Form 1

60-Day *Federal Register* Notice Public Comments

Table A: Unduplicated Count of Enrollees by Type and Primary Insurance Coverage

<table>
<tr><th>Comment Date</th><th>Commenter</th><th>Comments</th><th>Response</th></tr>
<tr><td colspan="4">Table A.1 Total Numbers Newly Enrolled and Served during reporting Period</td></tr>
<tr><td colspan="4">1. Enrollees</td></tr>
<tr><td>3/12/2012</td><td>CT Dept of Public Health-
Margie Hudson, Carol Stone
Jennifer Morin, Mary Emerling
MIECHV Team
Margie.Hudson@po.state.ct.us</td><td>Table A.1: Enrollees
Please add a column – Total # enrolled to the left of the column Numbers Newly Enrolled.

Total Numbers of Enrolled, Newly Enrolled and Served During Reporting Period<table><tr><td></td><td>Total Number Enrolled</td><td>Number Newly Enrolled</td><td>Number Served</td></tr><tr><td>Enrollees</td><td></td><td></td><td></td></tr><tr><td>Index Children</td><td></td><td></td><td></td></tr><tr><td>Families</td><td></td><td></td><td></td></tr></table></td><td>We did not add the suggested column. We can obtain the “total number enrolled” by adding the count for the “number newly enrolled” for all reported years to avoid adding reporting burden to grantees.</td></tr>
<tr><td>4/16/2012</td><td>Laura DeBoer, MPH
Idaho Department of Health and Welfare
MCH Program
MIECHVP
[DeboerL@dhw.idaho.gov]</td><td>Table A.1: It is not clear how one would report “person or persons” for an unduplicated count. It would be helpful to define unduplicated for this section and clarify all “persons” that can be included in this count.

Table A.1: Enrollees – is this everyone in the household including the index child?

Table A.1: Enrollees – is this everyone in the household including grandmothers, other children that local programs have collected data on at any point in the program?</td><td>We clarified in the form instructions the persons to be included within each household or family enrolled. The “enrollee” category excludes index children. The “enrollee” category only includes those individuals in the household who have signed up to participate in the program. Index children or other children in the</td></tr>
</table>

			household are not included in the enrollee category.
3/30/2012	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email: cheryl.leclair@health.ri.gov)	Table A1: Definitions need to be inconsistent (sic) with the terms/definitions that the evidenced-based models use model definitions in order to fit together.	The minimum data collection required, which involves data on the enrollee and the index child for each household is consistent with the practices of the evidence-based models.
5/1/2012	Brighton Ncube	Under Table A1: You may decide if it will be important to add a column that shows year to date totals or statistics.	The columns "Numbers newly enrolled" and "Numbers served" show statistics related to the reporting period which is one year.
2. Index Children			
3/30	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email: cheryl.leclair@health.ri.gov)	Table A1: If the target child is not living with the biological mother, do states count that child as the index child (the definition states that the index child is "the target child in an individual household" (What about children in the hospital or foster care?)	We clarified the definition of index child in the instructions. Since the identification of the index child is dependent on the caregiver voluntarily enrolled in the program, an index child could be in a hospital or in foster care. The primary caregiver enrolled in the program need not be the biological mother.
3. Families			
4/5/2012 **4/16/2012**	Cynthia Suire, DNP, MSN, RN MIECHV Program Manager Louisiana DHH-OPH-MCH [Cynthia.Suire@LA.GOV] Laura DeBoer, MPH	<u>Section A</u> Define "Family." Does family encompass the "enrollee?" Would enrollee = family? Table A.1: Families – perhaps households is more appropriate with a clear definition. Families can be	We clarified in the instructions what persons need to be counted at a minimum to constitute a household or family for purposes of data collection.

	Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	more difficult to define	Household and family are equivalent concepts in this context. A family or household encompasses the enrollee(s) and must include at least one enrollee and one index child(ren).
4/13/2012	Tom Jenkins (CO) Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org]	Section A, Table 1A: Does the family include the enrollee and index child	
3/12/2012	CT Dept of Public Health- Margie Hudson, Carol Stone Jennifer Morin, Mary Emerling MIECHV Team Margie.Hudson@po.state.ct.us	Table A.1- Families Please clarify what is meant by “Families”.	
3/30	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email: cheryl.leclair@health.ri.gov)	Table A1- A definition for family is needed. A definition has not been provided for Table A.1.	

Comment Date	Commenter	Comments	Response
Table A.2 Enrollees: Insurance Status			
1. Enrollees: Insurance Status			
3/23	Dianna Frick (MT) *Lead Maternal and Child Health Epidemiologist* *Family and Community Health Bureau* *Public Health and Safety Division* *Montana Department of Public* *dfrick@mt.gov*	Table A.2 We suggest combining the "Biological Mothers" and "Other Female Caregivers" categories into a "Female Caregivers" category. There does not appear to be any particular purpose for having a separate category for biological mothers or for requiring programs to report the information. Biological fathers are not a separate category from other male caregivers. Other types of female caregivers and their insurance status may have just as much influence on a child's health and well-being as the insurance status of a biological mother. Combining the "Biological Mothers" and "Other Female Caregivers" categories into a "Female Caregivers" category will reduce the data collection and reporting burden to home visiting sites and states and result in more consistent and high quality data about caregivers.	We agree and have subsumed the "Biological Mothers" into the "Female Caregivers" category. We have retained the distinction between pregnant women and other female caregivers. The distinction between pregnant women and female caregivers is justified since the legislation identifies pregnant women less than 21 years as a priority population.
4/16/2012	Tom Hinds (WI) Home Visiting Performance Planner [Thomas.hinds@wisconsin.gov]	Table A.2. We use the State's public health information database (SPHERE) to record data related to our MIECHV grant activities. Currently, SPHERE is not set up to differentiate between biological mother enrollees and other female caregiver enrollees. Through SPHERE, we record the sex of the enrollee and whether the enrollee is pregnant. We could make changes to SPHERE to capture this information; however, we do not want to make changes unless they are necessary, or we feel the changes would provide us, our sites, or HRSA with very useful information. While we see value in better understanding who caregivers are, and better understanding household composition, in general, we are trying to balance our desire for additional information with our sites' data collection burden.	
3/23	Dianna Frick (MT) *Lead Maternal and Child Health Epidemiologist* *Family and Community Health Bureau* *Public Health and Safety Division* *Montana Department of Public* *dfrick@mt.gov*	Table A.2- If an individual identifies themselves as having insurance coverage through the Indian Health Service (IHS), should we include them in the "No Insurance Coverage" category or the "Private or Other" category? We suggest that you clarify the guidance for this item, which will increase the quality and consistency of the information collected.	We clarified in the instructions that receipt of care through the IHS or other safety net provider such as a Federally Qualified Health Center does not constitute insurance coverage.

