

SUPPORTING STATEMENT

Affordable Care Act - Maternal, Infant and Early Childhood Home Visiting Program

Data Collection Forms for the Maternal, Infant and Early Childhood Home Visiting Program Information System

A. Justification

1. Circumstances making the collection of information necessary

The Health Resources and Services Administration (HRSA) is requesting that the Office of Management and Budget (OMB) review and approve two data collection forms for the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program.

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148). Through a provision authorizing the creation of the MIECHV program, the Act addresses the needs of children and families in vulnerable communities through evidence-based home visiting programs and provides an unprecedented opportunity for collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children and families.

The MIECHV program is designed: (1) to strengthen and improve the programs and activities carried out under Title V; (2) to improve coordination of services for at-risk communities; and (3) to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. The implementation of the program is a collaborative endeavor between the Maternal and Child Health Bureau (MCHB) at HRSA and the Administration on Children and Families (ACF).

In particular, the Social Security Act, Title V, Section 511 (42 U.S.C. 701), as amended by the Patient Protection and Affordable Care Act of 2010 (Attachment A), requires that MIECHV grantees collect data to measure improvements for eligible families in six specified areas (referred to as "benchmark areas") that encompass the major goals for the program. These include:

1. Improved maternal and newborn health
2. Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction in emergency department visits
3. Improvement in school readiness and achievement
4. Reduction in crime or domestic violence
5. Improvement in family economic self-sufficiency

6. Improvement in the coordination and referrals for other community resources and supports

The Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program (SIR, OMB control number 0915-0336) published on February 8, 2011, further listed a variety of constructs or measurement concepts under each benchmark area for which grantees were to select and submit performance measures (Attachment B). The SIR and subsequent MIECHV guidance documents for both competitive and formula MIECHV grants (OMB control number 0915-0339 and 0915-0340 respectively) require that grantees report annually on these performance measures and on demographic, service utilization, and other administrative data related to program implementation. The two data collection forms proposed in this request are designed to capture this performance, socio-demographic and service utilization information to be submitted by MIECHV grantees.

2. Purpose and use of information collection

HRSA and ACF are seeking approval for two forms to collect required data unique to the MIECHV program:

Home Visiting Form 1 - Demographic and Service Utilization Data for Enrollees and Children (Attachment C): This form will be utilized by all MIECHV grantees (including Tribes, Tribal Organizations, and Urban Indian Organizations that receive grants under the Tribal MIECHV program administered by ACF) to collect data in order to determine the unduplicated number of participants and of participant groups by primary insurance coverage. This form will also contain data on other socio-demographic characteristics of program participants as well as on service utilization.

Home Visiting Form 2 – Grantee-defined Performance Measures (Attachment D): States and other jurisdictions participating in MIECHV have already selected relevant performance indicators for the legislatively identified benchmark areas. This form provides a template for grantees to report aggregate data on their approved performance measures. Tribal MIECHV program grantees will not be submitting data via this form.

A working group was constituted in June 2011 with representation from HRSA and ACF to monitor and coordinate several data collection tasks required under MIECHV other than program evaluation projects, which were separately addressed. Prominent among these tasks was the development of the information collection request for submission to OMB including the development of new templates as needed with the explicit charge from leadership to minimize burden on grantees to the extent possible.

Accordingly, the HRSA/ACF data collection workgroup first reviewed all previously approved OMB forms currently in use by other HRSA grantees under the Discretionary Grants Information System (DGIS, OMB control number 0915-0298) and the Title V Information System (0915-0172). The DGIS electronically captures financial, performance measure, program, abstract data, and products and publications information from over 900 MCHB grantees to monitor and assess grantee performance as well as assist in monitoring and evaluating the bureau's programs. DGIS was selected as the most appropriate vehicle for electronic reporting and analysis for MIECHV data. The workgroup selected five existing forms from DGIS already utilized by MCHB grantees to similarly collect administrative and other data under MIECHV.¹ The workgroup subsequently developed the above mentioned two forms to meet the program's additional unique needs.

Uses of Information

As indicated above, the SIR and subsequent guidance documents for both competitive and formula MIECHV grants to states and jurisdictions, as well as guidance documents for grants under the Tribal MIECHV program, required that grantees report annually on demographic, service utilization and other administrative data related to program implementation. Home Visiting Form 1 will allow grantees to fulfill these requirements. It will serve to collect data of value to both grantees and the federal government such as the number of individuals served, those newly enrolled, legislatively defined priority populations reached, as well as the number of home visits performed by all implementing sites during the reporting period. The data collected will also provide an overall picture of the demographic and socioeconomic characteristics of the families served by state, tribal program grantee, and across the nation.

