Guardino, Taylor (HRSA)

From:	California Title V (CDPH) <CaliforniaTitleV@cdph.ca.gov>
Sent:	Tuesday, August 26, 2014 4:53 PM
To:	HRSA Paperwork
Cc:	Aguirre, Addie (CDPH-CFH-MCAH); Ahmad, Shabbir (CDPH-CFH-MCAH); Curtis, Mike (CDPH-MCAH-EAPD-SPE); Miglas, Jo (CDPH-CFH-MCAH-FMCO); Cima, Laurel (CDPH-CFH-MCAH-CHVP)
Subject:	Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172--Revision: California Title V Comments
Attachments:	MCAH Title V Comment Letter to Ms. Painter, 8-26-14.pdf; Stakeholder Comments listing-8 26 2014.docx

Thank you for soliciting comments from California concerning the Information Collection Request that will be submitted to the Office of Management and Budget. Our efforts at the state level were focused on attempting to capture comments relevant to the four areas specifically identified in your communication dated June 20, 2014. For the purpose of clarity, we broke down our comments into four individual responses with respect to each of the four areas. Lastly, MCAH included an "Other Comments" section for those comments not necessarily related to the other four areas previously identified.

Thank you again for requesting input on the draft Title V Guidance and we look forward to receiving your response after analyzing the input from all the states that contributed to this process. If you have questions, please contact Renato Littaua at (916) 650-0332 or at Renato.Littaua@cdph.ca.gov.

State of California—Health and Human Services Agency
California Department of Public Health

RON CHAPMAN, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

August 26, 2014

Jackie Painter, Acting Director
Division of Policy and Information Coordinations
HRSA Information Collection Clearance Officer
Room # 10-29, Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

INFORMATION COLLECTION REQUEST TITLE:
TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT TO STATES PROGRAM: GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT
OMB NO. 0915-0172—REVISION

Dear Ms. Painter:

Thank you for soliciting comments from California concerning the Information Collection Request that will be submitted to the Office of Management and Budget. Input contributed in the form of comments and suggestions to improve the Title V Guidance and Forms was provided by California MCAH staff from the following branches:

- Epidemiology, Assessment and Program Development,
- Program Standards,
- Policy, and
- Financial Management and Contract Operations

Although comments were solicited from the MCAH directors of the local health jurisdictions regarding your request, none were received by MCAH. Our efforts at the state level were focused on attempting to capture comments relevant to the four areas specifically identified in your communication dated June 20, 2014. For the purpose of clarity, we broke down our comments into four individual responses with respect to each of the four areas. Lastly, MCAH included an "Other Comments" section for those comments not necessarily related to the other four areas previously identified.

Thank you again for requesting input on the Title V Guidance and we look forward to receiving your response after analyzing the input from all the states that contributed to this process.

Sincerely,

Addie Aguirre, Acting Division Chief

cc: See Next Page

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Program Standards Branch
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California Title V Block Grant
Draft Guidance Comments

Agency: MCAH Program, CA Dept. of Public Health
Tuesday, August 26, 2014

Comments Regarding Utility/ Necessity of the proposed information collection

1. California's Title V Needs Assessment includes compiling information gathered from 61 independent local community assessments that were recently completed. The proposed information collection for the needs assessment component of the Guidance is very similar to the information collection for California's local community assessments further validating the local needs assessment procedures California developed for its local MCAH jurisdictions.

2. No other federal program comes close to Title V in enabling states to comprehensively assess the services provided to and the health of their MCAH population through the proposed information collection outlined in the Guidance

3. A stand-alone 3-page executive summary for the annual application/ report will be useful as a stand-alone communication tool for states to share with the public.

4. In the previous Guidance (expires 2015) there were 29 newborn screening tests that grantees are requested to report on with 3 tests listed in the Guidance and 26 others not listed in the previous Guidance but included in the drop-down menu for the Newborn Screening Form in the Electronic Handbook (EHB). MCHB could reconsider inclusion for annual reporting of the number and percentage of newborns screened, cases confirmed and treated (Form 4), including its derivative data reported in NHS/ OM 23, the percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed in a timely manner, in light of the following:

   a) The current relevance and utility for collecting detailed data for 29 newborn screening tests has not been documented in the previous Guidance nor was demonstrated by MCHB during the annual application/ report reviews; also, unlike other data reported by states, the newborn screening data by grantee is not available in a tabulated format in the Title V Information System;

   b) In the California review of past annual reports from all grantees (50 states and 9 jurisdictions) have consistently demonstrated that the percent of screen positive newborn who received timely follow-up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs have consistently been at 100% for ALL reporting

years for ALL grantees. From a national perspective, California does not see any variability in reporting data for newborn screening tests for all grantees in the next five years, unless reporting parameters change;

c) Data to report for this form is not easily accessible given strict state and federal confidentiality and privacy laws, particularly when very small numbers are reported for each screening test raising the potential for re-identification of cases reported;

d) Data entry is burdensome as staff must be well-versed with all 29 newborn screening tests to reliably enter data gathered to fit into one of the available tests listed in the EHB drop-down menu. For example, S Beta Thalassemia is listed in the drop down menu once but there are no clear instructions in the previous Guidance if, for reporting purposes, tests for S/ Beta 0 thalassemia or S/Beta+ thalassemia could be combined; HB-E, Hb-D and Hb-variant thalassemias are not included in the drop-down menu nor was there guidance if and how these will be reported.

e) If the intent is for states to demonstrate their ability to capture newborn screening tests, MCHB could consider selecting only one newborn screening test for states to report on as a sentinel indicator instead of having all 29 tests be available for reporting. Similarly, MCHB could select only one screening test to report for older children and women in the lower boxes of the form.