3/30	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email: cheryl.leclair@health.ri.gov)	Table A.2. - An "armed forces" (Tri Care) health insurance category is needed given that families in the armed forces are a priority MIECHV population. If a specific option is not provided for health insurance (Tri-Care) for those in the armed forces, how should states report on this insurance type? Should it be reported under the "private or other" category?	We added a column to include Tri-Care given that families in the armed forces are a priority population.
3/30	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email: cheryl.leclair@health.ri.gov)	Table A.2. - A "public/private" health insurance category is needed to capture health insurance programs where there is an employer/Medicaid cost share of premiums (e.g. Rhode Island's RIte Share Program).	Public/private insurance arrangements should be included under the "Private or Other" category.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Table A.2: Pregnant women and Biological mothers – please clarify the information to be reported here is collected at intake	We clarified that the information for all newly enrolled caregivers should be collected at intake and annually thereafter.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Table A.2: Male Caregivers – why are (aren't?) biological fathers considered a separate category of male caregivers to mirror the biological mothers and other female caregivers, especially given the National Fatherhood Campaign? Please clarify how to provide an unduplicated count of male caregivers when there might be both a biological father and a foster father included in the home visiting program	We considered this comment above and have subsumed the "Biological Mothers" into the "Female Caregivers" category. Because we combined categories, it is not necessary to separate out male caregiver categories to mirror female caregivers.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Table A.2: Insurance Status – In the Programmatic Letter dated 1/30/2012, HRSA clarifies "Grantees must report the health insurance status of all participates in the program or, at a minimum, of the index child and the primary enrolled adult." Please clarify in instructions the "unduplicated count" for persons with no insurance information in the enrolled family.	Insurance information is required for all enrollee(s) and the index child. "Unduplicated" means that the same person is not counted twice. If a foster father and a biological father are enrolled in the program,

			the unduplicated number of male caregivers for that index child would be 2.
4/16/2012	Kristen Rogers, PhD (CA) CA Home Visiting Program Branch CA Department of Public Health Maternal, Child & Adolescent Health Division [Kristen.Rogers@cdph.ca.gov]	Table A.2 – Enrollees' Insurance Status When is the status to be measured – at the beginning or end of the reporting period?	Insurance status for participants enrolled during the reporting period ("newly enrolled") should be collected at intake or shortly thereafter. Insurance information about participants served during the reporting period but previously enrolled should be collected roughly one year after enrollment and annually thereafter.
4/16/2012	Kristen Rogers, PhD (CA) CA Home Visiting Program Branch CA Department of Public Health Maternal, Child & Adolescent Health Division [Kristen.Rogers@cdph.ca.gov]	Table A.2 – Enrollees' Insurance Status There could be a mixture of publicly and privately funded programs included under the column heading, "Private or Other." Armed Services/Veterans insurance programs might be included here by some states, as well as programs whose Title XIX/XXI funding stream is not clear to staff, such as city, country, and/or non-profit-funded programs. It doesn't seem informative/helpful to include these programs with "Private" insurance programs	We included a separate column for Tri-Care/VA insurance programs. public/private insurance.
5/1/2012	Marisa D. Wang, ACA Tribal Home Visiting Program Project Director Planning & Grants Department Southcentral Foundation 4501 Diplomacy Dr., Ste 200 Anchorage, AK 99516 Telephone: (907) 729-4996 Fax:(907) 729-4997 E-mail: mwang@scf.cc	In Table A.2 #3, there are hash marks across the cell, which is confusing, should the data be reported or not. If not, we recommend deleting it from the form. If so, remove the hash marked row and have programs report to the side	The hash-marked area was removed to clarify that programs need to report this information.
5/2/2012	Brandi Smallwood	Table A.2 – Enrollees: Insurance Coverage	We clarified in the instructions

	Better Beginnings ~ Chahta Inchukka Tribal Maternal, Infant and Early Childhood Program Director Choctaw Nation of Oklahoma Phone: 580-326-8304 Fax: 580-326-0115 bsmallwood@choctawnation.com	In regards to the Choctaw Nation of Oklahoma, all Native Americans can receive medical care including but not limited to prenatal care, dental, family practice, labs and prescriptions through the Choctaw Nation Health Service Authority. Native Americans who are not covered by private health insurance often do not see a need to pursue other means of insurance as they rely on their Native American heritage to provide them with what they feel is adequate healthcare coverage.	that receipt of care through the IHS or other safety net provider such as a Federally Qualified Health Center does not constitute insurance coverage.
2. Index Children: Insurance Status			
4/16/2012 **4/16/2012**	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov] Tom Hinds (WI) Home Visiting Performance Planner [Thomas.hinds@wisconsin.gov]	Table A.2: Insurance Status Title XIX and Title XXI – in Idaho, Title XXI (CHIP) families do not apply for SCHIP as a separate program from Title XIX (Medicaid). Families enrolled in Medicaid will likely not know if they are enrolled in Title XIX or Title XXI as there are no practical differences in the programs. Title XXI is an expansion of Title XIX from 133% FPL to 185% FPL Table A.2. In Wisconsin, health insurance benefits through Titles XIX and XXI are combined under the State's Badger Care Plus program. It would be difficult for us to separately report on these two categories. We could report under one of the two categories and add a footnote explaining that enrollees covered by both Title XIX and Title XXI are included in the figure. HRSA might also consider combining the Title XIX and XXI columns in this table.	We combined title XIX and XXI into one column.

Table B: Enrollees and Children: Selected Characteristics by Ethnicity and Race

Comment Date	Commenter	Comments	Response
Table B Race and Ethnicity			
4/5/2012	Cynthia Suire, DNP, MSN, RN MIECHV Program Manager Louisiana DHH-OPH-MCH [Cynthia.Suire@LA.GOV] Tom Jenkins (CO) Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org] Dianna Frick (MT) *Lead Maternal and Child Health Epidemiologist* *Family and Community Health Bureau* *Public Health and Safety Division* *Montana Department of Public* *dfrick@mt.gov*	Table B.4.Ethnicity and race: Some clients may report race and not report ethnicity, or vice versa. If only one is reported, would the client automatically be "unknown/did not report" even though we have one aspect collected. Section B, Table B: Is the unknown/did not report for both race and ethnicity or both. Table B- Is the "Unknown/Did Not Report" column for both race and ethnicity? We recommend having one "Unknown/Did Not Report" category for ethnicity, and a separate "Unknown/Did Not Report" category for race. Some families may report ethnicity but not race, or vice versa. Having one "Unknown/Did Not Report" category that combines race and ethnicity date will result in more people with unknown data and less useful data overall.	We added an "unknown/did not report" category to the form for both the ethnicity and race categories.
3/12/2012	CT Dept of Public Health- Margie Hudson, Carol Stone Jennifer Morin, Mary Emerling MIECHV Team Margie.Hudson@po.state.ct.us	Table B- Race and Ethnicity Table- comments: • Consider changing Ethnicity to Hispanic or Latino only and delete Hispanic or Latino and Non - Hispanic or Latino columns. • Consider changing Race to *Non-Hispanic* only and keep categories *American Indian through White*. • Consider making a separate column for *More than one category selected*. • No changes to *Unknown/Did Not Report*	No changes were made to preserve compliance of categories with the OMB standards for data collection on race/ethnicity. We substituted the "More

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<td>1- People who consider themselves to be Hispanic or Latino regardless of race. 2- People who consider themselves to be Non-Hispanic and one race. 3- People who consider themselves to be of mixed race and/or ethnicity.
<table>
<tr><td></td><td>Hispanic Ethnicity (1)</td><td colspan="5">Race / Non-Hispanic Ethnicity (2)</td><td>More than one category Selected (3)</td><td>Unknown Did Not Report</td></tr>
<tr><td></td><td>(All Races)</td><td>American Indian or Alaskan Native</td><td>Asian</td><td>Black or African American</td><td>Native Hawaiian or Other Pacific Islander</td><td>White</td><td></td><td></td></tr>
<tr><td>4. Enrollees</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Pregnant Women etc.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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<td>than one race” category for the “more than one category selected”. This heading is compliant with OMB standards.</td>
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<td>4/16/2012</td>
<td>Laura DeBoer, MPH
Idaho Department of Health and Welfare
MCH Program
MIECHVP
[DeboerL@dhw.idaho.gov]</td>
<td>Section B Table B: Is it necessary to cross-tabulate or stratify all of the enrolled persons by race and ethnicity or are the primary caregiver and index children sufficient?</td>
<td>The table and instructions indicate that race/ethnicity data should be collected for all “enrollees” with the specific categories provided (ex. pregnant women,
female caregivers, and male caregivers) and the index child(ren). Enrollees should include at a minimum the primary caregiver of the index</td>
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			child.
4/13/2012	Tom Jenkins (CO) Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org]	Section B, Table B: The guidance indicates the total for ethnicity should equal the total for race; this may not occur if the client is self-seeking	Total numbers for ethnicity and race should equal the total numbers of enrollees served and will be automatically calculated by DGIS.
4/16/2012	Kristen Rogers, PhD (CA) CA Home Visiting Program Branch CA Department of Public Health Maternal, Child & Adolescent Health Division [Kristen.Rogers@cdph.ca.gov]	Table B – Enrollees and Children Selected Characteristics by Ethnicity and Race It would be helpful if the instructions for this table were for respondents to answer in both categories (ethnicity and Race)	We clarified in the instructions that data should be collected on ethnicity **and** race.