During the development of both instruments, we sought to align the required aggregate annual data reporting to the federal government by grantees with the instruments local program staff utilize in the field during actual delivery of services. We obtained for this purpose instruments currently utilized by various home visiting models to collect client information at intake in order to inform the categories listed in Home Visiting Form 1.

Accountability is a central programmatic concern for MIECHV since Congress allocated and appropriated \$ 1.5 billion in funding over a five-year period. Once collected, analysis of the relevant aggregate data will allow for public reporting on program activities. Analytic capacity will be developed and in place starting in calendar year 2013 to address inquiries from Congress, other interested parties and the public.

¹ These are DGIS Form 1 (MCHB Project Budget Details), DGIS Form 2 (Project Funding Profile), DGIS Form 4 (Project Budget and Expenditures by Types of Services), DGIS Form 6 (MCH Discretionary Grant Project Abstract) and DGIS Products, Publications, and Submissions Data Form.

Form 2 is a template for state and jurisdiction grantees to report data annually on their progress in improving performance under the six benchmark areas as stipulated in legislation. The SIR required grantees to propose a measurement plan for meeting the benchmark area requirements over an initial three-year period.² The SIR also listed a set of constructs or measurement concepts under each benchmark area for which grantees were to select and submit relevant performance measures or indicators.³

The measurement plan for the initial three-year implementation period submitted by each grantee followed generally accepted steps involved in indicator development and included the following information:

- One proposed performance measure or indicator for each construct within each benchmark area (e.g. “prenatal care” within the Maternal and Newborn Health benchmark area). Grantees were given discretion in the selection of performance measures but were encouraged to develop only one indicator for each construct that would be applicable across all the home visiting models implemented in their jurisdiction.⁴
- An operational definition for each performance measure selected including key terms, sub-populations of focus and type scoring (e.g., percentage, counts) and whether it was a process or outcome indicator. Description of the numerator and denominator if measure was a percentage or rate
- Measurement tool utilized or question(s) posed to capture each construct of interest
- Proposed data collection plan including the persons responsible for collecting the data initially (e.g., the home visitor), data source (e.g., self report by parent, home visitor’s observation, or administrative data), collection schedule and analysis

² Grantees developed their measurement plans (also known as “benchmark plans”) over the course of several months during which federal and technical assistance contractor staff provided general support (e.g., via webinars and ad hoc published briefs) as well as individualized TA conference calls and visits to grantee teams on performance measurement principles and best practices. The process involved iterative revisions by state teams, model developers, TA contractors and federal staff of submitted plans and culminated in plan approval by HRSA’s regional project officer. As of June 15, 2012, 48 out of 54 measurement plans have been approved.

³ Depending on whether grantees chose crime or domestic violence (domains that included respectively three and four constructs under benchmark area 4) each grantee submitted a total of 34 or 35 performance indicators associated with the constructs listed in the SIR.

⁴ The law requires that no less than 75% of funds allocated to state and jurisdiction grantees support implementation of evidence-based home visiting models. Following the criteria for evidence of effectiveness established by HHS under the program, 12 home visiting models have been identified to date as demonstrating improvement in the outcomes of interest. The vast majority of state and jurisdiction grantees have selected more than one evidence-based model for implementation.

The measurement plan submitted by grantees also included a definition of improvement for each selected indicator. Grantees had discretion to define improvement for each construct in a way that was meaningful for their program, taking into account contextual factors and different stages of measurement system implementation across grantees. Any incremental change in the desired direction would count as improvement (e.g., increase the rate of screening for a condition of interest among the client population between the baseline period and a subsequent comparison period within the three-year window stipulated in legislation). Maintenance of program performance at or above an acceptable target for a given construct could also constitute an instance of improvement.

Per section 511(d)(1)(B)(i) of the legislation, no later than 30 days after the end of the third year in which the grantee conducts the program, grantees are required to demonstrate improvement in at least four of the six benchmark areas. The SIR and subsequent MIECHV guidance documents for both competitive and formula grants to states and jurisdictions also required that grantees report annually on the grantee-selected performance indicators. The data collected for HV Form 2 will be used to document grantees' progress in demonstrating improvement under the various benchmark areas and, specifically, to show whether and individual grantee has met the threshold for improvement defined by Congress by the end of the initial three-year period of program implementation.⁵ Analysis of these in the interim by both grantees and federal agencies will help identify areas of concern and inform the provision of individualized and timely technical assistance.

