensus, and communication of administrators' priorities and perspectives to policymakers and other stakeholders.

When life was simpler, and many branches of extended families lived close together, new parents often had access to a large network of experienced adults. This network would lend a helping hand to coach parents, passing along proven techniques to bring down a fever, read to a toddler, or respond to a child's crying.

For many families, life is more complicated now. Families are more spread out. Retirement may be delayed. Parents may be struggling to manage two, or even three, jobs, or school, while taking care of their children.

Wouldn't it be wonderful if there were a way to offer parents of young children a network of support, mentoring and coaching in the home, available when they want it most?

There is. It's called voluntary home visiting, and it's available in hundreds of communities across the country.

Home visiting started in local communities that wanted a better way to help families. Along the way, home visiting efforts have attracted support from private donors and local, state and federal governments. That's because the research shows home visiting helps parents and improves outcomes for children, especially for the most vulnerable families.

THE VALUE OF COLLABORATION AMONG PEERS

In September 2014, the Richard W. Goldman Family Foundation provided start-up support to create a national organization of state and tribal administrators of home visiting programs hosted by the New Venture Fund. Managers of Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants, as well as state and tribal representatives administering home visiting funds from other sources, were invited to participate. The goal was to establish a member-driven forum for peer-to-peer support, exchange of information, and communication of a state perspective in policy discussions regarding implementation of home visiting. That forum became the Association of State and Tribal Home Visiting Initiatives (ASTHVI).

Prior to ASTHVI's creation, administrators lacked an organization that could facilitate sharing of best practices, development of consensus, and communication of administrators' priorities and perspectives. Administrators embraced this forum enthusiastically. At least one person from each of 48 states, 5 tribes and one territory registered to participate in the new nonprofit, nonpartisan, non-lobbying organization. In total, nearly 200 individuals representing states and tribes engaged in ASTHVI activities over the course of its first year. The feedback following the first in-person meeting in January 2015 illustrates that ASTHVI was already accomplishing several of its objectives:

This was an excellent experience to enable this collaboration of MIECHV/home visiting program lead administrators. We can support each other, learn from each other, become better partners with our models, the communities, and HRSA. This will assist us to improve our home visiting services in our states and communities.

This was the first forum that allowed me to connect with peers in a similar role. I learned an incredible amount of valuable information that will strengthen my ability to effectively administer our home visiting programs.

The gathering of state leads is timely and extremely beneficial. We were able to come together and brainstorm in a group that has never been brought together before, with the result of innovative and powerful ideas generated.

The greatest value is in the connections with peer administrators. It was a tremendous benefit to hear their experiences with implementing MIECHV.

There has been no previous way for Tribal MIECHV grantees to meet or connect related to the primary issues that ASTHVI has identified at this meeting, and I believe our voice is important in this process of implementing and improving home visiting.

ASTHVI has filled a gap and provided home visiting administrators with a forum to share and discuss that has never been offered to us before. I look forward to continued participation.

ASTHVI will provide me, as a state home visiting grant lead, the quality information, resources, and support I need to support our program staff and families in the implementation of quality home visiting, evidence-based services. The opportunity to be present has been of tremendous benefit to me professionally. The peer engagement and networking opportunities have been invaluable.

AN IMMEDIATE IMPACT ON HOME VISITING POLICY AND PRACTICE

ASTHVI offered administrators important opportunities to provide collective input into federal policies affecting home visiting programs in their states and communities. The organization was not yet six months old when two significant challenges to home visiting in states emerged. In both cases, administrators uniquely possessed the credibility to address and solve these problems, and they used ASTHVI as the organizing, umbrella entity to deliver their message.

MIECHV Extension

Barely three weeks after ASTHVI's January 2015 meeting, a rumor began to spread on Capitol Hill that, because of the timing of federal grants, states had not yet spent all their money and therefore it was unnecessary to reauthorize MIECHV on time in March. As this rumor gained traction, the risk increased that MIECHV would be de-linked from its "doc fix" legislative vehicle and left behind to try to find a path forward in the fall. ASTHVI stepped forward with a letter to the Committee Chairmen and Ranking Members explaining the consequences, from the state agency perspective, of allowing the home visiting legislation to lapse, and the importance of a timely extension. (See appendix for copies of ASTHVI communications.) Administrators carried unique credibility on Capitol Hill to refute the notion that there would be no adverse consequences to delayed reauthorization.

At about the same time, the Health Resources and Services Administration (HRSA) announced competitive grant awards to states for home visiting services. Multiple states with high

ASTHVI spoke with one voice to say that no state should be left in a situation in which it would be forced to abruptly cut current families mid-program.

quality programs (and strong Congressional champions) received surprisingly low scores, and were slated for substantial reductions in funds. ASTHVI members brought their collective expertise to bear on a serious situation. The ASTHVI Steering Committee, the states losing grants, and the ASTHVI membership at large participated in numerous conference calls to share information. ASTHVI spoke with one voice to say that no state should be left in a situation in which it would be forced to abruptly cut current families mid-program. ASTHVI collected information about the status of state budgets, number of families and staff potentially affected, and timing of grant spend-down. ASTHVI then worked to identify potential solutions to the problem, without advocating for any one particular approach.

The result was that states maintained a unified position that no state should have to go over a funding cliff; political support for the program was maintained despite funding losses; and HRSA was supported in identifying ways to minimize the mid-program loss of families and employees in affected states. With this input from ASTHVI, and significant advocacy from national and local home visiting champions, the home visiting extension proceeded as part of the doc fix bill and resources for children and families were secured for an additional two years.

MIECHV Service Sustainability

At ASTHVI's national meeting in May 2015, HRSA requested input from administrators regarding the future funding structure of MIECHV grants. ASTHVI convened an ad-hoc MIECHV Sustainability Committee to develop a consensus summary of how MIECHV's current funding structure has affected program implementation at the state level, and communicate priorities for future funding.

The MIECHV Sustainability Committee produced a formal letter to HRSA emphasizing the importance of funding predictability to the stability of service provision from year to year. The letter also highlighted the vital role systems funding has played in building and maintaining early childhood systems of care. Administrators noted that innovation and evidence have been key to MIECHV's success, and they expressed the need for a minimum grant award capable of funding a high quality program. When HRSA produced its Funding Opportunity Announcement in the fall of 2015 for a subsequent round of MIECHV grants, the announcement responded to multiple state priorities conveyed through ASTHVI. Chief among the changes to the funding structure was a shift toward greater stability through increased investment in the formula awards for each grantee.

ASTHVI as an Information Resource

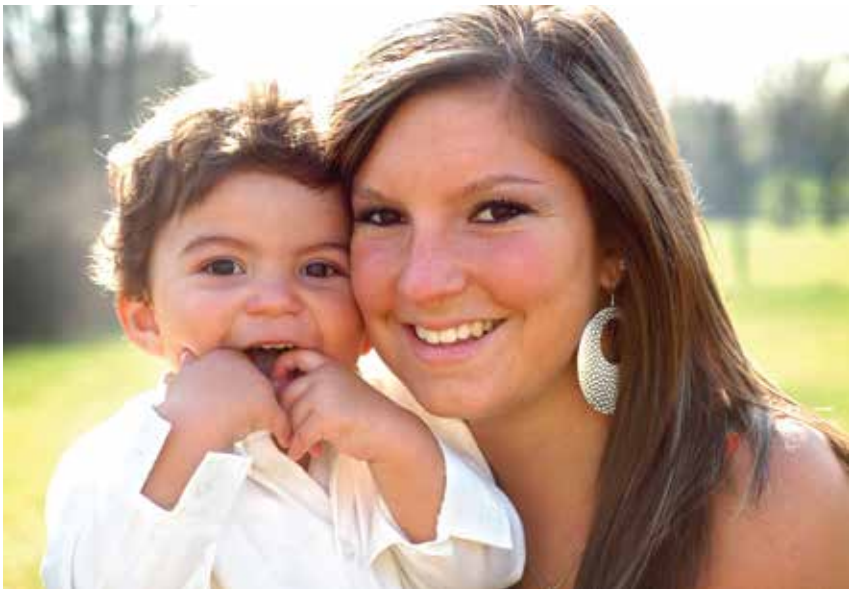
ASTHVI created, for the first time, the opportunity to organize collective state and tribal responses to requests by HRSA for feedback on proposed changes to the MIECHV program. In 2015, ASTHVI's Data Collection Committee produced multiple formal and technical responses to Federal Register notices asking for comments on the impact of data collection requirements on MIECHV implementation; quarterly data collection of MIECHV data; proposed changes to the MIECHV performance indicators and outcome measures; and proposed new MIECHV program constructs.