Comment Date	Commenter	Comments	Response
Table B.4 - Enrollees			
3/12/2012	CT Dept of Public Health- Margie Hudson, Carol Stone Jennifer Morin, Mary Emerling MIECHV Team Margie.Hudson@po.state.ct.us	**Table B – Pregnant Women/Biological Mother** Instructions- Also, please add more clarity to the difference between biological mothers and pregnant women by adding something like *"whether or not she is caring for another child who is in the program as an index child "*.	We combined the category "Biological mothers with "Female Caregivers". We revised the instructions to reflect the simplified categories.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Table B: 4. Per enrollee – are there cases in which there might be multiple females or males per enrolled family? Is this table to be completed for only the primary female and male caregivers?	The instructions define enrollee(s) as the person or persons who signed up to participate in the home visiting program. The category can include more than one member of the household if more than one individual is

			enrolled in the program (e.g., multiple female or male caregivers).
4/13/2012	Tom Jenkins (CO) Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org]	Section 1, Table 1B: is the insurance, etc. data self-report?	Data collection on insurance may be self-reported.

Comment Date	Commenter	Comments	Response
TABLE B.5 Enrollees: Marital Status			
3/12/2012	CT Dept of Public Health- Margie Hudson, Carol Stone Jennifer Morin, Mary Emerling MIECHV Team Margie.Hudson@po.state.ct.us	Table B- **Enrollees: Marital Status**- Please consider whether this indicator is really necessary. If so please consider eliminating "Cohabitating/Living with Significant Other". Please keep the "Unknown" category. "Cohabitating/Living with Significant Other" seems somewhat intrusive however if this is a common question in ACF or HRSA databases…..	Marital status is one factor considered in relationship to child outcomes, therefore was retained in the data set. To make categories mutually exclusive, we removed the "cohabitating/living with significant other" category. The "unknown, did not report" category will remain.
4/16/2012	Tom Hinds (WI) Home Visiting Performance Planner [Thomas.hinds@wisconsin.gov]	<u>Table B</u> We see the most value in indicating whether the enrollee is single and cohabitating; however, there are some questions re: whether families will want to record this, as it may affect benefit receipt. It seems, too, that the categories here would not produce an unduplicated count of enrollees (i.e., if someone is widowed and not remarried, s/he is also "single."). Is the intention that single means "never married"? If such detailed categorization is necessary, perhaps married/single should be separated, then "if single" leads to the other categories—separated, divorced, widowed, cohabiting, etc. Alternatively, HRSA might consider adjusting "single" to read "single, never married"	We changed the "single" category to "Never married" and removed the "cohabitating/living with significant other" category. Categories are mutually exclusive and should produce an unduplicated count.

4/16/2012	Tom Hinds (WI) Home Visiting Performance Planner [Thomas.hinds@wisconsin.gov]	Table B B.5., Marital Status: Currently, SPHERE includes three marital status fields: single, married, and unknown. While we see potential value in obtaining more detailed marital status information, we question whether the cost, labor and training needed to implement such detailed categories in our data system and home visiting practice will yield truly useful information.	The categories provide important information about family supports, including who could be involved in home visits. We revised the categories however to make them mutually exclusive and eliminated the "cohabitating/living with significant other" category.
4/16/2012	Kristen Rogers, PhD (CA) CA Home Visiting Program Branch CA Department of Public Health Maternal, Child & Adolescent Health Division [Kristen.Rogers@cdph.ca.gov]	Table B.5 – Enrollees' Marital Status Is it of interest whether she is living with the father of the index child? The father could be her husband, or her significant other (or neither).	The intent of this variable is to record the marital status of the enrollee, not whether the enrollee is married to the father of the index child or some other person.
4/16/2012	Kristen Rogers, PhD (CA) CA Home Visiting Program Branch CA Department of Public Health Maternal, Child & Adolescent Health Division [Kristen.Rogers@cdph.ca.gov]	Table B.5 – Enrollees' Marital Status Could the row categories be defined more specifically? Enrollees may fit into more than one of these categories as they appear now. For example, a woman may be separated from her husband, and living with a significant other. How would this be entered?	Data are self-reported, therefore the data should be entered according to the category selected by the enrollee. We revised the marital status categories to be mutually exclusive.

Comment Date	Commenter	Comments	Response
Table B.6 & B.7: Educational Attainment			
3/12/2012	CT Dept of Public Health- Margie Hudson, Carol Stone	**Table B 6. and B.7- Educational Attainment** – suggest eliminate "*High school eligible, not enrolled*" and combine "HS *diploma* with *GED* to become"	There are significant differences between the

	Jennifer Morin, Mary Emerling MIECHV Team Margie.Hudson@po.state.ct.us	HS *diploma or GED".* example, a teenage mother is 16 years of	categories. We therefore retained but revised the "high school eligible, not enrolled" category and the corresponding instructions. We also retained HS diploma and GED as separate categories since they are associated with different outcomes. We revised the categories to be more distinct, mutually exclusive, and hierarchical. "Of high school age, not enrolled" includes those individuals who are of high school age, and are not currently enrolled in school. For example, a teenage mother is 16 years of age and could be enrolled in high school, but has not finished her HS education. "Less than high school diploma", includes individuals who are not of high school age, who did not complete their high school education. For example, a 23 year old mother who did not finish her education would be included in this category because she is
3/23	Dianna Frick (MT) *Lead Maternal and Child Health Epidemiologist* *Family and Community Health Bureau* *Public Health and Safety Division* *Montana Department of Public* *dfrick@mt.gov*	What does "High school eligible, not enrolled" mean? Does the eligibility refer to the age of the enrollee? We have varying requirements and eligibility guidelines among the high schools in our state. An enrollee may be under 18 and have dropped out of high school but not be "eligible" to re-enroll in their local high school for a variety of reasons. We would include an enrollee in this situation in the "Less than HS diploma" category, since finding out each enrollee's eligibility to re-enroll in their local high school is unrealistic. We suggest removing the "High school eligible, not enrolled" category or clarifying who should be included which should improve the quality and consistency of the information reported.
4/16/2012	Tom Hinds (WI) Home Visiting Performance Planner [Thomas.hinds@wisconsin.gov]	There appears to be a risk of double counting; someone who is currently enrolled in high school could also be reported in the "Less than HS diploma" category. HRSA might consider adjusting the "Less than HS diploma" category to read "Less than HS diploma, not HS eligible" and provide a definition of this category in the form instructions (although, technically, anyone at any age can get a GED—how would this be defined?).
4/16/2012	Kristen Rogers, PhD (CA) CA Home Visiting Program Branch CA Department of Public Health Maternal, Child & Adolescent Health Division [Kristen.Rogers@cdph.ca.gov]	Presumably, the row headings are hierarchical, i.e., if a client is both "High school eligible, not enrolled" and "Less than HS diploma" she/he should be entered under the one that comes first. It would be helpful if this were made more clear.
4/16/2012	Kristen Rogers, PhD (CA) CA Home Visiting Program Branch CA Department of Public Health Maternal, Child & Adolescent	It is implied that "Vocational School/Technical Training" means attainment only, to the exclusion of clients who may be currently enrolled in such a training. It would be helpful to have this clarified, and/or to add an "enrolled" category.

