Home Visiting Form 2

60-day *Federal Register* Notice Public Comments

Comment Date	Commenter	Comment	Response
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 2 - 70 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 the Discretionary Grant Information System (DGIS) required of grantees. Data collection activities that are part of home visiting model or program requirements are excluded from the calculation. Of the two parties who commented on the reporting burden for this proposed data collection form, one estimated the burden would be 70 hours annually per respondent and the other estimated it at 774 hours. The estimate we put forth in the FRN for this form fell within these values, i.e., 313 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]	The burden estimate is underestimated, as each construct will need several hours of completion of the forms, analysis and reporting. In addition, there will need to be state established data collection processes instituted for those constructs not collected within model (i.e. Benchmark 6). MIECHV state staff and the state's Department of Children and Family Services will use man hours for requesting, compiling and exchange data regarding child maltreatment data. Louisiana estimate is closer to 774 annual 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 home visiting model or program requirements are excluded from the calculation. Of the two parties who commented on the reporting burden for this form, one estimated the burden would be 70 hours annually per respondent and the other estimated it at 774 hours. The estimate we put forth in the FRN for this form fell within

		rather than the 313 hours cited in the federal register.	these values, i.e., 313 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).
3/12/2012	CT Dept of Public Health- Margie Hudson, Carol Stone Jennifer Morin, Mary Emerling MIECHV Team margie.hudson@ct.gov	Request that the Grantee be allowed to make revisions in their Benchmark document to add columns for additional information not already captured in the document. Connecticut's Benchmark document already includes most of the information requested, with the exception of the data. It would be unnecessarily burdensome to complete a separate page for each construct which would be 35 separate pages.	The proposed data collection form is distinct from the Benchmark Plan developed by the grantee. Grantees may revise their benchmark plans as needed based on discussions with their Regional Project Officer. The proposed form is designed to collect information electronically into the DGIS for the duration of the MIECHV program for data aggregation, reporting and other accountability purposes at the federal level. The DGIS will have the capability to automatically populate fields that remain unchanged from year to year (e.g., name and type of performance measure) or to provide a "drop down menu" when the number of choices is discrete (e.g., tools utilized) [NOTE: need to clarify the distinction between benchmark plan and DGIS in 30-day FRN; may want to add language in form instructions]
April 16	Laura DeBoer, MPH Idaho Department of Health and Welfare Maternal and Child Health Program Maternal, Infant, and Early Childhood Home Visiting Program [DeboerL@dhw.idaho.gov]	**Benchmark Area:** There is no space to indicate the Benchmark Area such as Maternal and Infant Health or Economic Self-Sufficiency, which is important given the insurance status, is listed in both benchmark areas.	We concur and added a line to specify the benchmark area in the first section of the proposed form.
3/12/2012	CT Dept of Public Health- Margie Hudson, Carol Stone Jennifer Morin, Mary Emerling MIECHV Team margie.hudson@ct.gov	Request that the Data Collection Plan- OTHER be reported overall or for all measures, i.e. across programs or by model rather than per construct. Data Collection – OTHER- by construct could present a significant reporting burden.	The process of data collection may vary by construct (e.g., parties involved, frequency of collection, etc.) and therefore cannot be reported for all measures. For those instances in which the data collection process is the same from year to year, we will design the DGIS to automatically pre-populate this field from prior periods. We added language to the instructions to clarify the purpose of this