The first proposal the committee considered was a new quarterly data report to be submitted by all MIECHV grantees. The committee evaluated the reporting burden that these quarterly data reports would impose on grantees. Formal comments were approved by the membership and submitted in July. Later that summer, in response to a revised draft published by HRSA, the committee devoted additional time to full consideration of the impact of collecting and completing quarterly data reports. Final comments were approved by the membership and submitted in October.

The second issue tackled by the Data Collection Committee was proposed changes to the performance indicators and outcomes measures that all MIECHV grantees are required to collect and report annually. In June, the committee delivered a letter outlining the lessons administrators had learned through five years of reporting on the established MIECHV benchmarks and constructs. The committee consensus was that any reporting structure should aim to collect nationally comparable data, capable of telling a compelling and accurate story about the state of home visiting nationwide. This can only be accomplished when the required measures generate useful, reliable data. Administrators emphasized that nationally available and approved tools could improve the quality of data collection and simultaneously reduce the burden of collection and reporting. When HRSA released its proposal for new constructs and indicators, it was evident that it too was hoping to offer a more complete picture of home visiting nationally through the data it collected.

In response to HRSA's proposed changes to the MIECHV constructs, committee members produced a detailed comment that addressed every aspect of the proposed changes. The two

overarching themes the committee emphasized were the need for fewer constructs, and the need to measure outcomes that home visiting programs can actually influence. Both themes reflect members' desire to improve data quality, accuracy, and usefulness. The committee's comment was approved by ASTHVI membership and submitted in November.



In December, HRSA released its revised changes to the MIECHV constructs and performance indicators. The revisions respond to many of ASTHVI's overarching concerns and specific comments. HRSA further reduced the number of constructs, and clarified reporting requirements and definitions on several indicators such as tobacco use and early literacy activities. Several revisions reflect the reality of service provision in the community as highlighted by ASTHVI members. Constructs measuring breastfeeding, well child visits, maternal education, and insurance coverage were all revised to take into greater consideration the realities facing families receiving services.

The Data Collection Committee's work will continue into 2016 as it formulates best practices for administrators to consult when adopting these new reporting requirements. While HRSA has not incorporated ASTHVI perspectives in all of its policy proposals, the information gathered from states and provided to the Administration by ASTHVI has clearly impacted policies governing MIECHV grants.

Home Visiting Beyond MIECHV

Major legislative and administrative policy initiatives related to MIECHV occupied much of the ASTHVI membership's attention in 2014-2015. However, a wide range of funding sources support home visiting, and ASTHVI membership includes state officials who administer programs housed in state Departments of Education and other agencies. Dr. Libby Doggett, Deputy Assistant Secretary for Policy and Early Learning at the US Department of Education's Office of Elementary and Secondary Education, presented her Department's perspectives on home visiting at ASTHVI's January 2015 meeting.

An update to the Elementary and Secondary Education Act, called the Every Student Succeeds Act, with important new resources for home visiting was signed into law in December 2015. ASTHVI tracked the bill through the legislative process and updated the membership on new developments. Before the end of the calendar year, ASTHVI provided members a summary of the funding sources and opportunities for home visiting for their use in serving additional children and families.

BUILDING THE PLANE

While carrying out the substantive work discussed, ASTHVI members also worked to build the organization, building the proverbial plane while flying. A founding Steering Committee of state and tribal MIECHV leads was recruited to guide the process of recruiting members, establishing benefits, and creating by-laws, a mission statement, the policy committees, and communications efforts including the website, weekly updates, and state one-pagers. It was also tasked with planning for leadership continuity, sustaining the organization beyond its initial grant, and the Congressional reauthorization of the MIECHV program.

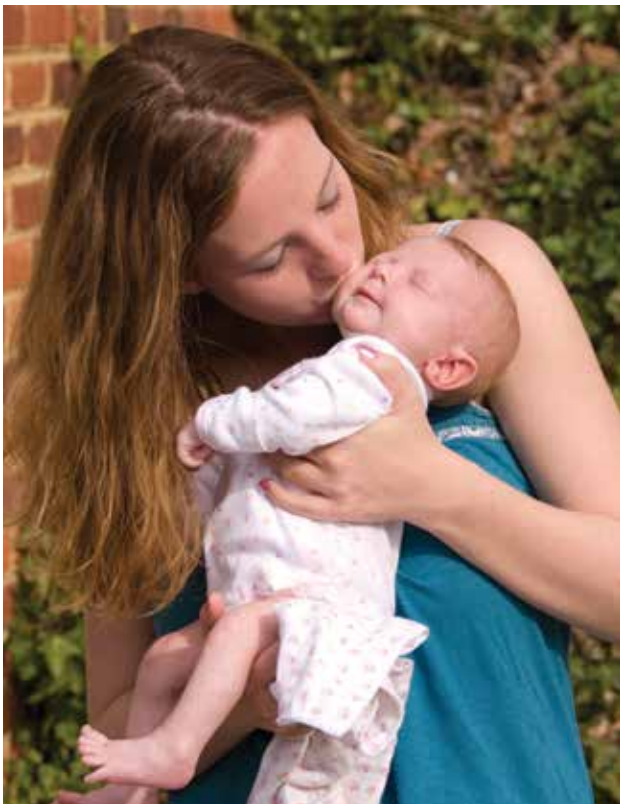
Steering Committee

ASTHVI's Steering Committee has been instrumental in building the association, recruiting members, and providing the early leadership a newly formed national association needs to be successful. The Steering Committee meets monthly to chart the upcoming activities and agendas for the association and its committees. The Steering Committee also responds to policy developments and delegates ASTHVI's responses to policy committees and working groups.

Founding Steering Committee Members:

- Bradley Planey, Arkansas
- Carol Brady, Florida
- Janet Horras, Iowa
- Lenore Scott, New Jersey
- Loraine Lucinski, Tennessee
- Suzanne Leonelli, Utah
- Laura Alfani, Washington
- Maria Brock, Native American Professional Parent Resources, New Mexico

Elections will be held in January 2016 for the next class of Steering Committee members.



Data Collection Committee

The Data Collection Committee convened at multiple times over the course of six months to develop consensus responses to various requests by HRSA for feedback on proposed changes to the MIECHV program.

Data Collection Committee Members:

- Lesley Schwartz, Illinois (Co-Chair)
- Angela Miller, Tennessee (Co-Chair)
- Sarah Hernandez, Colorado
- Virginia Holland, Florida
- Anita Brown, Georgia
- Mary Ann Wilson, Illinois
- Stacey McKeever, Illinois
- Carrie Higgins, Indiana
- Erin Wagner, Maryland
- Susan Manning, Massachusetts
- Christine Silva, Massachusetts
- Jess Goldberg, Massachusetts
- Nancy Peeler, Michigan
- Praveena Ambati, Missouri
- Karen Harbert, Missouri
- Beth Stieferman, Missouri
- Benjamin Hazelton, Oregon
- Michelle Hill, Pennsylvania
- Loraine Lucinski, Tennessee
- Thomas Hinds, Wisconsin

Tribal Issues Committee

The Tribal Issues Committee was tasked with considering the unique issues facing tribal home visiting programs and identifying opportunities for ASTHVI to meet tribal needs. One issue that both tribal and state administrators agreed on was the need for closer collaboration between tribal and state MIECHV grantees. This consensus resulted in a joint letter to the Administration for Children and Families and HRSA requesting their assistance in fostering greater coordination between the two groups of grantees. This letter received a positive response from both agencies and elicited especially thoughtful feedback on growing states' understanding of tribal business and proceedings.

Tribal Issues Committee Members:

- Earl Kast, Southcentral Foundation
- Katie Hess, United Indians of All Tribes Foundation
- Lynnette Jordan, United Indians of All Tribes Foundation
- Gerilene Tsosie, Arizona
- Mary Ann West, Indiana
- Benjamin Hazelton, Oregon

MIECHV Sustainability Committee

The MIECHV Sustainability Committee was an ad-hoc committee tasked with drafting a response to HRSA's request for feedback on MIECHV's funding structure. Committee members met biweekly to form a consensus statement on how MIECHV's current funding structure has affected program implementation at the state level. The final letter was approved by the ASTHVI membership and submitted to HRSA in June 2015.