	Health Division [Kristen.Rogers@cdph.ca.gov]		not of high school age and did not finish her HS education. We revised the "some college" category to "some college/training". This category includes those individuals currently enrolled in vocational or technical school.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Table B: 6. Female Enrollees Educational Attainment – are these exclusive categories? There may be many instances when a female caregiver might be eligible for both categories of: "less than a HS diploma" and "High school eligible, not enrolled." Please provide clarification on which category would be appropriate for instances such as: a sixteen-year-old mother who has dropped out of high school and then enrolls in the home visiting program. Table B.7: Male Enrollees Educational Attainment – all comments related to Table B.6 Female Enrollee Educational Attainment apply to Section B.7	
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Table B.6: Female Enrollees Educational Attainment Vocational School/Technical Training – it is becoming increasingly more difficult to distinguish between community college, online college, online training and vocational school/technical training in the current post-secondary education environment	Data are self-reported, therefore the data should be entered according to the category selected by the enrollee. The type of training/level of degree rather than the method of delivery should guide the category selection.
/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Table B.6: Female Enrollees Educational Attainment Other" – please provide an example or clarification of when reporting and other is appropriate	"Other" would include any type of education that would not correspond to any of the other categories. For example, a teen mother in middle school would fall into this category.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Table B: 6. Female Enrollees Educational Attainment - Does this include only the primary female caregivers? Please clarify if the information included in this section should only come from one of the following categories (pregnant Women, Biological Mothers, and Other female Caregivers)	Data should be provided for all female enrollees in the program. If more than one female is enrolled in the program (e.g. teenage mother and grandmother), data should be provided for both.

Comment Date	Commenter	Comments	Response
Table B.8 & B.9 – Female Enrollees: Age (in years)/Male Enrollees: Age (in years)			
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Table B.8: Female Enrollees Age (in years) – Does this include only female caregivers? Please clarify which female enrollees are including in this count	Data should be provided for all female enrollees in the program. If more than one female is enrolled in the program (i.e. teenage mother and grandmother), data should be provided for both.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Table B.9: Male Enrollees Age (in years) – Please further define "Male Enrollees" and "Make Caregivers" as there is inconsistency in terminology used throughout Form 1 (Enrollees, Families, Caregivers)	We clarified the meaning of enrollee in the instructions. There is only one category of male enrollees.
Comment Date	**Commenter**	**Comments**	**Response**
Table B.10 – Female Index Children: Age (in years) & Table B.11 – Male Index Children: Age (in years)			
4/5/2012	Cynthia Suire, DNP, MSN, RN MIECHV Program Manager Louisiana DHH-OPH-MCH [Cynthia.Suire@LA.GOV]	Table B.10 and 11.Female and Male Index child: For programs in which all enrollees enter before children are born, would there be anything to report here? Or, do we count the index child of the enrollee who was enrolled during the pregnancy?	Children born to women who were pregnant upon enrollment are counted as "index children" in the following reporting year.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP	Table B.10 and B.11: Female and Male Index Children Age (in years) – Reporting would likely be easier if the age categories were in months instead of years. Additionally, there should be more than three age categories, perhaps the following would be more appropriate: (0-12 months, 13-24 months, 25-36 months, 37-48 months, 49-60 months, and 61-72 months).	We did not modify the age categories. To reduce burden, response categories were limited to three. The response categories can easily be

	[DeboerL@dhw.idaho.gov]		translated from months into years based on the instructions provided.

Comment Date	Commenter	Comments	Response
Table B.12 – *Additional Children* (Birth – 18 years old) Living in the Home			
3/29	Angela Ward (UT) Office of Home Visiting Utah Department of Health award@utah.gov	Table B-12 asks for race and ethnicity information on "Additional Children." Currently we are only collecting information on the index child. Subsequent children may become an index child however, for school age or older children that are non-index children there is no mechanism in our database to collect this information. The home visiting programs are not impacting or tracking non-index children.	We removed this variable. Data should be collected on those individuals enrolled in the program (index child and caregivers participating in the home visiting program).
4/5/2012	Cynthia Suire, DNP, MSN, RN MIECHV Program Manager Louisiana DHH-OPH-MCH [Cynthia.Suire@LA.GOV]	Table B.12.Additional Children: The models do not collect this information and the extra data collection will be quite burdensome. This collection/analysis is not built into any present state data system.	
4/16/2012	Tom Hinds (WI) Home Visiting Performance Planner [Thomas.hinds@wisconsin.gov]	B.12. Currently, our sites do not necessarily record information in SPHERE on family members other than enrollees and index children. We anticipate collecting this type of information in the future, but have not prioritized this. We have been focusing on adjusting SPHERE and site data collection practices to be able to meet our federally approved benchmark reporting requirements. We may have missing data under B.12. in our initial reports.	
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Table B.12: Additional Children (Birth-18 years-old) Living in the Home – Please provide clarification of these are required fields and updated annually. Additionally, there should be more than four age categories such as the following (under 1 year, 1-2 years, 3-5 years, 6-12 years, 13-18 years)	
OTHER			

4/13/2012	Tom Jenkins (CO) Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org]	Section B, Table B 4-12: Please provide more clarification to states to complete this table. For example, is race and ethnicity required to be completed on each row?	Yes, data are required for each variable (row) in the table. The instructions clarify the categories and that ethnicity and race should be reported for each category. The DGIS will require counts for each field in every table, including a "0" where appropriate.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Table B: Total –Should the "total row" be equivalent to the "total enrollees" in Table A.1 or should states expect there to be discrepancy if all this information is not collected on other household/family members?	Yes, the total row should be equivalent to the total enrollees in Table A.1. We revised the instructions. Data should be collected on those individuals enrolled in the program (index child and caregivers participating in the home visiting program).

Table C: Socioeconomic Data

Comment Date	Commenter	Comments	Response
Table C.1: Family Relationship to Poverty Level			
3/12/2012	CT Dept of Public Health- Margie Hudson, Carol Stone Jennifer Morin, Mary Emerling MIECHV Team Margie.Hudson@po.state.ct.us	**Table C.1** - Please add "of Families" to "Number" = "Number *of Families"* for clarity.	We revised the column header to be "Number of Families."
3/23	Dianna Frick (MT) *Lead Maternal and Child Health Epidemiologist*	Table C.1 There is no category to report families who have an income of 301-399% of the federal poverty level. We recommend including another category or revising the existing categories so that	We revised the categories and added a new category for all families with income above

	Family and Community Health Bureau *Public Health and Safety Division* *Montana Department of Public* *dfrick@mt.gov*	information can be accurately reported.	300% of FP level.
3/29	Becky Berk (NH) Integrated Quality Improvement Director NH Children's Trust, Inc. www.nhctf.org bberk@nhchildrenstrust.org	1. There is an error in Section C, Table C.1. Question 13. There is no category that captures poverty level between 301 and 400% of poverty. The categories should be redefined to include this range, or this range should be added as a new line.	
3/29	Angela Ward (UT) Office of Home Visiting Utah Department of Health award@utah.gov	Section C asks for socioeconomic data to be reported in relationship to Federal Poverty Level. There is concern that the need to collect information on the entire household will be detrimental to the home visitor's relationship with the individual enrolled in the home visiting program. Currently home visiting programs are not gathering income information for the entire household. This would be a change and require multiple changes in data collection and data base structure. There is also some concern that this data may not accurately reflect the visited family's relationship to the Federal Poverty Level. The household for the definition of benchmark collection may be different than the household definition for poverty level. The definition of households will vary across state programs.	We issued a Programmatic Letter, dated January 10, 2012, and clarified the definition of household for reporting purposes. "Household includes the person(s) enrolled in the home visiting program funded by MIECHV. At a minimum, grantees should collect information on the enrollee(s) in the home visiting program. The category can include more than one member of the household if more than one member is enrolled in the program, participates in home visits, or otherwise contributes to the support of the index child or pregnant woman." These definitions apply for
3/30	Cheryl LeClair (RI) Comments from the Rhode Island	Table C.1. A definition of "family relationship to federal poverty level" is needed (are states reporting the mother's income or the family's income and what is the criteria for counting the family's income?	

