ASTHVI

ASSOCIATION OF STATE AND TRIBAL HOME VISITING INITIATIVES

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December 18, 2023

Dear Director Phillips,

Thank you again for the participation of your team at ASTHVI's annual meeting in St. Louis. We are writing to respond to your request for suggestions from ASTHVI members for reducing administrative burden in MIECHV by 15%, consistent with legislation. We appreciate the opportunity to offer the following recommendations and hope they are helpful to you.

Beyond the comments on specific reports, forms and applications, ASTHVI members expressed their hope that efforts to reduce administrative burden will also promote clarity and transparency, and offer awardees greater flexibility in reporting and application requirements. Administrators continue to question why many reports are required and how they are used. Improved understanding of what HRSA and ACF are trying to achieve, and how information will be used, would help improve accuracy and potentially reduce the number of revisions needed. Administrators also recounted instances where HRSA has asked for further information and clarification on reports as long as two years after they were submitted. At that point, the workload required for state staff to reacquaint themselves with the document and the context for the information before drafting responses or updates is significant. It would be very helpful if HRSA could establish a reasonable time frame after submission for questions to be asked and corrections to be requested, outside of which the document will be considered final.

ASTHVI members look forward to working with you to help inform plans to respond to the Congressional mandate to reduce administrative burden. As part of that process, ASTHVI

members recommend working with states to analyze the total, actual number of hours required to complete MIECHV required applications, reports, etc., and evaluate how this compares to the 10% administrative cap; this baseline will also be needed to calculate the 15% reduction. It is important to include in the analysis the additional resources being invested by states to subsidize MIECHV administration to stay under the 10% cap.

Grant Applications

State administrators are appreciative of HRSA's efforts to streamline the grant application; they are particularly grateful that the application was shortened and found the introduction of the assurances checklist very useful. In addition, the following changes would make this application less of a burden for both administrators and HRSA:

- Further shorten applications. While the state grant application was revised, fifty pages is still significant, particularly when much of the information is unchanged from previous years but may be required in a slightly different format, order, or level of detail. Applications would be streamlined if only changes to previous state plans or applications were requested.
- Continue the January deadline. The previous December deadline falls when many administrators (and the staff whose plan approvals are required) are out of the office. This is extremely challenging and disruptive to family holiday plans. The January 2023 deadline was appreciated, and administrators recommend making a January deadline permanent.
- Continue the assurance checklist, with a comment section under each checklist reference in the application. Inclusion of the checklist is effective in making the application process easier and more straightforward. Including the comment section would allow administrators to stay on one page as they are completing the application, rather than working from several different documents.

Prior Authorization Requests

States have experienced significant delays due to lengthy HRSA response times for prior authorization requests. When administrators are only officially sharing information on caseload expectations every few years, there are bound to be changes in staffing, funding, or grantees during that time. The process of submitting a PAR and writing a justification in order to revise caseloads is rigorous. Administrators would prefer to notify HRSA about caseload changes in a much more simplified way and would like to receive responses much sooner–or, have the flexibility to make certain caseload adjustments across LIAs by notifying HRSA but without requiring HRSA's permission. Some members report never having heard back from HRSA in response to caseload change requests, while others have said they were told upon submitting a PAR that it was not required. Clear, consistent guidance on HRSA's expectations for reporting caseload changes, that also prioritizes efficiency, would be appreciated.

Reporting requirements

There are several reports or sets of data that ASTHVI members recommend eliminating entirely. For example, ASTHVI members question why it is necessary to report zip codes served every quarter. Awardees believe it would be more efficient to make one report, at the end of the federal fiscal year, on zip codes served throughout the period. The lack of quarterly data would not impact program operation. They recommend that HRSA officials take another look at additional quarterly reporting requirements and determine whether any other data points could transition to an annual reporting structure.