Sustainability Committee Members:

- Benjamin Hazelton, Oregon (Chair)
- Jennifer Medley, Arkansas
- Carol Brady, Florida
- Deborah Chosewood, Georgia
- Tod Robertson, Hawaii
- Cassondra Kinderman, Indiana
- Janet Horras, Iowa
- Brenda English, Kentucky
- Pam LaHaye, Maine
- Jess Goldberg, Massachusetts
- Snaltze Pierre, Massachusetts
- Karin Downs, Massachusetts
- Nancy Peeler, Michigan
- Mary Jo Banken, Minnesota
- Vera Butler, Mississippi
- Beth Stieferman, Missouri
- Ashley Jenkins, Missouri
- Dianna Frick, Montana
- Jennifer Auman, Nebraska
- Lenore Scott, New Jersey
- Michael Acosta, New York
- Lari Peterson, Oregon
- Sarah Abrahams, Texas
- Suzanne Leonelli, Utah
- Ann Giombetti, Vermont
- Laurel Aparicio, Virginia
- Laura Alfani, Washington
- Leslie McAlister, Wisconsin

Membership Committee

The Membership Committee was an ad-hoc committee tasked with devising options to continue ASTHVI's activities after its founding grant expires. Committee members also enumerated possible benefits the association can offer its members, establishing the following priorities:

- Conference calls and webinars to share information and best practices
- Opportunities to network with other state and tribal administrators to share common challenges and potential solutions
- Annual, face-to-face meetings with peers, including guest speakers such as senior Congressional and Administration policymakers responsible for decisions affecting home visiting
- Policy committees to provide state and tribal perspectives on policy proposals and input into ASTHVI consensus building processes
- Weekly update email
- Periodic notification of urgent news/ emerging issues impacting home visiting
- Members-only website and listserv (introduced January 2016)
- Communications support, including development of state one-pager on home visiting initiatives
- Rapid response to challenges and issues facing state and tribal administrators.

The Committee also considered future association activities and resources. It evaluated the structure, funding sources and benefits of other comparable associations of state administrators, and developed multiple options for consideration by the Steering Committee. The full ASTHVI membership will vote on recommendations at the January 2016 national meeting.

Membership Committee Members:

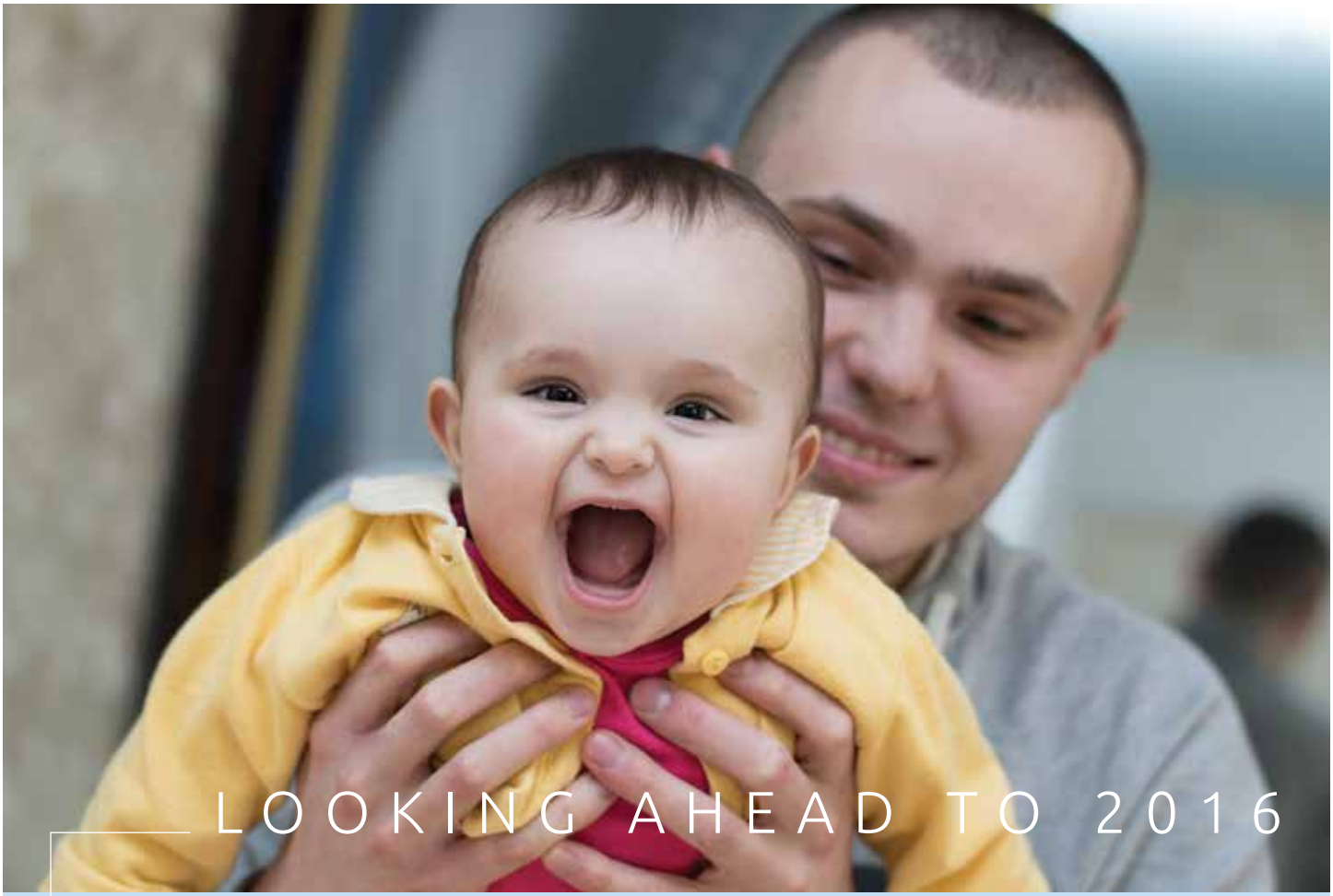
- Janet Horras, Iowa (Co-Chair)
- Annette Jacobi, Oklahoma (Co-Chair)
- Lesley Schwartz, Illinois
- Stacey Herald, Indiana
- Deborah Richardson, Kansas

Communications

In addition to its committee work, ASTHVI has spent the past year building the communications tools and relationships necessary to bring the administrators' voice to the national stage. ASTHVI joins meetings of the national Home Visiting Coalition, which is comprised of home visiting stakeholders. The experience and expertise of home visiting administrators has proven to be a valuable source of information for the coalition, particularly in developing a response to the proposed revision of the MIECHV constructs.

ASTHVI staff has also worked with individual states to create brief, colorful fact sheets highlighting their home visiting programs. These are intended to serve as an accessible overview of a state's home visiting work and investment, for audiences ranging from the media, to the state's legislature and Congressional delegation. ASTHVI intends to continue this effort in its second year of operation with the ultimate goal of serving as a national resource of state-specific home visiting information.

ASTHVI staff has worked with national news outlets to connect interested journalists with state home visiting administrators who can serve as a source of expert information for stories on home visiting. In January 2016, ASTHVI will roll out a members-only portal on its website that provides administrators with access to internal association news, resource documents, and research, as well as a listserv function to solicit and receive input from other administrators around the country.



LOOKING AHEAD TO 2016

2016 **represents ASTHVI's second full year of operations – and it will be a very full year.** Federal education legislation passed in December 2015 creates new opportunities to fund home visiting activities focused on school readiness. State and tribal MIECHV leads will grapple with changes to their funding formulas, competitive grants, and accountability systems. State legislatures will debate expanding – or creating – resources for home visiting. Congress will begin to prepare for reauthorization of MIECHV funds by April 2017.

ASTHVI's agenda for the coming year includes ensuring that administrators are supported, and their voices heard, through all of the changes outlined above. At the same time, ASTHVI leadership will be working to register ASTHVI as an independent organization and create a stable financial footing for its continuation. State and tribal home visiting programs play a vital role in meeting the needs of children and families across our country. In its first year, ASTHVI has proven itself to be a valuable resource to stakeholders who want to know more about home visiting, while helping support administrators in offering high quality, efficient programs. ASTHVI looks forward to a second year of contributing to home visiting success in communities nationwide.

AND BEYOND

ASTHVI
ASSOCIATION OF STATE AND TRIBAL HOME VISITING INITIATIVES

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www.statehomevisiting.org

March 23, 2015

Association of State and Tribal Home Visiting Initiatives

Senator Orrin Hatch, Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

Senator Ron Wyden, Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

Representative Fred Upton, Chairman
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

Representative Frank Pallone, Ranking Member
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Hatch, Ranking Member Wyden, Chairman Upton, and Ranking Member Pallone,

Thank you for your support and leadership in the effort to reauthorize the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). As the association of state and Tribal officials who administer MIECHV, ASTHVI would like to respond to questions that have been raised by Congress about the urgent need for extension of the MIECHV authorization for the longest possible reauthorization period.

Q: Why does MIECHV need to be extended?

A: Authorization for the MIECHV program is set to expire on March 31, 2015. These funds have been a vital catalyst to expand and strengthen state and Tribal home visiting initiatives. Without this stable source of funding, programs that are currently expanding services to new communities and building the infrastructure to sustain and enhance those services will be forced to scale back their efforts. This will deny at-risk children and families the access to services that have been proven to improve their health and well-being.

Q: If some MIECHV grants extend through 2017, why is additional funding needed this year?