	Department of Health Email: cheryl.leclair@health.ri.gov	For example, what if the father is present only intermittently?).	both socio-economic data and benchmark reporting.
4/13/2012	Tom Jenkins (CO) Nurse-Family Partnership, National Service Office Tom.Jenkins@nursefamilypartnership.org	Section C, Table C1: "Family" needs to be defined. In NFP, the "family" is defined as the client and indexed child	We revised the categories and added a new category for all families with income above 300% of FP level.
4/16/2012	Tom Hinds (WI) Home Visiting Performance Planner Thomas.hinds@wisconsin.gov	Table C.1., Family Relationship to Federal Poverty Level Our approved benchmark performance measure is "Percentage of households served by the program who report an increase in total household income and other sources of cash support between month of enrollment and 12-months post-enrollment." After consultation with our sites' staff, we constructed questions that get at a family's net income and allow household to be defined by the enrollees. Sites' staff strongly felt that this information was most relevant to families and to home visitors working with families to budget, meet monthly expenses, etc., and more likely to be accurate, compared to estimates of gross income.	
4/16/2012	Tom Hinds (WI) Home Visiting Performance Planner Thomas.hinds@wisconsin.gov	Table C.1., Family Relationship to Federal Poverty Level This table asks us to report income relative to the federal poverty level, which requires collecting gross income and using a specific definition of household. "Federal poverty level" implies a technical definition that is used for eligibility for a number of benefit programs, and we do not expect home visitors to acquire this specific information. Can we use net income and our definition of household for reporting under Table C.1.? Or would it be possible to provide sites with a procedure to roughly estimate where families fall in terms of the Table C.1. categories if sites are obtaining net income? If we are not tied to the federal poverty level definition (or maybe even if we are tied to the definition), HRSA may wish to change the table title to read "Estimated Family Relationship to Federal Poverty Level" and provide some guidance in the instructions regarding what is and is not acceptable when estimating. Also, as currently listed in Table C.1, there is no reporting category for 301-400%.	
5/2/2012	Brandi Smallwood (OK) Better Beginnings ~ Chahta Inchukka Tribal Maternal, Infant and Early Childhood Program Director	Table C.1 – Additional information will be necessary to adequately determine the category each family should be placed in and how to correctly derive the correct income level to calculate this measure.	

	Choctaw Nation of Oklahoma Phone: 580-326-8304 Fax: 580-326-0115 bsmallwood@choctawnation.com		
3/30	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email: cheryl.leclair@health.ri.gov	Table C.1. Why wouldn't there be a category for "100% and under"?	We added two categories: 1) under 50% and 2) 51-100% and revised the under 133% category to be 101 to 133%.
3/30	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email:cheryl.leclair@health.ri.gov	Table C.1. The table should include an "unknown/did not report" category rather than the current "unknown" category.	We added "unknown/did not report" to the table.
4/16/2012	Laura DeBoer, MPH(ID) Idaho Department of Health and Welfare MCH Program MIECHVP DeboerL@dhw.idaho.gov	Table C.1 Family Relationships to Federal Poverty Level – in most cases, programs will be collecting numeric data on income, not income according to FPL ranges	Household gross income and the number of family members are required data to determine the household income in relation to the Federal Poverty Guidelines. We added the link to the Federal Poverty Guidelines in the instructions, which describes the process.
4/16/2012	Laura DeBoer, MPH (ID) Idaho Department of Health and Welfare MCH Program MIECHVP DeboerL@dhw.idaho.gov	Table C.1 Family Relationships to Federal Poverty Level – It would be helpful to include a table of FPL and household in the instructions	We added the link to the Federal Poverty Guidelines in the instructions.
4/16/2012	Laura DeBoer, MPH (Id) Idaho Department of Health and Welfare MCH Program MIECHVP DeboerL@dhw.idaho.gov	Table C.1 Family Relationships to Federal Poverty Level – Please clarify if the income should be reported on family gross or net income	We clarified in the instructions that gross income should be reported.
4/16/2012	Laura DeBoer, MPH (ID) Idaho Department of Health and	Table C.1 Family Relationships to Federal Poverty Level – Nurse-Family Partnership documents family income in the following ranges, it may be difficult to re-categorize this information to provide data for	Household income ranges in relation to poverty guidelines

	Welfare MCH Program MIECHVP DeboerL@dhw.idaho.gov	Table C.1: 1. Less than or equal to $6,000 2. $6,001 - $9,000 3. $9,001 - $12,000 4. $12,001 - $16,000 5. $16,001 - $20,000 6. $20,001 - $30,000 7. Over $30,000	are informative. The number of individuals in the enrollee's household could be cross tabulated with gross income of those individuals. A consistent methodology should be applied to re-categorize data based on income ranges.
5/2/2012	Marisa D. Wang, (AK) **ACA Tribal Home Visiting Program Project Director** **Planning & Grants Department** **Southcentral Foundation** **4501 Diplomacy Dr., Ste 200** **Anchorage, AK 99516** Telephone: (907) 729-4996 Fax:(907) 729-4997 E-mail: mwang@scf.cc	Table C.1. 13, the Federal Poverty Level break outs are challenging, because the 134%-250% range will include those that do and do not qualify for Medicaid, WIC and other programs. Most break-off points are under 200%, so the relationship to Federal Poverty indicators will be hard to ascertain for that category.	We clarified the instructions to include the household income in relation to the Federal Poverty Guidelines. This variable asks for the household income in relation to the Federal Poverty Guidelines and does not ask for eligibility for other programs.

Comment Date	Commenter	Comments	Response
Table C.2: Enrollees: Employment Status			
3/29	Becky Berk (NH) Integrated Quality Improvement Director NH Children's Trust, Inc. Prevent Child Abuse NH www.nhctf.org bberk@nhchildrenstrust.org	Table C.2 Education/Training Status There is a discrepancy between the tables on age of enrollees (tables 8, 9, 16) and the tables on educational attainment (tables 6 and 7). Since the data collection of age starts at age 10, these enrollees may be attending middle school (or even elementary school), yet HS enrollment is the only choice.	Those participants attending elementary or middle school should be included in the "Other" category under educational attainment.
3/30	Cheryl LeClair (RI) Comments from the Rhode Island	Table C.2. - Definitions for "Employed Full-Time" and "Employed Part-Time" are needed.	The Department of Labor does not provide a definition of full

	Department of Health Email: cheryl.leclair@health.ri.gov		or part-time employment. http://www.dol.gov/dol/topic/workhours/full-time.htm. Grantees have discretion to define "employed full time" and "employed part time" for purposes of this data collection.
3/30	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email: cheryl.leclair@health.ri.gov	Table C.2. - Definitions for "Enrolled Full-Time" and "Enrolled Part-Time" are needed.	We changed the word "enrolled" to "student/trainee" in table C.2., item 14 to avoid confusion with home visiting program enrollment. We consolidated the full- or part-time student/trainee categories into one.
3/30	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email: cheryl.leclair@health.ri.gov	Table C.2. - The table should include "unknown/did not report" categories rather than the current "unknown" categories under both Employment Status and Education Status.	We changed the category "Unknown" in table C.2, items 13 and 14 to "Unknown/did not report"
4/5/2012	Cynthia Squire, DNP, MSN, RN (LA) MIECHV Program Manager Louisiana DHH-OPH-MCH Cynthia.Suire@LA.GOV	Table C2.14. Model data system does not collect employment information in this manner, particularly "not employed" vs. "unemployed." Current data system collection will have to be altered to accommodate and model may or may not change their data collection. Again, the state would have to add an additional data collection method-a cost and burden not anticipated with present resources.	We eliminated the unemployed category and limited the main categories in this table to employed (part or full time) and not employed.
"	Laura DeBoer, MPH (ID) Idaho Department of Health and Welfare MCH Program MIECHVP DeboerL@dhw.idaho.gov	Table C.2 Enrollees: Employment Status Not Employed – Please clarify the if the categories listed in parenthesis (student, homemaker, disabled, other) of just examples or grantees will be expected to report on these categories for reason the care	We clarified in the instructions that these are examples and removed them from the table to avoid confusion.
4/16/2012	Kristen Rogers, PhD (CA) CA Home Visiting Program Branch CA Department of Public Health	Table C.2 – Enrollees' Employment Status and Enrollees' Education/Training Status Having only one category for part-time employment and/or education means that enrollees working 35 hours/week are aggregated with those working 1 hour/week	The Department of Labor does not provide a definition of full or part-time employment.