Examples of data that states are required to collect and report on that administrators do not consider to be particularly helpful and/or for which the cost of data collection outweighs the value of the information obtained include, but are not limited to:

- Form 1, Table 4: participants by age are categorized into newly enrolled pregnant participants, newly enrolled caregivers, continuing pregnant participants and continuing caregivers. Categorizing participants into these breakdowns is tedious, time consuming, and does not offer useful information.
- Form 1, Table 9: adult participants educational attainment is also categorized by newly enrolled pregnant participants, newly enrolled caregivers, continuing pregnant participants and continuing caregivers. Again, the workload associated with reporting data this way is significant and the purpose and value of reporting data in these categories is unclear. Who is looking at this data, and how is it being used and by whom? It would be simpler, less costly, and more meaningful, to collect educational attainment at program enrollment and program completion/withdrawal.
- Form 1, Table 10: Employment status of adult participants is sorted by newly enrolled pregnant participants, newly enrolled caregivers, continuing pregnant participants and continuing caregivers. Again, the workload associated with reporting data this way is significant and the purpose and benefit of investing the effort into sorting data into these categories is unclear.
- Form 2, PM 13: All home visitors are required to ask about behavioral concerns at every home visit. Home visitors in some states report that constantly asking parents about their concerns frequently raises their anxiety and is understood as a suggestion that the home visitor thinks something is wrong with the child that the parent is supposed to be identifying or attending to. This measure is not particularly helpful as designed, and it is difficult to use the measure in a meaningful way, even though sites typically perform well on it. Many states have re-worked this measure and do not ask at every home visit. Is it necessary to collect this data?
- Form 2, PM 15: Many factors, circumstances, and considerations outside the scope of a home visitor's role and work influence whether a participant can continue and/or complete their education. The way in which this is operationalized is extremely time consuming for data managers in some states, as they must manually exclude previous year data in the data system. This performance measure does not speak to any of those factors, and as a result, is rarely used by sites.
- Form 2, PM 16: Continuous health insurance is reflective of state policy, particularly

Medicaid expansion, and offers little information about a home visitor's work with a family. If the measure is intended to gauge access to health care, other options including services provided by low-cost clinics would help to paint a more accurate picture. Home visitors should, of course, help uninsured families access health insurance in states where that is available. But what does this data point really tell us about home visiting? Who is using it, and how?

- Form 2, PM 17: Home visitors are very consistent about providing mental health referrals when relevant, but "completed" depression referrals is a receipt of service measurement dependent upon availability of mental health services in the community. Neither home visitors nor LIAs can influence availability of services. The way that this measure is written, home visitors receive no credit for the work of educating, coaching and supporting caregivers to seek additional services when concerns are present. A measure that looks at mental health referrals and home visitor follow up with the family (once or twice, not at every visit into perpetuity) to support the family in pursuing the referral would be more reflective of the work that can be done by home visitors.
- Form 4: Staff FTE information is not typically used and, as collected and reported, can actually paint a misleading picture.
- Form 4: Reporting zip codes creates substantial additional workload, with no obvious usefulness/benefit.
- Many ASTHVI members propose eliminating Form 4 entirely. Very few awardees find the data in Form 4 useful; even those who do value Form 4 data expressed that the usefulness of the report is outweighed by the workload required to collect, enter, perform quality control checks on, and report Form 4 data. Some administrators already look at enrollment, staffing, and related data more often than just completing form 4, and would continue that practice.
- Consider eliminating the fourth quarter report, as the data it represents is included in the annual report that is submitted at essentially the same time.
- Prior to requesting or requiring "nice to have" data, share with awardees a specific plan outlining how that data will be used. The use of the data should be shared with awardees annually. Conduct a regular review (perhaps every three years?) to assess the data collected, how it is used, and its usefulness. Eliminate or adjust data that is not useful in evaluating or improving home visiting services to children and families.
- Review data, performance measures, and outcomes to eliminate those that are not under the control of home visiting interventions. Systems outcome data, such as health insurance and access to mental health services, is typically available from other sources with similar populations.
- Lengthen the deadline for reports to allow states to complete data entry, analysis, and awardee leadership review. In particular, make the APR reporting timeframe more consistent with other federal programs, which typically allow 4-5 months after the end of the federal fiscal year to prepare and submit annual reports.
- Reduce the number of required reports on staff changes. Administrators believe it would be more efficient to report on most staff changes just once, as a snapshot in time,

perhaps in an annual report, with an opportunity for further discussion if HRSA has additional questions. Major roles - such as the state lead - would still be updated in real time when there are changes.