A: MIECHV grants to states are split between relatively small formula grants to strengthen state home visiting systems and larger competitive grants to support services to children and families. While some states have been awarded competitive grants with resources that can be used through 2017, failure to extend MIECHV in 2015 would result in the almost immediate reduction in the number of children and families served in virtually every state. It would also curtail program improvements, expansion to underserved, high risk communities, and disrupt the national evaluation of MIECHV program outcomes.

Q: What is the impact of a six-month or one-year extension on states and communities?

A: States and Tribes have learned from the past year that short-term reauthorization presents challenges to the efficient and effective program administration. Most home visiting models operate on a multi-year curriculum, with a commitment to each enrolled family for two years or longer. State legislative and budget cycles also require advanced, multi-year planning to meet Maintenance of Effort requirements. With an uncertain funding outlook, trained and experienced home visiting staff depart for more secure positions. Programs freeze

enrollment if they do not know they will be able to sustain family services. Short-term extensions make it difficult for communities and states to plan for a program designed to interact with families over the course of several years.

Q: How would a longer reauthorization period benefit states and Tribes?

A: A multi-year reauthorization, similar to the initial five-year authority, would give home visiting programs the stability they need to plan for, efficiently administer, and effectively serve disadvantaged children and families. This enables states to deliver the results Congress mandated, including improving health outcomes, preserving families, and promoting school readiness. A multi-year reauthorization would also ensure that MIECHV programs could complete the evaluation currently in progress to document the program's outcomes.

As state and Tribal administrators, we can say with confidence and first-hand knowledge, including evidence-base research, that home visiting works. Please do not hesitate to contact us if we can be of any assistance during the reauthorization process.

On behalf of ASTHVI,

Carol Brady, Project Director
Florida Association of Healthy Start Coalitions
ASTHVI Steering Committee Member

Janet Horras, Director
Iowa MIECHV Program
ASTHVI Steering Committee Member

Loraine Lucinski, Administrator
Tennessee Department of Health
ASTHVI Steering Committee Member

Judy King, Administrator
Washington Department of Early Learning
ASTHVI Steering Committee Member

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June 29, 2015

Dr. Michael Lu, Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20852

Dr. David Willis, Director
Division of Home Visiting and
Early Childhood Systems
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, Maryland 20852

Dear Dr. Lu and Dr. Willis,

Thank you again for the opportunity for the Association of State and Tribal Home Visiting Initiatives (ASTHVI) to provide HRSA with the experiences and lessons our members have gained over the past five years planning for and implementing MIECHV grants on behalf of their states and Tribes. We appreciate your commitment to maintaining an open line of communication with state and Tribal administrators, and we hope the information below will be helpful to you as you contemplate changes to the MIECHV grant structure.

Since we last saw you in May, ASTHVI's Sustainability Committee has met multiple times to discuss members' experience administering home visiting programs under MIECHV's current funding structure. Committee members contributed their challenges in planning multiple years in advance, as well as their understanding of how funding adjustments would affect their states and Tribes. Through these weekly discussions, the committee identified areas of consensus and shared experiences, as well as a common understanding of what sustainable MIECHV funding might look like. With the approval of the ASTHVI membership, the Sustainability Committee wishes to share its conclusions.

Stable funding for services to families is a high priority.

The committee first identified those functions that would benefit the most from greater funding stability. Every member's first priority was home visiting services to families. For a home visiting program to be successful, administrators believe the families and their home visitors must know that they will be able to complete the service period. As most models operate multiple-year curricula, the committee agreed that this would be more suitable for a more stable, formula funded grant.

Systems funding is also a priority for ASTHVI members.

The committee considered the implications of funding systems, infrastructure and quality activities through competitive grants, and concluded that these activities also deserve stable, predictable funding through formula funds. In some states where local funds are available for direct services, MIECHV is the only available source of support for infrastructure and systems-building work. MIECHV's continued investment in infrastructure and systems building, including professional development, is vital in virtually every state. ASTHVI members value the flexibility to select a range of models to meet family needs and to invest MIECHV funds in quality activities that may not directly increase the number of children and families served.

The committee recognizes that formula grants will need to be increased, relative to competitive grants if they are to primarily fund services and infrastructure. ASTHVI members are concerned that states and Tribes maintain the flexibility to select the evidence-based model(s) that best serve the unique needs of their communities without pressure to choose the lowest-cost approach or to minimize per-family cost.

ASHTHVI members also need to maintain the flexibility to make the appropriate investments in their programs that will allow for future growth. MIECHV funds invested in quality improvements, systems development, and capacity building do not directly increase the number of children and families served, but promote effective and thriving home visiting services. The committee agreed that administrators need a grant award process that allows them flexibility to meet the priorities and needs unique to that state or Tribe, without overemphasis on per-family cost.

Increased minimum grants are needed to support effective home visiting programs.

The committee unanimously confirmed the benefit a minimum formula award has provided in the past. Many smaller states with no pre-existing home visiting programs would not have been able to implement effective programs had they not been assured of the $1 million minimum award each year. If the majority of MIECHV funds are awarded under formula grants in the future, without the opportunity for substantial competitive awards, the committee believes the minimum award would need to be increased to support quality systems and direct services to families.

Focus on innovation and evidence is key to MIECHV success.

Another aspect of MIECHV that the committee was keen to preserve is the emphasis on innovation and gathering of new evidence. States do not want to sacrifice pilot programs and quality improvements in order to serve more families. The committee agreed that funding for innovative or time-limited, discrete projects could be maintained through competitive grants.

These discrete projects need not be limited to individual states or Tribes. The committee agreed that cost savings on infrastructure could be realized by sharing systems development and/or coordinated investments from HRSA. One example offered, among many, is the data system that each state currently develops and maintains independently. ASTHVI members believe nationally available infrastructure could also improve data consistency across states, and make national evaluations more reliable.

To avoid disruption of services to families, MIECHV grantees need the maximum possible time and notice to transition to a new grant structure.

Finally, the committee considered how a change in funding structure would affect grantees in the short term. Committee members were clear that their top priority would be to maintain services to families who are already enrolled. As funding is re-balanced across grantees and some areas see their grant amounts reduced, adequate time should be allowed for families served to be decline through natural attrition and program completion. Under no circumstances should enrolled families be dropped from the program as a result of rebalanced grants. For grantees that would face lower funding levels under a new system, the committee estimates that a two-year transition period would allow most states to avoid cutting off services prematurely. For the few states that might struggle with caseloads during the two-year transition period, the committee believes the competitive grant pool could offer temporary relief. Similarly, grantees that may experience funding increases will need sufficient time and advance notice to build capacity in order to serve additional families effectively.

Overall, the members of ASTHVI welcome a change in the MIECHV funding structure that promises to bring more stability and predictability to program planning and the provision of home visiting services to families in need. Administrators would also welcome a new system that could possibly offer more nuanced funding determinations, including considerations of past performance.

With such important changes under consideration, the members of ASTHVI would like to thank you for your consideration of our experiences in implementing MEICHV. We look forward to continuing this exchange of information in the future. If you have any questions regarding any of these comments, please do not hesitate to let us know.

Sincerely,

Catriona Macdonald
ASTHVI Senior Policy Advisor

Benjamin Hazelton, Chair
ASTHVI Sustainability Committee

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Dr. Michael Lu, Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20852

Dr. David Willis, Director
Division of Home Visiting and
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Maternal and Child Health Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, Maryland 20852

Dear Dr. Lu and Dr. Willis,

Thank you again for the opportunity for the Association of State and Tribal Home Visiting Initiatives (ASTHVI) to provide HRSA with the experiences and lessons our members have gained over the past five years with the MIECHV benchmarks and constructs. We appreciate your commitment to maintaining an open line of communication with state and Tribal administrators, and we hope the information below will be helpful to you as you contemplate changes to the MIECHV grant structure.

The ASTHVI Data Collection Committee has met multiple times to systematically discuss each MIECHV benchmark and administrators' challenges in collecting and interpreting the data for each. The committee considered Pew's Proposed Constructs table (ATTACHED) and the Title V benchmarks as references for its discussions. The first area of consensus the committee reached was agreement that one year provides states adequate implementation time for whatever changes HRSA eventually makes to the constructs. The most challenging changes to implement would be those requiring adjustments to data collection systems, but the committee feels confident that even those could be accomplished in a year.

Maternal and Newborn Health

When reporting on Maternal and Newborn Health, the committee noted that grantees report on maternal tobacco use differently. Administrators would appreciate clarification on whether they should collect data on cigarette use only or include e-cigarette and chewing tobacco use as well. The committee also identified interbirth intervals as a politically difficult measure for some to navigate.

ASTHVI members recognized that not all models enroll mothers early enough to have measurable affects on birth outcomes, such as birth weight and preterm births, or breastfeeding rates. Maternal depression also presents challenges for more rural areas with limited access to mental health resources. The committee agreed that data collected without taking into account the above factors does not tell a compelling or accurate story of Maternal and Newborn Health.

