60-day *Federal Register* Notice Public Comments

Comment Date	Commenter	Comment	Response
June 30, 2014	Noel Mathis, Montana Director of Public Health Services Jefferson County	Jefferson County, Montana is the "COUNTY" where I serve as the Director of Public Health Services. It has a land area of 1,658.9 square miles with a population of 11,406 as of the 2010 Census. Jefferson County has a larger land area then the State of Rhode Island and a population of 1.8 percent of the State of Rhode Island(Rhode Island's population in 2010 was 1,052,567). The population of my county is 11, 406 as of the 2010 Census. I have 1 Registered Nurse that provides School Nurse functions for six of the seven schools in the county. One other Registered Nurse and I provide ALL OTHER Public Health Services for the entire county. We have no hospitals in our county, one medical clinic that operates Monday through Friday from 8:00 AM till 5:00 Pm and one medical clinic that operates 2 days a week from 8:00 AM till 5:00 PM. Grant funds are distributed based on census. The more people the more money. Small populations have to make do with less grant funding. Large land areas with small populations require more time per client service than areas with a larger population ratio. It takes about 1 hour 30 minutes to drive from one end of the count to the other (3 hours round trip). How do you realistically expect Rural/Frontier Counties to pay to conduct a Health Needs assessment every 5 years. I believe there should be some form of compensating there less populated area for these studies beyond a population based approach.	

July 1, 2014	Barbara Howe- New Mexico Public Health Division - Dept of Health	The New Mexico Public Health Division appreciates the opportunity to help shape the future of the Maternal Child Health Block Grant. We fully support the AMCHP recommendations along with the following caveats. 1) Six Core Focus Areas – One could easily use all of its resources in one of the focus areas. Given that, please consider the states selecting from a listing of indicators within each of the core areas, with a minimum of three for each year, with those same three being targeted for the 5 year cycle. 2) Reporting Requirements – Significantly reducing the requirements is strongly encouraged. Consider HRSA staff compiling the related data and sending to the states. This would help assure better trend data and higher quality reporting. 3) Formatting Changes – This is so much repetition within the "Last Year's Accomplishments/Current Activities/Plans for The Year" sections. The only relevant actionable part is "Plans for the Coming Year", so please consider eliminating the other two areas entirely. 4) Working Upstream - Consider some process indicators for states that would support the Public Health System Capacity Services section of the pyramid. Perhaps there needs to be one policy indicator chosen within each of the core focus areas. HRSA needs to help support states to work on policy issues by making it mandatory in the Block Grant work. MCH Staff can benefit from working within their organizational	

		power/capacity to change systems for health improvement. 5) Mandated Partners? – If we accept that healthy choices are made where we work, learn and play, then Departments of Health need to be collaborating with Public Education Departments and Transportation Departments. 6) Involve Youth – In those indicators that affect youth, it seems good for everyone to have youth lead those initiatives that affect them. Consider advocating for this within the new MCHBG. 7) Overall Length – The annual application/report is too lengthy. Staff resources for both HRSA and the States could be better spent on programmatic work. Please consider limiting the entire document to less than 50 pages.	
July 24, 2014	Donna Yadrich- Member, Family Advisory Council, Kansas Health Services, Bureau of Family Health, Department of Health and Environment Family Delegate, ROI Learning Collaborative Member, Family & Youth Leadership Committee Member, Family Scholar (2012-13), and Family Scholar Applicant Reviewer, AMCHP Stakeholder, Missouri Family to Family Life Course Network Family Representative, National MCH Workforce Development Center Advisory Committee	Thank you for the opportunity to provide public input. Family Leaders in Kansas would appreciate consideration of three items and revision of the definition originally submitted: **#1 Adoption of the Recommended Revision of the Family/Professional Partnership definition** Our Kansas Title V CYSHCN Director allowed their Family Advisory Council (FAC) to review the Family/Professional definition submitted for inclusion in this federal register notice's supporting documents. The definition is copied below with bold typeface marking the requested edits. Family Advisory Council (10 family leaders) in KS, felt strongly that minimal yet important changes to the definition were needed and recommended the following: *"Family/Professional Partnership is the intentional practice of working together for the ultimate goal of positive outcomes in all areas throughout the life course. It is a*	

		*collaborative and respectful partnership, where all members are given the opportunity to share **their** information, preferences and values and share responsibility in **planning for and achieving** optimal outcomes. Family partnership reflects a core value and commitment to family leadership at **the individual, community and policy levels.**"* **#2 Consideration of our position at all levels of MCH work** The group felt strongly that the definition misrepresented the shared responsibility of both partners. They felt that the way it was written indicated that all parties share equal responsibility for obtaining optimal outcomes. In reality, this is not the case. Regardless of the public health, medical, or MCH partner adopting this definition, there may be shared responsibility in deciding the best course, however the actual responsibility for "making it happen" falls on the family. Many of the families felt that addressing the shared responsibility in helping to **achieve** outcomes would assist in showing that families want to partner throughout their journey, not only in the planning stages. They want a partner that will be by their side, working WITH them throughout each stage of the life course and each road bump, and helping them make decisions and take action to support a shared goal. **#3 Acknowledgement of the Kansas Title V open and supportive environment for family leadership expression, collaboration and development, especially our CYSCHN director:** **Heather Smith, MPH** Director, Special Health Services Kansas Department of Health and Environment 1000 SW Jackson, Suite 220 Topeka, KS 66612-	