	Maternal, Child & Adolescent Health Division Kristen.Rogers@cdph.ca.gov		http://www.dol.gov/dol/topic/workhours/full-time.htm. Grantees have discretion to define “employed full time” and “employed part time” for purposes of this data collection. We consolidated the full- or part-time student/trainee categories into a single category of “student/trainee”.
4/16/2012	Tom Hinds (WI) Home Visiting Performance Planner Thomas.hinds@wisconsin.gov	Table C.2.14., Employment Status Our approved benchmark measure related to employment is “Percentage of households served by the program who increase total weekly hours of paid employment for household members between month of enrollment and 12-months post-enrollment”. We developed this measure to capture a more holistic approach to supporting the family; incomes of "all" household members are included a) to begin to provide some information about fathers and other family members who provide support; and b) because we may not expect mothers enrolled prenatally to be working much at 12-months post-enrollment.	Reporting on benchmark data collection plans and their individual performance measures is distinct from demographic and service utilization data reporting under this form. Grantees must include at a minimum the caregiver of the index child enrolled in the program. In general, socio demographic information required for this form will be less detailed than that necessary to report on specific indicators selected by grantees under the benchmark area for family self-sufficiency.
4/16/2012	Tom Hinds (WI) Home Visiting Performance Planner	C.2.14. asks for employment status only for enrollees and in a very specific (different) way (full time or part time). We would need to make significant adjustments to SPHERE and home visiting practice to	We simplified the employment categories for

	Thomas.hinds@wisconsin.gov	collect this data. But a way to combine C.2.14 and our idea (to have a more holistic approach to employment information) could be to change C.2.14 to read "Families: Employment Status," and have states report the number of families/households with at least one member with full-time employment and the number of households with at least one member with part-time employment. If a household's members had both full-time and part-time employment, that family would be reported under "Employed Full Time". The total for C.2.14 would equal the number of families reported in Table A.1.	reporting in the table while maintaining the enrollee rather than the family as the unit of analysis.
4/16/2012	Tom Hinds (WI) Home Visiting Performance Planner Thomas.hinds@wisconsin.gov	Table C.2.15., Education/Training Status Currently, although we are collecting information regarding enrollees' educational activities, SPHERE is not set up to specifically collect full-time versus part-time education/training status. We could collect this information, but again, this would require significant changes to SPHERE and collection practices. Is the full/part-time necessary?	We consolidated the part- and fulltime student categories into one.
Table C General Comments			
4/16/2012	Laura DeBoer, MPH (ID) Idaho Department of Health and Welfare MCH Program MIECHVP DeboerL@dhw.idaho.gov	Table C.1 and C.2: Family Re Table C: 1 and C: 2. Family Relationship to Federal Poverty Level, Employment Status, and Educational/Training Status - Please clarify if grantees are to report information for either female and male caregivers or just primary caregivers. Instructions on page 8 state "…item 13 enter the unduplicated count of families' income level completed to FPL…item 14 enter the unduplicated count of enrollees by employment status…item 15 enter the unduplicated count of enrollees by their education status. Instructions must be clearer on which enrollees (male, female, both, all) grantees are to report on and how to generate an unduplicated count of these enrollees.	Grantees should provide information on all program enrollees. The enrollee category must include at a minimum the caregiver of the index child enrolled in the program but may also extend to additional enrollees at the discretion of the implementing agency and depending on how the home visiting model utilized prescribes data collection regarding family income, employment and training.

Table D: Demographics

Comment Date	Commenter	Comments	Response
Table D.1 Demographics: Enrollees: Age			
3/30	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email: cheryl.leclair@health.ri.gov	Table D.1- The table should include an "unknown/did not report" category rather than the current "unknown" category.	We revised the table to include an "unknown/did not report" category.
3/30	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email: cheryl.leclair@health.ri.gov	Table D.1.- Definitions for the "Age" categories are needed (For example, is it 10 to 14 years or 10 through 14 years?).	A note in the second paragraph of the instructions defines age ranges for all tables.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Section D: Other Demographics – General Feedback. It might be beneficial to include frequencies/counts of other variables, not cross-tabulated with ethnicity and race in the Other Demographic	Examples of other variables and a rationale for including was not provided, therefore this comment could not be addressed.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Section D: Other Demographics – Please provide clarification on how many caregivers to include in an unduplicated count of enrollees by age	These categories are mutually exclusive. Data should be reported on all enrollees in the program. For example, if a pregnant teen, her mother, and the biological father are all enrolled in the program, then data should be reported for each of these enrollees.
5/1/2012	Brighton Ncube	The MIECHV Form 1: Demographic and Service Utilization Data is well developed and I think it will be a useful document. I have a couple of suggestions which the developers may think about.	Not able to comment. Suggestions were not provided.

Comment Date	Commenter	Comments	Response
Table D.2 Demographics: Primary Language Exposure of Index Children			
3/29	Barbara Markiewicz (FL) The Lawton and Rhea Chiles Center for Healthy Mothers and Babies University of South Florida bmarkiew@health.usf.edu	**General Concerns Demographics** The proposal is to ask for demographic data for more members of the household than the primary client (usually the mother) and the target child. Our consent forms are signed by the primary client. So, technically, we do not have permission to collect data on other household members.	Grantees should collect information on the enrollee(s) and the index child in the home visiting program.
3/30	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email: cheryl.leclair@health.ri.gov	Table D.2. - More language categories are needed.	The "other" section under table D.2 is intended to capture other languages. A drop down menu of additional languages will be provided.
3/30	Cheryl LeClair (RI) Comments from the Rhode Island Department of Health Email: cheryl.leclair@health.ri.gov	Table D.2.- The table should include an "unknown/did not report" category rather than the current "unknown" category.	We revised the table to include an "unknown/did not report" category.
4/13/2012	Tom Jenkins (CO) Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org]	Section D, Table D2: This is not a required question in the NFP model, rather the question is asked of the enrollee (client). Recommend changing this question to the client/enrollee	Although the data table seeks to identify the primary language exposure of the index child, we expect caregivers to answer this question.

Table E: Priority Populations – Actual numbers Enrolled during Reporting Period

Comment Date	Commenter	Comments	Response
Table E: Legislatively Identified Priority Populations			
4/13/2012	Tom Jenkins (CO) Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org]	Section E: Recognizing that these priority populations are outlined in the legislation and the SIR (page 16); HHS needs to provide more detailed guidance to states about exactly what information needs to be collected. The categories are too broad for implementation and will lead to confusion and different interpretations. We recommend that HRSA develop a questionnaire that can be used by the home visitor to collect the information. We also recommend that HRSA provide specific guidance to states regarding the manner in which they should solicit information to complete the questionnaire to reduce any misinterpretation. If standard questions are provided, they can be completed when the client is referred to reduce or minimize any potential negative impact on the home visitor/client relationship.	The legislation identified, but did not provide definitions for the priority populations. Beyond the definitions provided in the form instructions, grantees have discretion in interpreting these categories for reporting purposes.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Section E: Priority Populations Actual Numbers Enrolled Ruing Reporting Period Table E.23: "Have or have a child/children with low student achievement" – this information is particularly challenging to capture in valid or reliable manner. Additionally, there is such a degree of subjectivity to defining low student achievement; it may be difficult to provide accurate information for this required information	
4/16/2012	Tom Hinds (WI) Home Visiting Performance Planner [Thomas.hinds@wisconsin.gov]	<u>Table E, Legislatively Identified Priority Populations</u> Based on the broad categories in the SIR, we had a sub-committee of our Home Visiting Evaluation and Program Improvement Work Group come up with more specific definitions (although broader for low income) to help home visitors identify these risk factors. You recommend possible flexibility regarding identification of low income--is there some flexibility for other categories as well? If so, we recommend stating this in the form instructions.	
4/13/2012	Tom Jenkins (CO)	In its current format, Form 1 does not define several key terms used to solicit	

	Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org]	demographic information. For example, terms contained in Table E, such as "low income," "low student achievement," and "interactions with child welfare services," do not have standard definitions, and thus are subject to inconsistent interpretations that may undermine the reliability of the information collected. We therefore recommend that these terms be defined with enough specificity to provide clear guidance to states regarding the information collected.	
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Section E: Priority Populations Actual Numbers Enrolled Ruing Reporting Period Table E.18 is currently stated "Have low incomes" and should be changed to "have low income"	We made this change.
4/16/2012	Kristen Rogers, PhD (CA) CA Home Visiting Program Branch CA Department of Public Health Maternal, Child & Adolescent Health Division [Kristen.Rogers@cdph.ca.gov]	Table E – Legislatively Identified Priority Populations #20-22 – History of child abuse/neglect; history of substance abuse; tobacco users in home. The instructions for this section specify counting enrollees, when the original legislation identified priority populations as families with tobacco use. Do you want to change "enrollees" to "families"?	The Supplemental Information Request further clarified priority populations to include enrollees.
3/29	Barbara Markiewicz (FL) The Lawton and Rhea Chiles Center for Healthy Mothers and Babies University of South Florida bmarkiew@health.usf.edu	**Specific Concerns – Table. D.1 DEMOGRAPHICS** • Many of the new proposed demographics rely on self-report from the primary client about past events: her performance in school, her previous experience with maltreatment and with the child welfare system, her prior learning disabilities. Unless there is a very important reason to collect these data, which have a high likelihood of inaccuracy, we should not collect them.	The purpose of the data collection in this section is to determine if the MIECHV program is enrolling the priority populations specified in H.R. 3590-220. In table E, items 17-24 enter the count of enrollees who were newly enrolled during the reporting period and meet each eligibility priority category as identified in the grantee's determination for eligibility, through the intake process, or through ongoing contact.
4/5/2012	Cynthia Suire, DNP, MSN, RN MIECHV Program Manager Louisiana DHH-OPH-MCH [Cynthia.Suire@LA.GOV]	Overall comments: Since the model does not collect much of this information, will the model (s) need to give concurrence to extra state data collection to capture these data points (as occurred with the benchmark plans)? See below for specific challenges for capturing these constructs. This data is not collected by model at the present time and the model has not made a decision as to whether they will add this to their repertoire of data collection and reporting. Thus, this would have to be collected by state with an additional data	Grantees are required to provide assurances that priority will be given to serve eligible participants who fall into the priority populations. The legislation identified, but did not provide definitions for the priority populations. Beyond the definitions provided in the form instructions, grantees have discretion

		collection system-a cost and burden not anticipated. Have a history of child abuse or neglect or have had interactions with child welfare services. Have a history of substance abuse or need substance abuse treatment. The "history" is not presently collected in model and the model has not made a decision as to whether they will add to collection. Are users of tobacco products in the home. Use of tobacco products by other than the enrollee is not presently asked via the model data collection efforts and will need to be added. The model has not made a decision as to whether they will add to collection. Have or have a child/children with low student achievement. The presence (or perception) of low student achievement for the enrollee is not being captured via the model's present data collection system and the model has not made a decision as to whether this collection will be added. Has a child/ have children with developmental delays or disabilities. An enrollee having a child with developmental delays or disabilities is not being captured and will need a new data collection procedure. Are in families that include individuals who are serving or formerly served in the Armed forces, including such families that have members of the armed Forces who have had multiple deployments outside of the United States. This construct is not captured by model data collection efforts and will constitute new data collection procedures and systems, again adding to burden/costs that were not anticipated. Please further define the family relationship that needs to occur for an enrollee to be counted as "Are in families that include individuals who are serving or formerly served in the Armed forces", particularly if enrollees are entered into program in pregnancy.	in interpreting these categories for reporting purposes. The instructions describe the legislative mandate for reporting of enrollment of special populations and populations of high risk. It is independent of models. This data would primarily be collected at the time of enrollment or intake process. It suffices for grantees to ascertain if enrollees and index children meet the criteria for the different priority population categories, although it is permissible to include other household members if information is available.

Table F: Service Utilization Across all Models

Comment Date	Commenter	Comments	Response
Table F: Family Retention Across all Models			
Currently Receiving Services			
3/29	Angela Ward (UT) Office of Home Visiting Utah Department of Health award@utah.gov	Section F (Table F) asks for service utilization across all models. There needs to be a clear operational definition for family retention. The first category "currently receiving services" is fairly straightforward, however, "successfully completed program" needs a clear definition. This is needed since the time length of enrollment specified by HFA (up to 5 years) and NFP (2 years) will create reporting challenges. Specifically, if all HFA participants were retained in the program, in order to consider them "successfully completing" they would not finish with the program until 2 or more years (depending on enrollment) after the first 3-year benchmark cycle is complete. Another challenge reporting these criteria in this format has to do with reporting across different models. Each model may have varying standards for the percentage of visits completed that should be considered. Additionally, a related issue has to do with model specific standards for frequency of visits. For example, NFP has established a goal for visits during pregnancy at 80% of expected visits. If the implementing agency does not achieve the 80% completion rate for visits during this phase of services, yet the clients are retained in the program for 2 years - - would this be considered "successfully completing" the program? We think there needs to be a performance standard linked to a clear definition for this section.	We eliminated the term "successfully" from the table. We revised the categories to include "currently receiving services," "completed program", "stopped services before completion" and "other."
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Section F: Service Utilization Across all Models Table F.26: Family Retention Across All Models – In many cases there is no definition of "successfully completed program." For example, there is no minimum length of program participation for either the Early head Start or Parents as Teachers models. There is no minimum number of home visits, duration of participation, or achievement of specific outcomes that indicate successful completion of either the Early Head Start or Parents as Teachers programs. Please provide further instruction on this element or remove it from Table F	
Successfully Completed Program			

3/12/2012	CT Dept of Public Health- Margie Hudson, Carol Stone Jennifer Morin, Mary Emerling MIECHV Team Margie.Hudson@po.state.ct.us	**Table F-** **Family Retention Across All Models** - Please define success.	We eliminated the term "successfully" from the table.
Terminated Services			
4/16/2012	Kristen Rogers, PhD (CA) CA Home Visiting Program Branch CA Department of Public Health Maternal, Child & Adolescent Health Division [Kristen.Rogers@cdph.ca.gov]	Table F – Service Utilization/Family Retention, Across All Models Terminated cases may differ greatly in length of service. Is it helpful to lump them together? For example, an HFA client who feels that she has benefitted enough from the program and drops out after 2 or 2 ½ years (when the model calls for 3 years) will be lumped together with a client who drops out after being visited only once	We revised the categories to include "currently receiving services," "completed program", "stopped services before completion" and "other." Models may use their discretion in determining program completion.
Other			
4/13/2012	Tom Jenkins (CO) Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org]	Section F: Based on the guidance, it appears that the expectation is: - Number of clients enrolled and receiving services this year - Number of clients enrolled in this calendar year to successfully complete the program - Numbers of clients enrolled in this calendar year and have terminated for any reason	The reporting period for the MIECHV grants, for purposes of this data collection, coincide with the project period indicated in the Notice of Award. Total number of clients includes those newly enrolled during the reporting period and those enrolled in previous years who are still actively participating in the program at the beginning of the reporting period.