Child Injuries, Child Abuse, Neglect, or Maltreatment, and Emergency Visits

The committee noted that all grantees collect data on child abuse and neglect administratively. This constitutes a very low burden on administrators, and the committee agreed that collecting both reported and substantiated cases provides a more complete picture of child abuse than either of the measures alone. Conversely, the committee did not feel that the other constructs under this benchmark produce compelling information about the MIECHV program.

The committee acknowledged that measuring child development under the School Readiness and Achievement benchmark has been difficult because of the individual nature of child development itself. All grantees, however, use ASQ scores to measure and report this construct. So despite difficulty in collecting meaningful data on this construct, the committee believes the universal adoption of the ASQ presents an important step toward better reporting on child development.

Closely related to child development is parental capacity. This construct is measured by a wide variety of tools that differ significantly across grantees. The construct is also largely measured directly by home visitors, which makes it uniquely labor intensive. The committee agreed that this is an important area to measure and that administrators could benefit from nationally available tools designed for this construct. The committee also agreed to nominate one of its members to work with Pew as it continues to develop its own recommendations on the parental capacity construct.

Crime and Domestic Violence

For the Crime and Domestic Violence benchmark, the committee noted that only two states or territories currently report on crime. All grantees, however, measure domestic violence and use some variation of the same relationship assessment tool for screening. While most members felt that measuring completed referrals was not particularly helpful in this area, acknowledging that most partners do not seek help after the first or even second positive screening, they did recognize the benefit of measuring the entire process from screening to safety plan completion. The committee also discovered that grantees choose to screen different partners. Some screen women only, while others screen men and women. This flexibility is highly valued by ASTHVI members.

Family Economic Self-Sufficiency

Measuring Family Economic Self-Sufficiency has proven problematic for administrators, largely due to their focus on high needs families. Household income and employment are difficult to measure in highly mobile families. Grantees also use different definitions for these constructs, with some measuring the income of the mother only and others measuring the incomes of anyone currently residing in the home. For these reasons, the committee believes that measuring maternal educational achievement over the course of the enrollment period is the only reliable predictor of family economic self-sufficiency.

Coordination and Referrals for Other Community Resources and Support

Coordination and Referrals for Other Community Resources and Support has yielded a similar mix of helpful and reliable data. The committee recognized this benchmark as an excellent opportunity to measure systems building work and progress. For instance, the other benchmarks covering maternal depression, child development, and domestic violence could help standardize the data reported under each of these constructs. Then administrators could report on their work to integrate these constructs into their larger systems of care by recording completed referrals under this benchmark.

Completed referrals, whether reported under Benchmark #6, #4, or #1, pose challenges to grantees with limited mental health resources, women's shelters, and other community resources. Therefore, the committee acknowledged the need for a comment box large enough for administrators to explain the local factors preventing higher rates of completed referrals. The committee also believes the addition of a standardized opportunity for reporting significant local measures not required under the benchmarks would provide helpful context for the overall picture of home visiting in a given state or Tribe.

Overall, ASTHVI members want to tell a compelling, reliable, and complete story about their MIECHV programs. They also want their data to be similar enough to other grantees' data to form a comprehensive snapshot of home visiting nationally. The past five years have given administrators ample time to tweak tools and improve the quality of the data they collect. And they see the upcoming changes to the MIECHV constructs as another great opportunity for HRSA to further improve the home visiting data it collects and uses.

Thank you, again, for requesting the feedback of state administrators as you consider changes to a program whose hallmark is evidence-based and evidence driven services. We look forward to working with you as you continue to advance the cause of the nation's children and families.

Sincerely,

Catriona Macdonald
ASTHVI Senior Policy Advisor

Lesley Schwartz, Chair
ASTHVI Data Collection Committee

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ASTHVI
ASSOCIATION OF STATE AND TRIBAL HOME VISITING INITIATIVES

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July 10, 2015

To: Jim Macrae, MA, MPP Acting Administrator
Health Resources and Services Administration

Mark Greenberg
Acting Assistant Secretary Administration
for Children and Families

Re: The Maternal, Infant, and Early Childhood Home Visiting Program Quarterly Data Request

OMB No.: 0906-xxxx-New

Dear Mr. Macrae and Mr. Greenberg,

Thank you for the opportunity for the Association of State and Tribal Home Visiting Initiatives (ASTHVI) to provide HRSA and ACF with comments from our members based on their experiences collecting and reporting data under MIECHV for the past five years. We appreciate your commitment to maintaining a transparent and collaborative rulemaking process, and we hope the information below will be helpful to you as you contemplate changes to the MIECHV data collection process.

ASTHVI members were pleased that the Quarterly Data Request would not constitute an added administrative burden in most of the proposed categories. Most administrators are already collecting this data on a quarterly basis for their state or Tribe. The reporting method, however, could add significantly to the administrative burden if grantees are required to submit quarterly data through the HRSA data collection system (DGIS). So long as the data can be submitted via email, administrators estimate they can collect, process, and send quarterly data to HRSA and ACF within 60 days of each quarter's end.

The overarching concerns our members expressed after examining the proposed Quarterly Data Request were centered on questions of alignment and purpose. To avoid duplicative and/or conflicting reporting across quarterly and annual data, it is imperative that the definitions and service periods align with those already established by the annual reporting and proposal processes. It is also unclear how this quarterly data will be used relative to grantees' annual reports and what benefit HRSA and ACF hope to gain by collecting the proposed data more frequently. These concerns are outlined in greater detail in the sections below.

Program Capacity

Although grantees currently collect data on program capacity throughout the year, aligning different models' systems and definitions is a challenge. Counting families, for instance, is difficult because some models use a weighted system that gives greater weight to families receiving services more frequently than others. Different models also define "family" differently, with some counting households and others counting individual parents and children.

Some grantees have begun working directly with models to establish expected enrollment since model guidance is not always clear. When measuring program capacity nationwide, however, ASTHVI members were uncertain whether a universal measure set by HRSA and ACF would be more beneficial than directing each grantee to set expected enrollment numbers. Regardless of the source, it would be useful to have a clear and consistent expectation for enrollment for each evidence-base model approved under MIECHV.

The nature of home visiting itself also makes measuring caseload difficult. Caseloads can fluctuate at any time due to new staff training, family turnover, or new program startup. Complicating this fluid dynamic are the high caseload estimates the models set for themselves. Many of the states establishing their own expected enrollment numbers have adjusted model caseload estimates down to better reflect the reality of fluctuating caseloads.

Finally, some models have unique requirements for "creative outreach" to families that can push their capacity to over 100%. For these reasons, grantees believe that measuring both point in time enrollment as well as a cumulative measure showing services provided to date is the best way to accurately reflect program capacity.

Place-Based Services

Tracking a family's zip code on a quarterly basis represents a substantial burden for administrators and raises concerns about alignment with future grant applications and past needs assessments. First, grantees believe that reporting each family's zip code every quarter will be difficult and burdensome given the highly mobile nature of those receiving home visiting services. Moreover, grantees are not certain what purpose reporting family zip code would serve or what value is added by allowing states to define "community."

Second, because many grantees do not define community beyond the county level, grantees worry that reporting family zip code could create alignment issues. Zip codes may not align with the target populations grantees have identified in their grant applications and needs assessments, for instance. Or a family may move out of a "defined community" while continuing to receive home visiting services. Large, rural areas with low population density could appear underserved if reported by zip code instead of county. Each of these concerns could lead to discrepancies between quarterly and annual reports that could negatively impact future grant applications.

Family Engagement

When discussing family engagement, grantees noted that the terms "households" and "families" were used interchangeably throughout the Quarterly Data Request and the draft DGIS-HV form. For clarity and consistency, HRSA and ACF should choose one term to use throughout. Grantees also worried that Tables A.1 and A.3 would lead to inconsistent or misleading data. ASTHVI's Data Collection Committee drafted a unified chart that would report program capacity and family engagement together. That chart is attached for reference.

ASTHVI's illustrative chart was drafted with two goals in mind: clearly report program capacity and family engagement with point-in-time and cumulative measures and define program completion beyond graduation. Point-in-time and cumulative measurements provide necessary information about family engagement in addition to program capacity. And grantees felt it would be helpful to expand the definition of program completion to capture those families that choose to stop services because they feel empowered by the program to continue on their own.

Staff Recruitment and Retention

Reporting on this measure with two tables presents a duplication of effort that ASTHVI members believe can be corrected by solely reporting staff vacancies. The simple number of staff vacancies should provide the information needed to determine retention of staff from quarter to quarter. If HRSA and ACF decide that reporting staff recruitment and retention is still necessary, however, grantees would find it helpful to clarify that Table A.4.1 is reporting point-in-time numbers for a specific quarter and not a cumulative statistic. The instructions for reporting Continuing and New FTE MIECHV staff could be clarified to indicate reporting from only the most recent quarter.