		1274 Direct: 785-296-4747 / Fax: 785-296-8616 hsmith@kdheks.gov Thank you for your consideration of the input from KS families and please do let me know if any clarification is needed, or how I may help further with your work.	
August 9, 2014	Amber Norris Williams Executive Director Safe States Alliance Atlanta, GA	First, we would like to commend HRSA for including national performance measures and health status/outcome measures related to childhood injury including safe sleep (#4), child safety/injury (#6) and bullying (#8). As you well know, injuries are the leading cause of death for children in the United States. Given that there is no federal injury and violence prevention program, and the risk and protective factors for childhood injuries cross many disciplines, it is imperative that maternal and child health programs continue to provide leadership as well as support state injury and violence prevention partners. While we appreciate HRSA's desire to provide greater flexibility and accountability among state MCH programs, we believe injury related national performance measures should be required for all states.	
August 6, 2014	Christine Wood Executive Director Association of State and Territorial Dental Directors	The Association of State and Territorial Dental Directors (ASTDD) would like to express support for the Title V National Performance Priority Areas that include children's oral health. In this letter, we submit comments on two Title V National Measures that are related to children's oral health. • Percent of children, *ages 1 to 6 years,*	

		who have decayed teeth or cavities in the past 12 months (National Health Status/Outcome Measure #14) • Percent of infants and children, ages *1 to 6 years*, who had a preventive dental visit in the last year (National Performance Measure #12B) Recognizing the pivotal role of the National Health Status/Outcome and Performance Measures that will guide states in MCH needs assessment, development of strategies and activities and monitoring the impact of MCH programs, we suggest the measures change to **include all children age 1 to 17,** as follow. • Percent of children, ***ages 1 to 17 years,*** who have decayed teeth or cavities in the past 12 months (National Health Status/Outcome Measure #14) • Percent of infants and children, ages ***1 to 17 years***, who had a preventive dental visit in the last year (National Performance Measure #12B) Many school age children, still need continuous and coordinated public health attention to reduce the burden of dental decay. As recent national and state oral health surveillance findings consistently report, a significant proportion of children of all ages, particularly children living in poverty and minorities, are still unable to obtain needed preventive and restorative dental care. Due to the complexity and unaffordability of a pediatric dental coverage option for low-income families, many children are expected to be left dentally under- or un-insured even in the era of the Affordable Care Act.	

		Inclusion of children aged 1 to 17, in the MCH National Performance Measures, should encourage states to identify the oral health gaps/needs of this age group and continue their efforts to ensure all children's optimal oral health through evidence-based oral health intervention programs. Further, these proposed changes are relevant to one of the Healthy People 2020 Leading Health Indicators (LHIs): OH-7. Increase the proportion of children, adolescents, and adults who used the oral health care system in the past 12 months. The recent revision of the AMCHP Lifecouse Metrics, National Oral Health Surveillance System and Chronic Disease Indicators all highlighted the oral health needs of children 1-17 years of age. ASTDD would again like to thank the HRSA Maternal and Child Health Bureau and representatives from the Association of Maternal and Child Health Programs (AMCHP) for inclusion of oral health measures in Title V and for the opportunity to comment on the proposed measures under consideration.	
August 12, 2014	Mary Frances Kornak, MPH Title V Program Coordinator DC Department of Health	I believe these will increase the quality, utility, and clarity of the information to be collected. p. 13 Where are the 6 population health domains listed; they are talked about in the Executive Summary. Please repeat them and/or refer to the table they are in. p. 17 Logic model Is this the only format to be used for the logic model or can you submit a logic model using the format we wish? Pleases state clearly. p. 29 State Action Plan Will this be required in the 2015 application along with the Needs	

		Assessment since the needs assessment is being done in 2014. Or will this apply for future needs assessments covered under this guidance. Thank you for accepting my comments.	
August 14, 2014	Rachel de Long, M.D., M.P.H. Director, Division of Family Health/Title V Program New York State Department of Health	See attached letter.	
August 14, 2014	Julie Ellingson, RDH Oral Health Coordinator, SD Department of Health	I really like the new performance measures for dental health! Thank you – it is so important to address the issues earlier as these measures indicate! Mom's, when pregnant, are especially aware and supportive of efforts to improve health outcomes both for themselves and their children. And prevention is the key when tackling dental concerns – by having infants/children seen for early intervention and care is so very important.	
August 15, 2014	SANDY PERKINS, MS, RD/LD Association of State Public Health Nutritionists	See attached letter.	
August 20, 2014	Children's Dental Health Project Meg Booth Director of Policy	See attached letter.	
August 22, 2014	Lauren Agoratus Family Voices NJ	See attached letter.	
August 24, 2014	Lauri Kalanges, MD MPH Deputy Director, Office of Family Health Services Virginia Department of Health Richmond, VA	See attached letter.	
August 25, 2014	Kris Spain, MS,RD,LD, Chief	See attached letter.	