ASTHVI members also propose creating a working group of state administrators and model representatives to make recommendations regarding streamlining data collection and reporting, including consideration of which data points are most useful in documenting home visiting outcomes. Ideally, this working group would include parents and home visitors, so they can share their perspective on what data points most accurately capture the value of home visiting to families, and what data is most useful to home visitors in supporting children and parents. Home visitors are trained to recognize and address nuance in the home environments of vulnerable families and should be given flexibility to support families. This group could also seriously examine what data is "nice to have" and what is actually necessary.

Performance Measures

ASTHVI members would like to see an overall reduction in the number of performance measures. As mentioned above, they specifically suggest removing performance measure 13 on behavioral concerns. As it is a process measure, it is expected to be an inquiry at every home visit. ASTHVI members also suggest shortening the Performance Measurement Plan and change it to a spreadsheet format. This change would make it easier for administrators to navigate and complete this form.

Site Visits

ASTHVI members recommend HRSA conduct in-person monitoring visits every five years for low-risk states. Visits every three years are not necessary for a well-established and strongly functioning program, and is a low-risk opportunity to reduce administrative burden. This change would also free HRSA resources to better support states whose MIECHV programs need additional attention and assistance.

Technical Assistance

Some ASTHVI members reported their belief that the requirement to project their upcoming technical assistance requirements provides an opportunity to connect with other states. However, the majority of feedback on this technical assistance requirement was that it is unnecessary and not the most productive use of time. States find it challenging to anticipate technical assistance needs so many months ahead of when assistance is needed, and ASTHVI members recommend removing this requirement.

Continuous Quality Improvement

Reporting on CQI has become a burdensome task for administrators, who believe the reporting could be shortened significantly. ASTHVI members recommend that once a state CQI process has been developed and approved by HRSA, the state should not have to file a complete plan every year; updates on material changes should be sufficient.

Additional Recommendations

Additional steps that ASTHVI members suggest could be taken to reduce the data and reporting burden at all levels of the program, improve the usefulness of the data that is collected, and eventually free up resources to serve additional children and families are as follows:

- Review the time frames in which an activity must occur for it to "count" for MIECHV to see whether the definitions/ limitations are clinically meaningful, whether they are consistent with other programs/standards, and whether they make data collection unnecessarily frequent and/or burdensome.
- Establish a working group with models, state administrators, and home visitors to standardize definitions of data points across models, streamline collection/aggregation, and make the data collected more useful/representative (i.e., dates of well child checkups). Especially if a national MIECHV dashboard is going to be created, it will be important for the data to be more standardized than it is currently. Eliminating the necessity for states to align, re-format, re-categorize and otherwise standardize or massage data for MIECHV reporting purposes would result in a meaningful burden reduction and cost savings for many states.
- States also recommend that the data requirements are cleaned/standardized/accepted and put in place, they be left alone. Even small changes to data collection cost states and LIAs a considerable amount of money to put into place, from training home visitors on the change to updating data systems. Again, the value add of the "refinement" of the changes often does not appear to be sufficient to justify the system-wide cost.
- When setting deadlines, consider timelines for state coordination with LIAs and state internal approval processes. In general, most states need a minimum of 30 days to prepare even simple revisions/responses and clear them through internal processes. For longer or more complex revisions/responses/reports/plans/applications, more than 30 days should be allowed.
- Consider holidays when setting due dates. Eliminate deadlines that fall at the same time as other reports or during HRSA scheduled/supported events such as all-grantee meetings or the Home Visiting Summit

Thank you for your attention to these comments. We look forward to continuing to work with you in the coming months to reduce the burden on administrators according to MIECHV statute.

Sincerely,

Catriona Macdonald

Catriona Macdonald
Executive Director