Currently, the titles for staff positions in the Federal Register differ from those in the draft DGIS-HV form. It would facilitate accurate reporting if HRSA and ACF adopted one consistent set of titles and descriptions. For instance, clarification on how to classify program managers, directors, and finance staff would help administrators report vacancies quickly and accurately.

Corrective Action Constructs

For those grantees that are currently on an Improvement Action Plan, reporting the applicable construct quarterly does not add a significant administrative burden. Those grantees are concerned how reporting under Section B of the draft DGIS-HV form relates to Tables A.1 (program capacity) and A.3 (family engagement). Specifically, members need to know whether Section B is intended to capture only those families receiving services at the time the Improvement Action Plan was implemented, or all families regardless of when services began. Clarification is also needed to establish whether Section B is measuring cumulative/ year-to-date data or quarterly data.

With such important changes under consideration, the members of ASTHVI would like to thank you for your consideration of our concerns. We look forward to future opportunities to comment on further changes to the MIECHV program. If you have any questions regarding any of these comments, please do not hesitate to let us know.

Sincerely,

Lesley Schwartz, Chair
ASTHVI Data Collection Committee

Catriona Macdonald
ASTHVI Senior Policy Advisor

Table A.1: Program Capacity and Family Engagement

Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I	Column J	
Number of Continuing Households	**Number of New Households Enrolled**	**Households/ Families Served in Quarter**	**Families who Completed Program**	**Number of Families who stopped Serviced Before Completion**	**Total Families Disenrolled**	**Attrition Rate**	**Current Caseload (Capacity? Number of Families Curently Receiving Services?)**	**Maximum Service Capacity**	**Capacity Percentage**	
Count of all households/ families enrolled on last day of previous quarter	*Count of families with initial enrollment in quarter covered by current report*	*All households/ families served at any point in quarter* *A+B*	*Total number of families who were disenrolled due to program completion: Child aged out, met all goals, other successful "graduation" as defined by model*	*Total number of families disenrolled during the quarter due to loss to follow-up, declination of services, or other reason not categorized as succesful "graduation" from program*	*Total number of families who disenrolled in quarter, either to program completion, loss to follow-up, declination of services, or other reason.* *D+E*	*The total number of families who stopped service before completion divided by families served, minus those who completed program* *E/(C-D)* ***Those who successfully completed program are not included, as that is the goal. Of interest is how well families are retained in program*	*Equals number of families enrolled on last day of current quarter. Will become column A in next quarter's report.* *A+B-F*	*Need standardized definition of capacity from HRSA* *(For illustrative purposes, maximum capacity=15)*	*H/I*	***Definitions***
0	10	10	0	2	2	20.0	8	15	53.3	**Q1: October 1-December 31**
8	4	12	1	1	2	9.1	10	15	66.7	**Q2: January 1-March 31**
10	4	14	0	3	3	21.4	11	15	73.3	**Q3: April 1-June 30**
11	4	15	2	0	2	0.0	13	15	86.7	**Q4: July 1 - September 30**

ASTHVI
ASSOCIATION OF STATE AND TRIBAL HOME VISITING INITIATIVES

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October 14, 2015

Jim Macrae, MA, MPP
Acting Administrator
Health Resources and Services Administration

Mark Greenberg
Acting Assistant Secretary Administration
for Children and Families

Re: The Maternal, Infant, and Early Childhood Home Visiting Program Quarterly Data Request

OMB No.: 0906-xxxx-New

Dear Mr. Macrae and Mr. Greenberg,

The Association of State and Tribal Home Visiting Initiatives (ASTHVI) appreciates this opportunity to provide feedback on the updated proposal for collecting quarterly data from state and Tribal MIECHV programs. ASTHVI was grateful for the response from HRSA and ACF regarding the concerns our members raised to the original Quarterly Data Request. We remain confident that a collaborative policymaking process can yield reliable and timely home visiting data that is easily and efficiently collected.

ASTHVI would like to take this opportunity to reiterate and expand upon two concerns expressed in our original comment submitted on July 13, 2015. Overall, administrators believe the flexibility they have had in the past to establish program capacity and define communities should be preserved. The ability to adapt home visiting models and services to unique, local circumstances is one of the hallmarks of the MIECHV program. This flexibility allows administrators to comply with national data collection requirements while maintaining a fair and accurate picture of a program's success.

Beyond the need to preserve flexibility, ASTHVI members have the following specific concerns over how program capacity and place-based services data will be collected on a quarterly basis.

Program Capacity

Reporting program capacity on a quarterly basis has the potential to paint a skewed picture of a program's long-term success if staff turnover coincides with the end of a reporting period. Home visiting staff fluctuate, for reasons varying from maternity leave to graduate school to retirement. While programs work hard to maintain a full staff of skilled home visitors, hiring and training new recruits takes time. Administrators worry that natural staff turnover could negatively affect a comprehensive evaluation of program capacity if the quarterly reports capture a snapshot of a program during the hiring process.

In order to provide this data quarterly and avoid any misleading inferences, administrators believe that staff retention and program capacity data should be considered together. The table reporting staff recruitment and retention can provide meaningful context for evaluators struggling to interpret sudden drops in program capacity measures. Additionally, administrators believe a comment field below the program capacity table would allow them to offer context that helps explain fluctuations from one quarter to another.

Place-Based Services

ASTHVI agrees that local and national success of the MIECHV program requires that home visiting services reach the high-risk communities identified by state needs assessments. We also understand that accomplishing this will require reliable, nationally comparable data on place-based services. Our members have reservations, however, that reporting households by zip codes will yield accurate information.

As we noted in our original feedback on the Quarterly Data Request, zip codes do not necessarily align with the communities grantees have identified for home visiting services. As you know, distinct communities can be entire counties or they can be neighborhoods within larger towns or cities. These communities have organic boundaries and can have multiple zip codes or share zip codes with neighboring communities not selected for MIECHV services. If place-based services are reported and evaluated by zip code, administrators worry that geographical discrepancies could negatively impact future grant applications.

Adding zip code data to the reporting requirements could also significantly increase the data reporting burden state and Tribal administrators shoulder. ASTHVI members are unclear whether HRSA and ACF want administrators to report households based on zip codes or communities. Reporting households by zip codes, however, would be much more time- and resource- intensive than reporting by community. Similarly, states that must collect zip code data directly from local implementing agencies each quarter, requiring a record review, would have a larger reporting burden than those states that can pull data from a statewide system.

The members of ASTHVI would like to thank you for your ongoing consideration of our feedback on these important changes to the MIECHV program. If you have any questions regarding any of our comments, please don't hesitate to contact us.

Sincerely,

Catriona Macdonald
ASTHVI Senior Policy Advisor

Lesley Schwartz, Chair
ASTHVI Data Collection Committee

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November 9, 2015

Jim Macrae, MA, MPP
Acting Administrator
Health Resources and Services Administration

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

OMB No.: 0906-xxxx-New

Dear Mr. Macrae,

Thank you for the opportunity for the Association of State and Tribal Home Visiting Initiatives (ASTHVI) to provide HRSA with feedback from our members based on their experiences collecting and reporting data under MIECHV for the past five years. We appreciate your commitment to maintaining a transparent and collaborative rulemaking process, and we hope the information below will be helpful to you as you contemplate changes to the MIECHV data collection process.

I. Participant Demographics, Service Utilization, and Clinical Indicator Data

In discussing the proposed changes to the MIECHV constructs, our members agreed that the more complex data reporting requirements become, the more data quality and reliability suffer at the aggregate level. This concern surfaced most frequently in discussions of the Form 1 proposed changes. Our comments on Form 1 are rooted in our members' desire to collect and report accurate and meaningful data that furthers the MIECHV program's goal of providing quality, evidence-based service.

Clear Definitions and Guidance

Several tables on Form 1 included terms or categories that, if implemented today, would cause confusion among administrators. For this data collection effort to yield nationally comparable data each year, administrators in different states, Tribes, and territories need to read and understand the form in the same way. To ensure each MIECHV grantee reports the same data, our members believe clarification is needed on several tables within Form

When reporting "Index Child by Age" on Table 5, administrators noted that some home visiting models allow children over the age of five to remain enrolled in the program. These are mostly school readiness models that have an interest in continuing visits with a family for some time after the index child has started kindergarten. Clarification on how to report these children on Table 5, which does not currently have a field for children over five years old, could prevent discrepancies on this measure.