Table G: Comments and Other

Comment Date	Commenter	Comments	Response
Table G: Comments			
3/12/2012	CT Dept of Public Health- Margie Hudson, Carol Stone Jennifer Morin, Mary Emerling MIECHV Team Margie.Hudson@po.state.ct.us	Instructions- **On page 7 last paragraph- second sentence-** • "who have been enrolled in the program while pregnant – **please add**- ***at any time***- during the reporting period."	We added the phrase "at any time" where requested.
3/21/2012	Yvonne Goldsmith (AK) yvonne.goldsmith@alaska.gov Unit Manager AK Dept. of Health & Social Services | MCH-Epidemiology	I estimate the following amount of time will be required, on an annual basis, to fill out: Form 1 – 150 hours	The estimation of data collection burden for respondents is based on the additional effort involved in data collection (e.g., at the local implementing agency), data entry and transfer (e.g., to state program), analysis, and uploading into DGIS required of grantees. Data collection activities that are part of the home visiting model or program requirements are excluded from the calculation. Of the two parties who commented on the reporting burden for the proposed HV form 1, one estimated the burden would be 150 hours annually per respondent
4/5/2012	Cynthia Suire, DNP, MSN, RN MIECHV Program Manager Louisiana DHH-OPH-MCH [Cynthia.Suire@LA.GOV]	Overall, the burden, 731 hours, for Form 1 seems underestimated. Louisiana estimates 5418 hours of additional burden for this particular form, as data collection, reporting and analysis processes will need to be instituted, as model (s) does not collect or report on this particular data. Other questions/comments are included below.	

			and the other estimated it at 5418 hours. The estimate we put forth in the FRN for this form fell within these values, i.e., 731 hours annually per respondent. In light of the uncertainty involved in estimating with accuracy the collection burden of these activities separately from other existing programmatic data collection requirements, we will reassess the burden estimate once actual data collection is underway (e.g., after two years of experience since the burden is likely to be higher during the first year).
4/5/2012	Cynthia Suire, DNP, MSN, RN MIECHV Program Manager Louisiana DHH-OPH-MCH [Cynthia.Suire@LA.GOV]	Introduction Please provide example of "reporting period" since the dates will vary from grantee to grantee.	The reporting period for the MIECHV grants, for purposes of this data collection, coincide with the project period indicated in the Notice of Award.
4/13/2012	Tom Jenkins (CO) Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org]	HRSA should define demographic terms and provide states with uniform questions regarding demographic information to ensure the reliability of information and minimize burden or models. In addition, Form 1 leaves the manner in which states solicit demographic information to each state and territory. Each state therefore has discretion regarding how they pose questions to participants to ascertain their demographic characteristics. As a consequence, it is likely that 47 states will ask participating families the requested information in 47 different ways to solicit the same information.	Demographic terms likely to be subject to differing interpretations have been defined to the extent practical in the instructions to the form.

		Allowing states to seek this information in different and varied ways may undermine the reliability of the information because questions asked in different ways yield different answers. For example, a question asked of a family in one manner in New York and another manner in Colorado may yield different results based solely on the manner in which the question was asked. For these reasons, we recommend that you provide states with uniform questions with which to solicit demographic information.	
4/13/2012	Tom Jenkins (CO) Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org]	**HRSA Should Clarify How Clients will be Counted** Form 1 does not clarify how children and families enrolled in home visiting models will be accounted for over time. For example, will the count restart every year in order for a family to be considered unduplicated for more than one-year? In Nurse-Family Partnership's model, an NFP client enrollee will participate for up to three calendar years with an index child for up to two years. In this instance, it is not clear whether the client/index child and family would be considered unduplicated only once or each year.	We added language to the instructions to clarify the term "unduplicated". Specifically, the count of families or enrollees continuously participating from one reporting period to another restarts for each reporting period.
4/13/2012	Tom Jenkins (CO) Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org]	**Estimates of Burden for Form 1 Fail to Take into Consideration the Burden on the Implementing Agency and Models** We believe that the burden estimate of 731 hours per response may be appropriate for the states; however, the estimates do not account for the significant time that individual agencies administering the program must devote to collecting, compiling and submitting the requested information to the state. We believe that the burden to implementing agencies and home visitors who must solicit the information directly from the families may exceed 731 hours per response per family. This burden is compounded by the fact that many states have not yet implemented data systems necessary to easily collect this type of information, making it likely that this information will be collected manually by pen and paper. We therefore recommend that you minimize the burden by clarifying and streamlining the requested information with uniform questions.	The estimation of data collection burden for respondents is based on the additional effort involved in data collection (e.g., at the local implementing agency), data entry and transfer (e.g., to state program), analysis, and uploading into DGIS required of grantees. Data collection activities that are part of the home visiting model or program requirements are excluded from the calculation. We added language to the instructions in response to specific comments to clarify terms. We also simplified in

			some instances the information requested to minimize burden.
4/13/2012	Tom Jenkins (CO) Nurse-Family Partnership, National Service Office [Tom.Jenkins@nursefamilypartnership.org]	Nurse-Family Partnership appreciates the significant work and progress that you have made to implement the MIECHV Program in a short time frame. We are also grateful for the collaborative approach you have taken to engage and solicit advice from the model developers. We look forward to continued dialogue regarding the data collection and other important aspects of the implementation of this important program.	Thank you.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare- MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Instructions for Completion of Home Visiting Form needs clarification on how to generate unduplicated counts, further definition needed between enrollees, caregivers, and families, and when during the reporting year the data should be extracted to populate all elements on Form 1	We agree and clarified the instructions, revised the categories to be mutually exclusive, and specified that data needs to be collected at the time of intake and annually thereafter.
4/16/2012	Laura DeBoer, MPH Idaho Department of Health and Welfare MCH Program MIECHVP [DeboerL@dhw.idaho.gov]	Unduplicated Count Of Enrollees by Type and by Primary Insurance Status, in the "Instructions for Completion of Home Visiting Form 1" – it states "The <u>enrollees'</u> include the *person or persons* who signed up to participate in the home visiting program. The category can include more than one member of the household if more than one individual are enrolled in the program or if the program collects data on them."	We clarified the instructions and revised the categories to be mutually exclusive.
4/16/2012	Kristen Rogers, PhD (CA) CA Home Visiting Program Branch CA Department of Public Health Maternal, Child & Adolescent Health Division [Kristen.Rogers@cdph.ca.gov]	<u>Overall Comment</u> It might be helpful to include both number and percentage in tables that report on current clients. For example, the number of clients insured (Table A.2) or number of clients employed (Table C.2) is not nearly as informative as the percentage would be. Of course, the percentage could be calculated using the number served (Table A.1) However, including the percentages in the tables might make the reporting both more accurate and better understood by the reporters	The forms are for data collection only and do not include the types of analysis that will be conducted. To minimize burden, we have not added calculations to the table.
4/16/2012	Tom Hinds (WI) Home Visiting Performance Planner [Thomas.hinds@wisconsin.gov]	<u>Additional Comments</u> Although we understand the process for finalizing federal reporting forms is time consuming, we hope that this form is finalized as soon as possible, so we can make the adjustments necessary to our data system and home visiting practices required to complete it. Some of our sites have been serving families under the MIECHV grants since last July and really want to know what they have to report, so they can	We understand and are following the procedures in the Paperwork Reduction Act of 1995, Pub. L. 104-13 to complete the forms as

		finalize their data collection procedures and focus even more of their energy on using their data and serving families. We have made many adjustments to our data system and home visiting practices to align with our approved federal benchmark data collection plan, and we want to avoid as much as possible asking sites to report on some topic one way, then later asking them to report information differently. Given the expectation communicated to us that the Demographic and Service Utilization form will not be finalized until the fall, we will, as instructed, continue to prioritize our time, money and efforts to aligning our data collection practices with our federally approved benchmark plan, and then will make the adjustments needed to report on this form. We expect that our first year report for this form will reflect some missing information, but that completeness will improve over time. In the future, we think it would also be helpful for the Benchmark TA providers to work with the developers of the demographic/service utilization form, particularly if there are overlapping constructs that one group wants measured in a certain way. This would reduce the current confusion and burden around categories such as education and employment, for example.	expeditiously as possible. Forms 1 and 2 were considered in the context of the benchmark requirements.