	Bureau of Clinical and Preventive Services Boise, Idaho		
August 25, 2014	Nurit Fischler, MS MCH Policy Lead and Title V Coordinator Maternal and Child Health Section Center for Prevention and Health Promotion Oregon Health Authority	See attached letter.	
August 25, 2014	Stephanie Birch RNC, MPH, MS, FNP MCH Title V Director Division of Public Health Department of Health and Social Services Anchorage, Alaska	See attached letter.	
August 25, 2014	Sally Fogerty Deputy Director, Center for Study & Prevention of Injury, Violence & Suicide Director, Children's Safety Network Education Development Center (EDC) Waltham, MA	See attached letter.	
August 25, 2014	Ann Buss 2204 Alpine Drive Helena, MT 59601	Thank you for the opportunity to offer my comments on the proposed rule changes to the Title V Maternal and Child Health Services Block Grant to States Program. As taken from the FRN, it is my understanding that the rule changes are designed to reach the aims of the MCH Block Grant to States Program transformation which are threefold: (1) Reduce burden to states, (2) maintain state flexibility, and (3) improve accountability. I appreciate that the data information for the National Performance Measures (NPM) will be prepoulated by HRSA/MCHB as that will decrease the reporting burden currently felt by the states. I did not read in the guidance as to a timeline when states could expect the data from HRSA/MCHB. It is essential for states to receive	

		this information prior to developing their activities/strategies. When can a timeline for the data be developed and shared with the states? I am concerned that for some states, the HRSA/MCHB data source will be too outdated for practical use, i.e. PRAMS data. In looking at the number of states with and without PRAMS, it is apparent that not all states will have PRAMS data. Go to: http://www.cdc.gov/prams/ HRSA/MCHB and several other partners recently hosted CoINN meetings for all states, with the goal for each state to develop action plans to reduce their infant mortality rates. One evidence based approach is to place an infant on their backs to sleep, which is NPM 4--to increase the number of infants placed on their backs. NPM 4 relies on PRAMS data; however, how can states such as California, Montana, North and South Dakota select NPM 4 if there is no current or reliable PRAMS data? PRAMS data is also used for NPM 12 which addresses oral health for women during pregnancy and infants and children ages 1 to 6. The new guidance allows states the flexibility of selecting fewer NPM and developing State Performance Measures (SPM). The guidance requires states to choose five SPM. I would suggest that states be allowed to choose up to five SPM; therefore, reducing the reporting burden on the states during this time of major changes to the MCHBG. I would also suggest that prior to the guidance being finalized, that HRSA/MCHB provide a glossary of terms and clearer reporting instructions. Without these documents, how can it be accurately stated that states will have less of a reporting burden? For example, what is meant	

		by a direct reimbursable MCH healthcare service? Or: what is a non-reimbursable primary and preventive healthcare service? Another area from the guidance that is in need of further explanation, is how will a state report on "level of commitment to consistently engage family and consumer partnerships?" Does this mean that once a year or once a month, the state's Title V agency is to engage families and consumers? And more importantly, what is the expectation for "engaging" the families and consumers? Thank you for your consideration of my comments.	
August 25, 2014	Maria Nardella, MA, RD, CD Manager - Healthy Starts & Transitions (includes CSHCN Program) Office of Healthy Communities Division of Prevention & Community Health Washington State Department of Health	Here are my comments to the draft Title V MCH Guidance: To improve clarity I suggest HRSA/MCHB: • Increase the consistency of the terminology "CYSHCN" throughout the guidance document. For example, NHS/OM 18 and 19 include CSHCN in the title, but youth in the description. Clarifying the terminology will help us determine when age groups are specifically included or left out. To improve inclusion of CYSHCN and demonstrate the diverse needs of this population: • Separate data summaries for CYSHCN in NPM 6, 7, 8, 9, 10, 11 and 12 from non-CYSHCN. • Add "with and without special health care needs" to NPM 5, 7, 8, 9, 11 and 12B. We would like to increase the focus on CYSHCN as they are identified in NPM 13 and 14.	

August 25, 2014	Amy Spieker, MPH MCH Epidemiologist/Wyoming PRAMS Coordinator Wyoming Department of Health Cheyenne, WY 82002	I am excited about the coming changes as they reflect a commitment to accountability and change. My only comments on the process are related to timing. It has been very difficult to prepare for the needs assessment and SSDI applications without knowing the final guidance or national performance measures. As a result, some of the aims of these programs may change as we learn more information. I ask that as new information is released there is acceptance of change in goals or focus from the states as they align their actions with expectations. Overall, I am looking forward to being held accountable for our choices and changing programs and policies to accomplish our goals.	
August 25, 2014	Alisa Sanders, RN, IBCLC President United States Lactation Consultant Association	See attached.	
August 26, 2014	Bob Peck Florida Department of Health Bureau of Family Health Services Maternal and Child Health Section	See attached.	
August 26, 2014	Nan Streeter, MS, RN Utah Department of Health Deputy Director, Division of Family Health and Preparedness Director, Maternal and Child Health Bureau Salt Lake City	See attached	