Table 5 also presents a reporting challenge because a child's age will naturally change from year to year. In the past, some administrators have been advised to take a static measure for these fields at the time of enrollment and leave the data unchanged over subsequent program years. Others have updated these measures from year to year to reflect the inevitable changes in these fields. Guidance on when and how often HRSA expects these

measures to be collected and updated could create more consistent data on child age (Table 5), pregnancy (Table 1,3, & 4), marital status (Table 8), employment status (Table 11), and homelessness (Table 12).
In addition to questions over timing and frequency of reporting, Tables 10 and 11 include terms that are interpreted differently by various MIECHV grantees. Reporting "Adult Student Status" in Table 10 involves determining what types of programs constitute training. For instance, some states may consider an adult taking English language classes to be a student/trainee but not someone who is enrolled in parenting classes. Similarly, the definition of full time and part time employment in Table 11 differ slightly from one jurisdiction to the next. Clear definitions of the terms "student," "trainee," "full time," and "part time" would prevent regional understandings of those terms from producing a national data set based on non-comparable data.

In order to report Home Visitor Full Time Equivalents (FTE), administrators will need to know whether Table 18 is requesting the number of funded or employed FTE home visitors. Our members note that if the table is requiring the number of employed FTEs, then guidance on reporting a point-in-time number on an annual form would be welcome. Clarification on whether FTE home visitors includes supervisors and support staff will also help administrators report consistent data with their peers.

When it comes to reporting a usual source of dental care in Table 21, our members note that many children enrolled in home visiting are too young to have teeth. Those states implementing models focused on prenatal and infant care could be penalized for reporting large numbers of children without dental care. To create a more fair and accurate measure, administrators believe Table 21 should be consistent with the American Academy of Pediatric Dentistry's recommendation that children twelve months and older receive dental care.

Alignment with Other Federal Programs

Our members have experienced difficulty and participant pushback when collecting data on race and ethnicity over the past five years. With increasing immigrant and refugee populations from every part of the world, many administrators are finding that traditional categories of race do not neatly capture families from regions such as the Middle East. Some states have received negative feedback from families when asking for their race and ethnicity. Based on these experiences, our members emphasize the importance of the comment fields. Many programs need a large comment field to explain the unique racial aspects and attitudes in their state.

As families enrolled in home visiting become more diverse, so do the primary languages their children learn. Table 13 "Child's Primary Language" collapses the categories to a simple English, Spanish, and Other choice, which does not present any increase in reporting burden. Our members note, however, that many children in home visiting programs are too young to have a primary language at all. Other children are truly bilingual, learning two languages simultaneously. For these reasons, our members believe that labeling the table "Primary Language Exposure" would better account for the very young and the bilingual children they serve.

Measuring housing status in Table 12 is another sensitive piece of data for home visitors to collect. Unlike race and ethnicity, however, our members are concerned that more detailed categories of housing status will lead to negative feedback and unreliable data. The categories that include sharing housing or living with family members, for instance, are not mutually exclusive. Our members also question how meaningful such detailed data can be when measuring a highly mobile population. The McKinney-Vento Act definition of homelessness is widely used by school districts and housing programs to identify homeless families and children. This comprehensive definition of homelessness could produce reliable data for MIECHV and further align the home visiting with other federal programs.

Reporting Burden

Our members expressed deep concern over the requirement in Table 3 to report on programs outside of their control and authority. MIECHV administrators cannot compel other state programs to provide information to them. Many states are unable to produce data on non-MIECHV home visiting programs for state reports. Unless Table 3 is asking for data on programs partially funded by MIECHV, our members believe this table will be nearly impossible for many states.

While most states currently collect data on adult educational attainment, they do not separate technical training and associate degree categories. To accurately report educational attainment under Table 9, states would need to alter their existing data collection systems. Separating those fields, however, would be more labor intensive and expensive than collapsing two categories into one. And states would need plenty of lead time to make those technical changes to their data collection systems, home visitor questionnaires, and training manuals.

Table 20 will also require extensive changes to data collection systems and additional training for home visitors. As with Table 9, these changes will be expensive and time consuming. Our members are also concerned that this table may not yield meaningful data. Because it is a self-reported measure and families often receive care from multiple sources, they may be confused over what constitutes a "usual source of medical care." Our members believe a clear definition could prevent much of that confusion.

II. Performance Indicators and Outcomes Measures

The six benchmarks and their constructs are a hallmark of the MIECHV Program. They have served to uphold the program's focus on evidence-based services, and they have provided a structure that keeps local programs moving continually toward higher quality. States have so consistently improved, in fact, that many are eager to shift their focus toward maintaining the impressive progress achieved over the past five years. The benchmarks also affect future funding opportunities for states, Tribes, and territories. Therefore, it is important to ensure that any changes to the benchmarks accurately measure home visiting outcomes.

When discussing the proposed changes to the performance indicators and outcomes measures, our members expressed two overarching concerns. First, they are still too numerous. Administrators strongly believe that the more data they are required to report, the more likely it is that data quality could suffer. Second, they worry that many of the proposed changes are designed to measure outcomes over which home visiting has little to no influence. Many of the constructs are labeled as systems outcomes, but administrators are unsure how these constructs will be evaluated or affect state performance determinations. Our members are passionate believers in the effectiveness of home visiting, but they are also conscious of its limits.

Maternal and Newborn Health

The first construct under the first benchmark illustrates some of the limits of home visiting and the difficulty in accurately measuring its influence on family outcomes. Preventing preterm birth is possible for medical models that enroll an expectant mother early in her pregnancy. However, if the model is non-medical or if the mother is enrolled the week of delivery, then home visiting services have little opportunity to affect birth outcomes. In order for this construct to properly measure a program's effectiveness in improving preterm birth rates, it must allow for a significant amount of dosage prior to delivery.

Similar allowances for dosage should be built into the breastfeeding construct. To influence a mother's decision to breastfeed, home visiting services need to begin prior to delivery. Our members also noted that measuring exclusive breastfeeding rates at six months is a big jump from the current breastfeeding measure. It is also more stringent than most advice mothers receive from their pediatricians, who recommend introducing cereals at four months of age. Our members agree that a more realistic measure of success would be exclusive breastfeeding at three months or any breastfeeding at six months.

States have the capacity, tools, and experience to effectively screen for maternal depression, but the most widely used screening tool is not designed to screen fathers or other caregivers. Altering the third construct under Maternal and Newborn Health to include primary caregivers will require states to either adapt existing tools or develop new ones to apply to caregivers other than mothers. This effort will constitute a significant cost for programs and an increased reporting burden for administrators.

When it comes to reporting on depression, administrators are concerned that home visiting programs were not designed to treat adult depression. Recognizing that this is a systems outcome, many programs will nonetheless feel pressure to show improvement in this construct. The Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN) crafted a similar measure for depression and experienced difficulty gauging

impact. Depression can vary widely in its severity, and meaningful data on a national scale will be difficult to collect. To ensure that the data set is at least comparable across states, administrators believe that the second point in time for a follow up depression screening should be defined and the denominator should only include families that have received a follow up screening.

The construct measuring well child visits appears to be four constructs collapsed into one. Administrators are unsure whether their data systems will be able to collect data on four separate time frames in a single field. Beyond technical concerns, there are timing issues that could dilute the utility of this construct. First, there is little room in this measure for families to get back on track with their well child visits if they fall behind one month. That means a family that misses one visit at six months will likely remain behind at twelve, eighteen, and twenty four months. The narrow schedule would also penalize programs for families enrolling late in a program and beginning well child visits behind schedule.

In practice, pediatricians can condense several visits worth of information into one to help a family catch up if necessary. And a successful impact for some families enrolled in home visiting may be a renewed commitment to making the recommended well child visits. Administrators believe that this construct should allow for more flexibility in the timing of well child visits to reflect the realities of the families they serve. Otherwise, the construct should be limited to only those children enrolled prenatally so that programs have the opportunity to influence this measure.

When reporting on preconception and interconception care, administrators are concerned that the term "at delivery" can be applied differently from state to state. A clearly defined window for "at delivery" could improve data comparability across states. Specifying mothers who reach the eight-week post partum mark in the construct's numerator would also increase the accuracy of this measure.

Administrators believe measuring inter-pregnancy intervals is problematic for several reasons. In order for home visitors to have an adequate opportunity to influence inter-pregnancy intervals, they need to be working with mothers who enroll prenatally and receive at least six months of dosage. Many states find pregnancy intervals too difficult to measure and choose instead to measure inter-birth intervals, which can be more easily verified. Still others focus on the development of a reproductive plan with new or expecting mothers. While our members understand this construct will be measured as a systems outcome, they are concerned that it is another outcome outside of many home visiting models' scopes.

The eighth and final construct under the Maternal and Newborn Health benchmark needs further clarification to yield consistent and accurate data on tobacco use in the home. A defined time period for the baseline and follow up measures would ensure consistent data across states, and including only those families that reach follow up in the denominator would improve the measure's accuracy. Clear guidance on whether e-cigarettes and vaporizers constitute tobacco use under this construct would also lead to more consistent reporting.

