



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

February 16, 2021

Dear Ms. Phillips,

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

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

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

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

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

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

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

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

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

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

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

## Form 2: Performance and Systems Outcome Measures

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

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

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

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



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

Sincerely,

Kasondra Kugler, Washington  
ASTHVI Data Committee Co-Chair

Ginny Zawistowski, Minnesota  
ASTHVI Data Committee Co-Chair