August 26, 2014	Crystal C. Tetrick Parent Child Health Manager Community Health Services Division Public Health Seattle King County Seattle, WA	Thank you for this opportunity to provide comments on the Title VI MCH Block Grant application. Two main weaknesses were noted. First, was the lack of emphasis on life course theory and Adverse Childhood Experiences research in setting an expectation that grantees develop services and programs based on the life course framework, ACE's and the latest brain development research. The application gives a brief nod to life course theory and the importance of the health trajectory across the life span; however, the performance measures are limited to developmental screening and outcome measures to school readiness. It is suggested that a National Performance Priority Area be created that is focused on reducing ACE's so that it is clear this is a priority of the block grant. Second, the State Action Plan narrative requires a section on Health Care Reform (F.b.4) that states "States should describe the actions taken and the evolving role that state Title V agencies have in supporting health reform efforts...if relevant, states should describe ways in which the Title V MCH Block Grant Program is providing gap-filling health care services to MCH populations." In an earlier part of the application, under Legislative Requirements, Application for Block Grant funds (IV, C), it states that at least 30% of Title V funds must be used for services for CSHCN and "Such services include providing and promoting family-centered, community-based, coordinated care (including care coordination services) for CSHCN and facilitating the development of community-based systems of services for such children and their families". It would be beneficial if there was stronger language about how states need to work with managed care organizations to ensure care coordination for CSHCN as required under the Affordable Care Act. In other words, there needs	

		to be guidance on the interface between the care coordination requirement under the Affordable Care Act, Medicaid as the payor, and the assurance role of Title V.	
August 26, 2014	Marcus Johnson-Miller Bureau of Family Health | Iowa Department of Public Health | Des Moines, Iowa	See attached.	
August 26, 2014	Mary Castro Summers	See attached.	
August 26, 2014	Marilyn Sue Hartzell, M.Ed., Director, OCCYSHN / Oregon Center for Children and Youth with Special Health Needs Institute on Development and Disability (IDD) at OHSU	Thank you for the opportunity to comment upon changes to the Title V Block Grant Guidance and reporting forms. The work to re-vision a MCH 3.0 has provided welcome opportunities for rich and thoughtful discussions on the future of the Title V MCH program. The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN), Oregon's Title V CYSHCN program, works in close partnership with our Oregon Title V MCH program. I echo and support the comments already delivered to you by Cate Wilcox, Oregon Title V MCH Director, regarding reporting burden, total number of performance measures to be addressed within what are essentially dwindling Title V funds (due to level or decreased funding over many years), and issues related to budgeting/fiscal accountability. These are important. I would like to add an additional comment or two on behalf of OCCYSHN that focus on children and youth with special health care needs. Since the inception of Title V, children with special health care needs have represented a significant portion of the effort and funds (30%) assigned to states for the care of, and now the	

		development of effective systems of care. From our reading of the guidance and listening to the presentations it is our understanding that the stated requirement around the 8 national and 5 state performance measures may, technically, allow a state to address no more than 1 single performance measure on behalf of CYSHCN. This is of great concern. This lacks a parallel emphasis for this population commensurate with the allotted funds (30% of the budget) within Title V and does not further the cause to assure that this vulnerable population will receive sufficient time and attention with the states. We applaud the movement in how Family/Consumer Involvement/Partnership is being addressed. We recommend that the guidance be modified to require states present their family/consumer involvement/partnership efforts in a manner that makes explicit the domain(s) they are addressing, recognizing that there could be, and likely would be, an overlap across some domains. It is also important that we stretch harder, and be required to demonstrate our reach to underserved, underrepresented populations of diversity. These could criteria by which we report our ability/success reaching and engaging/partnering with a diverse population. We think this would better serve the larger program and efforts on behalf of our targeted populations.	
August 26, 2014	Barb Dalbec, RN PHN Section Manager, Children & Youth with Special Health Needs MN Department of Health	See attached.	
August 26, 2014	Annette Mente Planner, Family Health Services Division Department of Health State of Hawaii	Thank you for this opportunity to comment on the proposed Title V guidance. Our comments on the draft guidance are presented below.	

		Overall Hawaii appreciates the revisions to the Title V guidance. The new reporting products/format will be of greater value to the state Title V agency and will improve our ability to tell the MCH story: the importance of MCH as a field, Title V program, and how we are making a difference. The guidance supports more systematic planning and creates more accessible reporting products for programs, partners and consumers (Executive Summary, Needs Assessment Summary, a 5-Year Plan), and assures greater accountability for work (structure and process measures). Hawaii also appreciates the reduced number of National Performance Measures.as well as the ability to select from a menu of measures; however, we would like to see the state measures be made optional (allowing states to choose "*up to* five state performance measures") since the state priorities identified in the needs assessment often overlap with national measures/issues. When the state priority overlaps with a national priority, the State Title V agency must then select a separate but related state measure that results in duplicative reporting since both measures address the same health issue. Moreover, Hawaii is a small state yet must shoulder the reporting requirements as larger states with greater resources. The reporting burden should show more flexibility given the range of resources and size of states. We also look forward to getting clearer definitions/examples for many of the new reporting items/categories including: • Forms for Budget and Expenditures by Type of Service including definitions for: o Direct Reimbursable MCH	