Child Maltreatment, Injuries, and Emergency Room Visits

The proposed construct on safe sleep among infants enrolled in home visiting presents a few challenges to state administrators. There is no indication of how often administrators need to collect this data. While states currently monitor safe sleep practices, home visitors do not report on the measure after every visit because it would increase their reporting burden significantly. The requirement that infants be placed on their backs, without bed-sharing and soft bedding conflicts with some state agencies' existing guidance on safe sleep. And a measure that parents self-report is less rigorous than one derived from an assessment or tool. For these reasons, administrators believe this construct would be more meaningful as a process measure designed to record the spread of safe sleep information.

States are already collecting data on child injury-related visits to the emergency room (ER) and do not expect this construct to increase their reporting burden. Based on their experiences, however, administrators note that ER visits tend to rise as children age and become more mobile. In order to prevent the overall number of ER visits from rising year to year, administrators believe this construct should only reflect the ER visits that occurred during each reporting year.

Child maltreatment is the most controversial construct under the second benchmark. There is no clear consensus among the states on whether adverse impacts are best indicated by reported, investigated, or substantiated cases of child maltreatment. Our members do agree, however, that reporting child maltreatment on a yearly basis is too short a time frame to adequately measure improvement under this construct.

School Readiness and Achievement

There are many reasons for parents to feel stress, many of which can be unrelated to their duties as parents. In states where this has been measured for several years, administrators have learned that parents often give more honest answers regarding stress levels after they have established trust with their home visitors. This means that baseline measures often underreport parenting stress. Therefore, the denominator should only include primary caregivers who receive a baseline and follow up screening. States would also benefit from a defined list of validated tools to ensure they are accurately measuring home visiting's influence on parenting stress.

Administrators agree that a list of validated tools designed to measure parent-child interactions would also help produce meaningful data for this construct. States are also concerned that this construct does not take dosage into account. Because it is an outcomes measure, administrators believe that a minimal length of enrollment or number of visits should be specified in the denominator to guarantee the home visitor has an opportunity to impact parent-child interactions before reporting.

Our members expressed a need for clarification on how to report early language and literacy activities. Based on the proposed construct, administrators are unclear whether this construct is intended to be assessed and reported after each visit, monthly, quarterly, or annually. They are also uncertain if this information should be gathered from parents self-reporting on their daily activities or from the use of an unnamed tool. Whatever the final structure, administrators believe it is important for this construct to align with the other School Readiness and Achievement constructs in terms of dosage, tools, and assessment periods.

The construct on developmental screening would be difficult to report as it is currently written. As with other constructs, the denominator for developmental screening does not require a minimal amount of program dosage before assessing outcomes. And because the numerator includes three distinct time frames for screenings, the reporting burden for administrators is the same as requiring three separate constructs. Although states are already collecting this data, the administrators worry that it will not be meaningful if reported as proposed.

States are currently not collecting data on behavioral concerns for each visit conducted by every model. Administrators are reluctant to increase the reporting burden for home visitors, especially when it would add paperwork to every visit they complete. It would also be burdensome for administrators and home visitors to ensure that each model uses consistent documentation on this construct.

Family Economic Self-Sufficiency

The administrators do not anticipate the maternal education construct to increase their reporting burden since all states are currently collecting this data. They did note, however, that many home visiting models enroll teenage mothers who are too young to have already graduated from high school. To ensure that these participants are counted, the numerator should include those primary caregivers who remain enrolled in high school or a GED program. In other words, many primary caregivers will be enrolled in high school when they also enroll in a home visiting program, and it should be considered a successful outcome if they remain in school through the entire reporting period.

It should also be considered a success if a home visitor helps a family regain health insurance after a lapse in coverage. Currently, many states do not have the capacity to track continuous insurance coverage with their data collection systems. These states would, out of necessity, report this construct based on a family's coverage status at two points in time during the reporting year. Clarification on how often administrators should collect insurance data and whether they should report parents and children separately would help create a comparable data set at the national level.

Coordination and Referrals

States expressed deep reservations about measuring home visiting success by the number of completed depression referrals. Our members believe this is outside the purview of home visiting programs. There are many reasons a family might not follow through on a referral for mental health services. Access to services may be limited by geography or by the mental health resource's caseload. A more fair and accurate assessment of home visiting's impact on adult depression would be a process measure that counts the number of referrals made following a positive baseline screen.
Like the construct measuring developmental screening, the numerator for measuring completed developmental referrals includes three very different scenarios for reporting. Again, the administrators are uncertain that their data collection systems can treat these three scenarios as one construct. If they must separate the three parts of the numerator, the reporting burden will be similar to reporting on three separate constructs. To safeguard data quality in either case, these two constructs should be as consistent as possible.

To qualify for developmental services in many states, a child must receive positive screen results. This means that referrals made on parental concern alone will never be completed in those states. Our members believe that measuring only referrals from positive screens would create a more comparable and meaningful national data set.

With such important changes under consideration, the members of ASTHVI would like to thank you for your consideration of our feedback. We look forward to future opportunities to comment on further changes to the MIECHV program. If you have any questions regarding any of these comments, please do not hesitate to let us know.

Sincerely,

Lesley Schwartz, Co-Chair
ASTHVI Data Collection Committee

Angela Miller, Co-Chair
ASTHVI Data Collection Committee

ASTHVI
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November 9, 2015

Ms. Linda Smith
Deputy Assistant Secretary and Inter-Departmental Liaison for Early Childhood Development
Administration for Children and Families, HHS

Dr. David Willis, M.D., FAAP
Director, Division of Home Visiting and Early Childhood Systems
Maternal Child Health Bureau
Health Resources and Services Administration
U.S. Department of Health and Human Services

Dear Ms. Smith and Dr. Willis,

The Association of State and Tribal Home Visiting Initiatives (ASTHVI) is grateful for the support and collaboration you have extended to us over the past year. During the association's first year of operation, your willingness to engage with our members on the myriad issues they face within their state and Tribal programs has underscored ASTHVI's own commitment to fostering discussion across silos. It is in that spirit of openness that we ask you to help our members find ways to increase collaboration among state and Tribal grantees of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV).

With grants to Tribes and states administered by different offices, it is understandable that the programs feel separate and distinct. They have separate technical assistance, grant managers/officers, and national meetings. Outside of ASTHVI and the annual Home Visiting Summit, Tribal and state administrators have limited opportunities to interact. Our members, however, are eager to learn from one another, and there are several ways that ACF and HRSA can facilitate greater collaboration among all MIECHV grantees.

First, state administrators have spent the past four years building the infrastructure necessary for an integrated system of early childhood care so that they can more efficiently serve those families with the highest needs. In states with significant Tribal populations, the communities with the highest risks of adverse maternal and child outcomes are often on Tribal lands. Unfortunately, state grantees understand that they are prohibited from expending MIECHV funds on Tribal communities. This perceived restriction discourages two of the MIECHV program's top goals – to build up statewide systems of care and to serve those families most in need of home visiting services.

Some states and Tribes have found smaller, but significant, ways to share tools and resources. Professional development and training sessions can be opened to all home visitors in a state, including home visitors in Tribal communities and non-MIECHV funded programs. Data collection systems can be shared to eliminate the burden of developing and operating two such systems in one state. For Tribal communities with small MIECHV grants, reducing costs by sharing resources directly translates into more families served. Identifying and encouraging other opportunities to share infrastructure is a good way to begin a more collaborative relationship between the Tribes and states.

As any home visitor can tell you, personal relationships and trust are resources just as important as referral networks and data collection systems. State and Tribal grantees should be able to share those resources as well. Staff members and home visitors who have established trust in Tribal communities can be valuable assets to both Tribal and state grantees. These staff have the potential to facilitate collaboration, build trust, and reduce inefficiencies for both grantees, but they are often limited to the grant that provides their salaries. Without the human relationships that make collaboration work, sharing tools is unlikely to lead to true systems integration.

HRSA and ACF can also encourage greater collaboration between states and Tribes by providing opportunities for relationship building. Any relationship always begins by learning more about the other person. The annual Home Visiting Summit has provided the Tribes an immersive experience of home visiting outside their respective

nations. State grantees, however, have had very few opportunities to learn about the Tribes and how they administer home visiting programs. Perhaps interested state administrators could be invited to audit several upcoming Tribal grantee calls and webinars to begin the learning process.

As MIECHV matures, it will be important to continually ensure the program remains true to its purpose. The systems of care established in the first four years of the program can and should be expanded so that all high-risk children and families can realize the benefits of home visiting services. With your guidance, MIECHV administrators can work together to make that type of integration happen.

Thank you for your time and for all you do on behalf of the nation's children and families.

Sincerely,

Catriona Macdonald
Policy Advisor
Association of State and Tribal Home Visiting Initiatives

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