Of note is that grantees have set performance measures that not only meet federal accountability requirements but are also meaningful and appropriate for their own programmatic purposes. At the grantee level, the performance measures selected will provide data to be used internally by local implementing sites and state teams to continuously improve the quality of their home visiting program.

3. Use of improved information technology and burden reduction

HRSA and ACF will use information technology, whenever possible, to minimize respondent burden and to collect data efficiently. We have selected the existing Discretionary Grant Information System (DGIS) already utilized by MCHB grantees for the electronic transmission of reports. We are in the process of modifying this web-based data entry and reporting system to integrate the specific data collection requirements represented by the two proposed forms.

The electronic system will generate automatic calculations of rates, percentages, and other appropriate types of scoring. The electronic system will also carry over unchanging data from year to year to reduce burden on respondents. The system will also ensure that data are only

⁵ If the report submitted by an individual grantee fails to demonstrate quantifiable improvement in at least four of the areas specified, section 511(d)(1)(B)(ii) requires that grantees submit a corrective action plan to the Secretary.

entered once even when used in multiple tables. Whether a grantee has demonstrated improvement at the end of three years will be also automatically determined. We plan to conduct one or two webinars prior to actual data collection to guide and familiarize all respondents with the DGIS workflow and interface specific to home visiting reporting.

4. Efforts to identify duplication and use of similar information

The data to be submitted on the proposed collection forms are unique and are not available elsewhere in any other manner.

5. Impact on small business or other small entities

This activity does not have a significant impact on small entities. Local implementing agencies are already bound to report program data to grantees as contracted sub-recipients.

6. Consequences to collecting information less frequently

The grantee must respond once annually for both forms per the Supplemental Information Request and subsequent guidance documents as mentioned earlier. The annual collection of information on the number of individuals and families served, household demographics and service utilization will provide program staff with basic information about who is being served and whether services (e.g., home visits) are provided efficiently.

Section 511 to Title V of the Social Security Act, requires that MIECHV grantees collect data to measure improvements for eligible families in the six specified areas benchmark areas and the SIR requires that this information be reported annually (i.e., by fiscal year). A less frequent collection of performance measure information would undermine the federal government's ability to track progress of grantees in achieving improvement and would limit the ability to provide technical assistance in a timely and targeted manner during the three-year period defined in legislation.

7. Consistency with the guidelines in 5 CFR 1320.5(d)(2)

The data are collected in a manner consistent with guidelines contained in 5 CFR 1320.5. There are no special circumstances requiring deviation from these guidelines.

8. Consultation outside the agency

The 60-day notice required in 5 CFR 1320.8(d) was published in the *Federal Register* on February 16, 2012 (Volume 77, Number 32, Pages 9257-9258) requesting comments from the public on the two draft data collection forms. The comment period closed on April 17, 2012. Attachments E and F list all the comments received and the responses crafted by the HRSA/ACF federal data work group on the draft home visiting forms 1 and 2 respectively. We made revisions to the draft forms including streamlining demographic categories and clarifying instructions based on this public feedback.

Prior to the publication of the 60-day FRN and after developing the initial data collection draft forms, the HRSA/ACF data work group engaged in a sustained collaboration with stakeholders to revise and refine both instruments. First, home visiting model developers had an opportunity to discuss and provide input on the draft forms at a meeting held with both federal agencies on October 28, 2011. Minor edits were incorporated into the draft forms at the time. Second, we reached out to a group of MIECHV state grantees on November 14, 2011 who also provided feedback on the draft forms. Attachment G and H contain the list of participants involved in these two activities.

9. Explanation of any payment/gift to respondents

Respondents will not be separately remunerated or compensated for this task. Respondents are state, territorial and tribal grantees who expect to participate in the data collection as part of their grant agreement.

10. Assurance of confidentiality provided to respondents

This request does not involve the collection of personally identifiable information and only requires reporting of aggregate data.

11. Justification for sensitive questions

Questions in surveys and other instruments on which respondents will base their reporting may be potentially sensitive for program participants. Parents are asked by home visitors about topics such as substance abuse, family income or intimate partner violence in the course of assessment and delivery of care. The two forms are part of program operation. All data will be reported to HRSA in the aggregate.