		Healthcare Services o Non-reimbursable Primary and Preventive Healthcare Services o Public Health Services and Systems for MCH Populations o Types of Individuals Served • Reporting Instructions / Number of Individuals Served Under Title V • Structural and performance measures, examples will be useful • State Action Plan Key Strategies / Activities. It would be helpful to include examples of strategies, particularly evidence based or evidence informed strategies. Also given the large number of continuing and new Health Status/Outcome Measures to be reported, we are relieved to hear most of the data will be pre-populated by the Bureau. What is the expected timeline for MCHB to make the data available to states and which data items will be pre-populated. Could the Guidance also describe the relationship between how the Health Status/Outcome Measures relate back to the NPMs and to the six population domains? The correlations can be included in the detail sheets or in a comprehensive data system diagram/table. Lastly we are concerned about whether the Three Page Executive Summary will be of sufficient length to capture the "major accomplishments and significant challenges" for the state's performance on each of the measures under the new framework. Thank you again for this opportunity to comment and we look forward to receiving additional information, definitions and examples to help clarify some of the new reporting concepts	

		proposed in this transformation of MCH and the Title V Block Grant.	
August 26, 2014	Tammy Sajak The Texas Department of State Health Services, Office of Title V and Family Health (OTVFH)	See attached.	
August 26, 2014	Linda Hale, RN BSN EMT WI Title V MCH Director Chief, Family Health Section Bureau of Community Health Promotion Division of Public Health WI Department of Health Services	See attached.	
August 26, 2014	Lowest Jefferson, REHS/RS, MS, Maternal and Child Environmental Health Consultant Washington State Department of Health - Prevention and Community Health Office of Healthy Communities - Access, Systems & Coordination - Healthy Starts & Transitions/Child Development	My comments on the Title V MCH Guidance are: • **NPM 8:** Bullying is important, but the middle childhood age group (6-12) and children with special health care needs should be included. • There is an inconsistent use of "children with special health care needs" and "children and youth with special health care needs" and "CSHCN" or "CYSHCN." I am unsure if your intent is to leave youth out in some instances. This is also true for the Health Status/Outcome Measures (18, 19, 19.2) and PM 13 where youth is not even mentioned. Separating the data for the following NPMs would ensure the needs of the CYSHCN are met. o NPM6 – o NPM 7 - Adolescent Well-Visit o NPM 8 - Bullying o NPM 9 - Adequate Insurance o NPM 10 - Breastfeeding o NPM 11 - Physical Activity o NPM12 - Oral Health	
August 26, 2014	Michael D. Warren, MD MPH FAAP Director, Division of Family Health and Wellness	See attached.	

	Tennessee Department of Health		
August 26, 2014	Kathy Messenger Senior Budget Planner, Bureau of Family Health and Nutrition Massachusetts Department of Public Health	See attached.	
August 26, 2014	Addie Aguirre, Acting Div. Chief Maternal, Child and Adolescent Health Division/Center for Family Health Sacramento, CA	See attached.	
August 26, 2014	Nora Wells Co- Director | Family Voices National Center for Family Professional Partnerships	See attached.	
August 26, 2014	Kim Mertz, Director Division of Family Health/Title V MCH North Dakota Department of Health	See attached.	
August 26, 2014	Brent M. Ewig, MHS Director of Policy and Government Affairs Association of Maternal & Child Health Programs, Washington, DC	See attached.	
August 26, 2014	Shaheen Hossain, Ph.D. Manager, Data Resources Program Division of Family Health and Preparedness Utah Department of Health	We are excited about the proposed changes in block grant application process and looking forward to the MCH 3.0. However, we would strongly request to delete Form 11: "SDD#4A (miscellaneous)". This Form 11 used to be Form 21. It takes considerable time for the program to compile all the needed data for Form 21 and since they are generated from multiple sources there are no consistency in data reporting years. Form 5: Number of individuals served, also has the same issue. It used to be Form 7 based on current guidance. The data that we report for this form comes from MCH service reports of 12 local health departments (LHD) in Utah. Each LHD has their own data system and they are not comparable. Some report visits, some report numbers served and some reports duplicated count. It's difficult to draw meaningful conclusion based on data from Form 7.	