			section. Grantees could utilize the "Other" field to report any changes from one year to another.
April 16	Laura DeBoer, MPH Idaho Department of Health and Welfare Maternal and Child Health Program Maternal, Infant, and Early Childhood Home Visiting Program [DeboerL@dhw.idaho.gov]	**Data Collection Plan – Other:** It may be clearer to rename this "How" or equivalent given the instructions "How the data will be collected…and reported…"	We added language to the instructions to clarify the purpose of this section.
3/12/2012	CT Dept of Public Health- Margie Hudson, Carol Stone Jennifer Morin, Mary Emerling MIECHV Team Margie.Hudson@po.state.ct.us	Please - Remove/omit/delete – Rationale For The Measure. The Measures are required.	Selection of a performance measure per construct is required. The measure can be selected by the grantee, therefore the rationale for selection is informative. Grantees have discretion in selecting from a variety of possible indicators that capture the given construct in accordance with individual grantee's goals and constraints.
April 16	Laura DeBoer, MPH Idaho Department of Health and Welfare Maternal and Child Health Program Maternal, Infant, and Early Childhood Home Visiting Program [DeboerL@dhw.idaho.gov]	**Rationale for the Measures**: It is unclear why this element is necessary for the Performance Measures, as the justification for all the measures were approved with the grantee benchmarks plans.	Grantees have not universally provided the rationale for indicator selection in their measurement plans. Also, the proposed form is designed to collect information electronically into the DGIS for the duration of the MIECHV program for data aggregation, reporting and other accountability purposes at the federal level, and is distinct from the approved benchmark plans. We will design the DGIS to pre-populate this field from prior periods since the rationale for an indicator is not likely to change from year to year.
April 13	Thomas R. Jenkins, Jr. President & CEO Nurse-Family Partnership Tom.Jenkins@nursefamilypartnership.org	HRSA should define how states detect improvements in benchmark areas. Draft Form 2 is intended to demonstrate improvements by state in benchmark areas; however, the form does not appear to include baseline information from which a state can assess improvements in the benchmarks. We recommend that the form be revised to include baseline information and to specify how states assess progress toward the benchmark areas. We recommend that the following questions be addressed:	Grantees will collect baseline information as specified in their approved benchmark plans, which includes specification of baseline and comparison periods under their definition of improvement. We have added language to clarify the concepts of baseline and comparison periods in the proposed form instructions under the "Definition of Improvement" section. ○ Grantees have already identified baseline period data and how to track progress of participating families in their approved benchmark plans. ○ Grantees have also identified in their benchmark plans their data collection plans, including frequency of collection by the state or

		o How will states identify baseline data and track progress of participating families in the benchmarks? o How often will data be collected on the benchmarks? o Will any of the data be used for the national evaluation of the MIECHV Program? If so, how?	territorial program. ○ The proposed form is designed to collect information on performance indicators and is not part of the MIHOPE national evaluation.
April 16	Laura DeBoer, MPH Idaho Department of Health and Welfare Maternal and Child Health Program Maternal, Infant, and Early Childhood Home Visiting Program [DeboerL@dhw.idaho.gov]	**Form 2: Grantee Performance Measures** 1. **Relevant Construct**: Is this the same as the "Construct" listed as the first definition in the instructions page? Please clarify and ensure consistency between the form and the form instructions.	We removed the word "Relevant" and made the titles in the proposed form sections consistent with those of the instructions.
April 16	Laura DeBoer, MPH Idaho Department of Health and Welfare Maternal and Child Health Program Maternal, Infant, and Early Childhood Home Visiting Program [DeboerL@dhw.idaho.gov]	**Value for Annual Reporting Year – Data (N**): Please be clearer in the instructions, as stated it is not clear how the N for each construct is to be calculated.	The "n" is the count of the number of individuals who provided data for a given indicator value calculation. We added clarifying language to the instructions and distinguished n1 (number of program participants involved in creating the value of the performance measure for the baseline period) from n2 (number of program participants involved in creating the value of the measure for the comparison period.)
April 16	Laura DeBoer, MPH Idaho Department of Health and Welfare Maternal and Child Health Program Maternal, Infant, and Early Childhood Home Visiting Program [DeboerL@dhw.idaho.gov]	**Data Considerations**: Grantees may need more space (# allowed characters) in the data considerations than currently appear on the draft form 2.	We will ensure that the DGIS allows adequate space for narrative (i.e., number of characters) in this section.
April 16	Laura DeBoer, MPH Idaho Department of Health and Welfare Maternal and Child Health Program Maternal, Infant, and Early Childhood Home Visiting Program [DeboerL@dhw.idaho.gov]	**Data Considerations Three-Year Improvement (Yes/No):** Please provide further clarification that there should be no response to this is element until the third reporting year.	We added language to the instructions specifying the purpose of this item. Also, the function to provide this information will be disabled in DGIS until the third year, when improvement should be reported.

April 16	Laura DeBoer, MPH Idaho Department of Health and Welfare Maternal and Child Health Program Maternal, Infant, and Early Childhood Home Visiting Program [DeboerL@dhw.idaho.gov]	**General Comment:** Will this form only be relevant through reporting year 3 or will states continue to complete this form through reporting years 4 and 5?	We expect that this proposed form will be utilized throughout the 5-year period defined in legislation. OMB grants approval for a three-year period which can be renewed.