12. Estimate of annualized hour and cost burden

Table 1 shows the average annual burden in hours of the activities described in this supporting statement.

Table 1 – Estimated Annualized Burden (in hours)

Reporting document	Annual number of respondents	Number of responses per respondent	Total responses	Average burden hours per response	Total burden hours
HV Form 1: Demographic and Service Utilization Data for Enrollees and Children	81	1	81	731	59,211
HV Form 2: Grantee Performance Measures	56	1	56	313	17,528

Total	81		81		76,739
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Explanation for the difference in the number of respondents between the two home visiting forms follows:

In addition to the expected 56 state, territorial and non-profit organization grantees reporting on both forms, up to 25 tribal grantees will also utilize Home Visiting Form 1 to report on demographic and service utilization data for all participant families (for a total of up to 81 respondents). Tribal MIECHV grantees are currently developing performance measures for their program and will be reporting data on their progress in improving performance under the six benchmark areas to HHS separately from the state and jurisdiction grantees.

The burden of data collection and reporting to respondents will likely vary based on the number of families served by each grantee and data system capacity. The burden estimates for the two forms were developed based on feedback from selected grantees that participated in a panel on November 14, 2011. Once the first two sets of annual data are collected through the Discretionary Grant Information System (DGIS), HRSA will conduct a burden reassessment and submit a change request to OMB if necessary. Table 2 shows the average annual cost of the activities described in this supporting statement.

Table 2 – Total annual cost

Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
State or other grantee official	76,739	\$40	\$ 3,069,560

13. Estimates of other total annual cost burden to respondents

There is no additional capital or start up cost for this activity. Grantees are expected to utilize their existing management information systems and other equipment (e.g., computers and software) to carry out this task. These costs were anticipated and built into the grantees' 2010 and 2011 budgets under management information systems.

14. Annualized cost to the federal government

We estimate the annual cost of work group meeting time (6-10 persons convening for one hour 2-4 times per month) and individual or small group review time outside of regular meetings to be approximately \$50,000. Currently 30% of one Federal staff GS-15 full-time equivalents (FTEs) is directly associated with the activities required to accomplish this project, with an average cost of \$65,000 including salary and benefits. In addition, about \$500,000 in contract costs will be required annually for the operation of the system for automated reporting and analysis of data under a modification to the DGIS contract. On this basis, the estimated annual cost to the Federal government is \$615,000.

15. Explanation for program changes or adjustments

This is a new project.

16. Plans for tabulation and publication and project time schedule

The collection of data utilizing the proposed two instruments will take place annually over a three-year period of program implementation. The annual reporting period will be the previous federal fiscal year for all respondents. Grantees are expected to begin socio-demographic, utilization and performance measure reporting utilizing the proposed forms in October, 2012 and yearly thereafter.

HRSA will develop “web reports” for the MIECHV program in a manner similar to other MCHB programs whose information is currently displayed under the Discretionary Grants Information System (<https://perf-data.hrsa.gov/MCHB/DGISReports/>) and under the Title V Information System (<https://perfddata.hrsa.gov/MCHB/TVISReports/default.aspx>). In addition to facilitating accountability and transparency, the database and reporting capabilities will allow users to search and sort out data of interest for analysis and reporting (e.g., utilizing key words).

The MIECHV legislation requires that the Secretary of HHS submit a report to Congress no later than December 31st, 2015 based in part on data collected in this project. Specifically, the report must include “the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified.”

17. Reasons for not displaying the OMB expiration date

Both instruments will display the expiration date of OMB approval.

18. Exception to certifications for paperwork reduction act submissions

No exceptions are necessary for this information collection. This project complies with CFR 1320.9.

Attachments

Attachment A – The Social Security Act, Title V, Section 511 (42 U.S.C. 701), as amended by the Patient Protection and Affordable Care Act of 2010

Attachment B – MIECHV Benchmark Areas and Corresponding Constructs

Attachment C – HV Form 1- Demographic and Service Utilization Data for Participating Adults and Children

Attachment D – HV Form 2- Grantee-defined Performance Measures

Attachment E – Public comments: Consolidated response table – HV form 1

Attachment F – Public comments: Consolidated response table – HV form 2

Attachment G – Participant List- HHS/Model Developer Forum

Attachment H – Participant List- State Panel for Review of Data Reporting Forms