		So, we request that both proposed Form 5 and 11 be deleted and not have the states to report under the new guidance. We appreciate the opportunity to comment on FRN.	
August 26, 2014	Linda P. McElwain Maternal and Child Health Unit Community Health Services Section Public Health Division Wyoming Department of Health	I am excited to see this new guidance. In some respects there may be more work, but it will definitely be more focused, describe more accurately, not only what we are doing, but also demonstrate how we are improving the health of women, infants, children and their families. I have worked in maternal and child health as a nurse for over 30 years. I have worked in public or community health, overseas and in the states, for local agencies, and the military. Four years ago, for the first time, I entered state government. I did not have a blueprint for MCH. And no one could share that with me. I have been frustrated with the current Title V application and reporting process as it is full of repetition that tells no one anything. Public Health, 30 years ago was not what it is today. I have had to do much learning and have much more to learn! I see this new guidance bringing together what I have learned for public health and MCH and providing me a framework that will tell our story. And I might actually get people to want to read it! Yes, there will be many questions. Yes, there will be frustration. Change won't happen without both of those. I look forward to it! Thank you to MCHB for having the foresight to create this new way of doing our work!	
August 26, 2014	Sally Kerschner, RN, MSN Coordinator of MCH Planning and Programming Vermont Department of Health	1. Consider alignment of age cohorts reported by Title V against national standards and age ranges reported in available data sources. This has been an	

	Division of Maternal and Child Health	issue in past Title V reporting. 2. Form 5. Number of Individual Served under Title V, by primary insurance coverage. I believe MCH capacity to report this measure will depend on developing a more robust CSHN definition of Vermont children served, and an improved system for tracking service delivery and insurance type. For example, at one end of the spectrum, if a member of the public calls CSHN with a question about services available for their child -- does this count as a client served? If so, how do we track this? 3. Form 11; SDD#04A&B. Miscellaneous Demographic Data. For a majority of the categories in these tables, Vermont data on race and ethnicity currently do not align with OMB federal reporting, for example, for TANF, Medicaid/CHIP; food stamps; foster care; juvenile crime arrests; and high school drop-out rates. 4. Health Status/Outcome Measure 6. Sleep-related sudden unexpected infant deaths. Because this measure depends on how the underlying cause of death is coded on death certificate, and because medical examiners and coroners differ in their working definition of SIDS (ICD-10 code R95) in particular, it follows that rates will not be comparable between states. Vermont may end up reporting a higher rate than some other states simply because of the rigorous way in which cause of deaths in infants is reviewed and recorded by the Chief Medical Examiner in this state.	

		5. Health Status/Outcome Measure 8.5. Percent of non-medically indicated early term deliveries. There are two significant limitations to this measure. (a) The NCHS standard U.S. birth certificate (in use in Vermont) does not require healthcare providers to report a number of the maternal pre-existing conditions included in the Joint Commission list that would possibly justify early elective deliveries, for example, antiphospholipid syndrome; chronic pulmonary disease; renal disease. (b) There is evidence from the VT PRAMS Data Quality Improvement Project (DQIP) [unpublished data] that the maternal risk factors that are included on the birth certificate are being under-reported by hospitals, for example, DQIP found the sensitivity of reporting on the birth certificate for gestational hypertension was 62%, premature rupture of membranes (47%), and pre-existing diabetes (31%). These limitations in data availability/quality will tend to result in an over-estimation of the incidence of early term deliveries that were not medically necessary. 6. Performance Measure 5. Percent of children 9-71 months receiving a developmental screen. The only data source currently available, and the data source identified in the guidance is based on parent self-report on National Survey of Children's Health. In 2011-12 the NSCH estimated 32.1% (95% C.I. 26.1 – 38.1) of Vermont children received a	

		screen. Independent chart reviews by Vermont Child Health Improvement Program indicated that NSCH estimates based on parent self-report were substantially too low.	
August 26, 2014	Carol L Miller, MPH Healthy Starts & Transitions Consultant Mental Health Integration/ Universal Developmental Screening Dept. of Health Office of Healthy Communities Access, Systems, Care Coordination Children with Special Health Care Needs Point Plaza East-310 Israel Rd. S.E. PO Box 47880 Olympia, WA 98504-7880	Please accept my comments for the Title V MCH Guidance: - Do a word search throughout the document for the intentional use of "CSHCN" or "CYSHCN", it's currently inconsistent and unknown if youth are intended to sometimes be left out. The same is true for "children with special health care needs" and "children and youth with special health care needs". Even the Health Status/Outcome Measure (18, 19, 19.2) have CSHCN in the title but include youth in the description. PM 13 doesn't mention youth at all even the age range is 0 to 18. PM 14- "youth" should be in the title. - To improve inclusion of CYSHCN and demonstrate the diverse needs of this population: o PM6 should state that it includes a separation of data for CYSHCN. o PM 7 on Adolescent Well-Visit should state that it includes a separation of data for CYSHCN. o PM 8 on Bullying should state that it includes a separation of data for CYSHCN. o PM 9 on Adequate Insurance should state that it includes a separation of data for CYSHCN. o PM 10 on Breastfeeding should stats that is includes a separation of data for infants with special	

		health care needs o PM 11 on Physical Activity should state that it includes a separation of data for CYSHCN, ages 6-17. o PM12 on Oral Health should state that it includes a separation of data for CYSHCN, ages 6. Thank you for the opportunity.	
August 26, 2014	Rachel (Berroth) Sisson, MS, Director Bureau of Family Health Kansas Department of Health & Environment Kansas Title V Director	See attached.	
August 26, 2014	Stephanie Dunkel Child Health Consultant Healthy Starts and Transitions Unit Access, Systems and Coordination Section Office of Healthy Communities Division of Prevention and Community Health PO Box 47880 Olympia, WA 98504-7880	Please register the following comments on the Title V MCH Guidance: - Do a word search throughout the document for the intentional use of "CSHCN" or "CYSHCN", it's currently inconsistent and unknown if youth are intended to sometimes be left out. The same is true for "children with special health care needs" and "children and youth with special health care needs". Even the Health Status/Outcome Measure (18, 19, 19.2) have CSHCN in the title but include youth in the description. PM 13 doesn't mention youth at all even the age range is 0 to 18. PM 14- "youth" should be in the title. - To improve inclusion of CYSHCN and demonstrate the diverse needs of this population: o PM12 on Oral Health should state that it includes a separation of data for CYSHCN, ages 6.	

		○ PM 11 on Physical Activity should state that it includes a separation of data for CYSHCN, ages 6-17. ○ PM 10 on Breastfeeding should stats that is includes a separation of data for infants with special health care needs. ○ PM 9 on Adequate Insurance should state that it includes a separation of data for CYSHCN. ○ PM 8 on Bullying should should state that it includes a separation of data for CYSHCN. ○ PM 7 on Adolescent Well-Visit should state that it includes a separation of data for CYSHCN. ○ PM6 should state that it includes a separation of data for CYSHCN.	
August 26, 2014	Jessica Foster MD, MPH, FAAP Physician Administrator, Bureau for Children with Developmental and Special Health Needs Medical Director, Children and Youth with Special Healthcare Needs Ohio Department of Health	See attached.	
August 26, 2014	Kathryn Akeah Healthy Communities Washington Project Manager Office of Healthy Communities Washington State Department of Health	See attached.	
August 26, 2014	Astrid Newell, MD | Community Health Manager | (360) 676-4593 Ext #50802 Whatcom County Health Department	Overall the direction of the new guidance is positive and aligns well with an emphasis on results and accountability. I notice that there is some flexibility for states to choose their own measures which opens up an opportunity to address some of the missing elements. I like the emphasis on family/consumer partnerships on page 6 of the main guidance document: "*The intentional practice of working with families for*	

		the ultimate goal of positive outcomes in all areas through the lifecourse." Locally and statewide there seems to be an emphasis on family engagement as it relates to CYSHCN, but I think this could be strengthened throughout our MCH work. There is a noticeable lack of attention or acknowledgement of adverse childhood experiences/toxic stress and the importance of healthy relationships and household functioning in healthy child and youth development and the reduction of health disparities. This would be a perfect opportunity to highlight and increase action in this critical area. Even though the document identifies a few different population domains across the lifecourse (Women/Maternal, Pregnant Women/Perinatal, Children, Adolescents), the life course perspective (connection and interaction between the life stages, recognition of cumulative impacts of stressors) is not very strong. There is also a lack of attention to the emotional and physical health of women before/during/after pregnancy, as well as social-emotional health in general (children, youth, etc..) The national performance measures seem somewhat random and heavily focused on medical interventions (e.g., well-visits, screening, insurance coverage, medical home, etc), when we know that the most impact on maternal and child health outcomes will come from interventions outside the medical system. I also wonder if HRSA considered the AMCHP Life Course indicators (http://www.amchp.org/programsandtopics/data-assessment/Pages/LifeCourseMetricsProject.aspx) as there did not appear to be a strong link.	

August 26, 2014	Beth Wilson, MEd. Program Manager for Maternal Child Health and Access to Care Tacoma-Pierce County Health Department	In general, the direction for the changes is positive and aligns well with an emphasis on results and accountability. There is some flexibility provided for states to choose their own measures which opens up opportunities to address some of the missing elements. I appreciate the emphasis on family/consumer partnerships on page 6 of the main guidance document: "*The intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the lifecourse.*" Locally and statewide there seems to be an emphasis on family engagement as it relates to CYSHCN; this could be strengthened throughout our MCH work. However, the document seems to be trailing local public health practice and efforts in Washington State as described below. There is a noticeable lack of attention or acknowledgement of adverse childhood experiences/toxic stress and the importance of healthy relationships and household functioning in healthy child and youth development. This would be a perfect opportunity to highlight and increase action in this critical area. Further, the application could address the need to identify the public health role in ACEs/Complex Trauma and to train existing staff to do this work. Even though the proposal identified a few different population domains across the lifecourse (Women/Maternal, Pregnant Women/Perinatal, Children, Adolescents), the life course perspective (connection and interaction between the life stages, recognition of cumulative impacts of stressors) is not very strong. This is a major concern. There are no National Performance or Outcome Measures that directly focus on ACEs or lifecourse. Given what we now know about	

		the importance of healthy early childhood development on lifecourse and lifelong health and prevention of chronic disease, it seems that federal policy and programs ought to put significant focus on that issue. There is also a lack of attention to the emotional and physical health of women before/during/after pregnancy, as well as social-emotional health in general (children, youth, and parents). The national performance measures seem somewhat random and heavily focused on medical/clinical interventions (e.g., well-visits, screening, insurance coverage, medical home, etc), and do not appear to address the root causes of many MCH issues. Considering the AMCHP Life Course indicators (http://www.amchp.org/programsandtopics/data-assessment/Pages/LifeCourseMetricsProject.aspx) could have been an important opportunity. Other areas of local public health concern include: 1. There is little emphasis on fathers and their status. 2. Universal Developmental Screening is not called out although; given the importance of UDS it is important to address it. 4. There is little emphasis on population based approaches, nor the need to create interdisciplinary teams to more effectively do population based work. 5. Resiliency is not discussed at all. 6. There is nothing in the documents that address disparities and/or inequities. If we are going to improve outcomes, addressing health disparities and/or inequities is necessary.	

		7. The document emphasizes the importance of working with community partners but does not discuss importance of collective impact strategies. 8. The document discusses the importance of public health continuing to provide gap-filling services but doesn't talk about the importance of collaborating with FQHCs or other providers, when possible, to meet the need. 9. Does the MCH health assessment data include the status of overall family health such as things like: • Parenting satisfaction • Life stressors • Mental Health issues of both the mother and father as well as children • ACEs • Safety • Disparities • Inequities • Poverty level 10. Since MCH programs have taken the brunt of recent public health budget cuts, the assessment or application should address the significant loss of MCH programs and staff in this nation over the past five years. 11. The assessment or application should address the issue of the aging work force and the need to recruit and train new staff for this work and the difficulty of doing this in the current economic climate. 12. The application might address the legalization of Marijuana that seems to be moving forward across the nation and is already in place in our state and the potential impact it could have on prenatal and postpartum health and potential	

		impacts on the fetus and child.	
August 26, 2014	Laura Rooney, MPH President-Elect National Network of State Adolescent Health Coordinators, Ohio	See attached.	
August 26, 2014	Lydia Buchheit Community & Family Health Manager Mason County Public Health & Human Services WSALPHO Community Health Committee Mason County Early Learning Coalition Chair	To whom it may concern, Thank you for allowing us opportunity to comment on the Title V Maternal and Child Health Services Block Grant to States. As a local health jurisdiction in Washington State from a small rural county, much of our work in our small community around maternal child health is supported by Title V dollars that we apply for through our state Department of Health. We have a strong community health improvement partnership in our community and support performance measures and outcome based work. In order for smaller communities to do this work we need to pick strategies that fit our local culture and needs. We support broad language allowing opportunities for work to be designed at the local level to address the more specified performance measures and outcome measures listed. We appreciate the emphasis on family partnerships on page 6 "The intentional practice of working with families for the ultimate goal of positive outcomes in all areas through the life course." We also support an increase in integrating the lens of life course work throughout the MCH perspective in this grant including connection and interaction between the life stages, recognition of cumulative impacts of stressors, brain development, adverse childhood experiences, toxic stress, importance of healthy relationships and household functioning in healthy child and youth development. It would help to identify the public health role in	

		ACEs/Complex trauma given what we know about the importance of early childhood development in life course and lifelong health and prevention in chronic disease. There also seems to be a lack of attention to the emotional and physical health of women before/during/after pregnancy, as well as social-emotional health in general for children, youth and parents. There is little emphasis of fathers yet research shows that if we would begin to offer support to fathers we could improve child and family outcomes. More emphasis on population based approaches and interdisciplinary teams to more effectively do this population based work. It would be beneficial if the MCH health assessment included data of overall family health such as parenting satisfaction, ACEs, safety, disparaties, inequities, poverty levels, mental health issues of mother, father and children and life stressors. Although the document talks about community partners, it could discuss the importance of using collective impact strategies. With the recent budget cuts to public health across the nation, the assessment application should address the significant loss of MCH programs and staff over the past 5 years. Thank you again for the opportunity to share some of our thoughts on this document.	
August 28, 2014	Yvette McEachern, M.A. Chief, Title V MCH Programs	Below are Maryland comments on the proposed Block Grant guidance. Thank you for the	

	Office of Family Planning and Home Visiting MCHB, Prevention and Health Promotion Administration Maryland Department of Health and Mental Hygiene	opportunity to comment. 1. National Performance Measure 9 should be changed to add a pull-out for CYSHCN: "Percent of children 0 through age 17 years **with and without special healthcare needs** who are adequately insured." The data source for this performance measure, the National Survey of Children's Health, distinguishes children with and without special health care needs. Existing data show significant disparities in attainment of this national performance measure for children with special health care needs compared to those without special health care needs. 2. National Performance Measure 11 should be changed to add a pull-out for CYSHCN: "Percent of children ages 6-11 years and adolescents ages 12-14 years **with and without special healthcare needs** who are physically active at least 60 minutes per day." The data source for this performance measure, the National Survey of Children's Health, distinguishes children with and without special health care needs. 3. National Performance Measure 12B should be changed to add a pull-out for CYSHCN: "Percent of infants and children, ages 1 to 6 years **with and without special healthcare needs** who had a preventive dental visit in the last year." The data source for this performance measure, the National Survey of Children's Health, distinguishes children with and without special health care needs.	