5. The Guidance did not specify which NHS/OMs and SDDs will be made available to states so the following statements may be moot. With regard to insurance status for children < 18 of years of age, there are two measures to include in the report: HS/OM 13, Percent of children without health insurance and NPM 9, Percent of children who are adequately insured. Basically NPM 9 = HS/OM13 + % children inadequately insured. One can change the definition of HS/OM13 to say Percent of children without health insurance/ inadequately insured and thus HS/OM13= 100%-NPM 9.

6. Providing national or MCHB-specific targets for National Performance Measures is a way for MCHB to demonstrate the utility of collecting the data to assess if desired outcomes have been achieved. While it can be assumed that the Healthy People 2020 (HP2020) targets provided in the detail sheets are the same as the MCHB performance targets, there are NPMs which are similar but do not correspond to HP2020 measures. Since most of the NPMs are related but not identical to the HP2020 objectives (NPMs 1, 3, 5, 6, 7, 9, 11, 12, 13, 14 and 15), it will be helpful if the final guidance provide MCHB-specific targets. The same can be said about the NHS/OMs 10.3., 10.4, 10.5, 11- 18, 20, 21, and 14. There were no HP2020 related or corresponding targets for NHS/Oms 8.4, 8.5, 9, 19.1, 19.2 and 19.3. This will

demonstrate to states the importance of target setting, particularly when Guidance require states to provide targets for their state performance measures.

7. Data reported in SDD# 4, the number of children ages 0-19 can be derived from SDD # 01, Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race/ethnicity, if a sub-total of infants and children ages 0-19 is added to SDD # 1. This will minimize double entry for SDD #04, which can be derived from data in SDD # 01.

8. SDD#4's, collection of the number enrolled in CHIP could be made optional. Most states have transitioned children enrolled in CHIP to Medicaid if their state opted to expand their Medicaid programs under the Affordable Care Act.

9. MCHB may thoughtfully consider if there is justification to require all states to report all SDD data annually when the data collection schedule for some SDDs are not on an annual basis. For example any data using the national survey of CSHCN may be reported every five years instead of having states report the same rate for the next four years. Plotting the data annually gives a distorted perception of a flat trend line, until the fifth year of reporting when the data point changes.

10. With regard to NHS/OM 18, less than 2% of children are diagnosed with ASD. Due to small state sample participating in the NSCH, state estimates may be unavailable or unreliable.

11. The Guidance should provide specific directions on how the composite index for NHS/ OM 18 can be calculated using the NSCSHCN as the Data Resource Center for Child and Adolescent Health query system does not allow for calculation of this data. Since transition services for youth is included in calculating the index, the Guidance should provide direction on how to include children who are not at the developmental stage of receiving transition services.

Comments Regarding Accuracy of the Estimated Burden

1. The estimated burden of the annual reporting is highly underestimated. In California, there are a lot of activities involving multiple staff from two primary state departments (California Department of Public Health and the California Department of Healthcare Service) in gathering, reviewing, formatting and editing the narrative information even before it is ready to be reported in the EHB. Similarly a lot of effort goes into gathering, analyzing, validating and documenting information for the budget and data forms before it is ready to be uploaded in the EHB on an annual basis, notwithstanding the proposed collection of the NPMs and NHS/OMs by

MCHB for states. A time study conducted by states may more accurately provide the estimated burden for completing the annual application/ report.

2. The estimated burden for the needs assessment is seriously underestimated. California initiated its needs assessment process of strategizing and operationalizing its needs assessment enterprise two years ago. This involved weekly planning meetings, multiple discussions with stakeholders to get feedback and piloting of information collection instruments so the State can fully address the expansive breadth and scope that the draft Guidance wants grantees to cover in their Needs Assessment report. This does not include development of an action plan, a new mandate, which will involve doing a problem analysis and logic model for each priority, logistical planning for vetting out the proposed objectives and planned activities with a diversity of stakeholders for each population domain, strategically developing SPMs and S&P measures and target setting. A time study conducted by states may more accurately provide the estimated burden for completing the needs assessment.

3. The estimated burden does not take into account the time and number of staff attending the face-to-face annual review process, state preparations for the annual review and any additional modifications in the uploaded annual application/report when EHB is opened post-review.

Comments Regarding Ways to Enhance Quality, Utility and Clarity of Information to be Collected

1. The Guidance could be written with the grantee staff completing the report as the main audience in mind, and not grantee administrators who may want detailed information regarding the history, legislative mandates and conceptual frameworks used by Title V. Thus, discussion of the reporting instructions should be at the heart of the Guidance document instead of being buried in various parts of the main document and having additional instructions repeated in the appendix. Discussion related to historical context, legislative mandates, and conceptual frameworks could be brief in the main body of the document and relevant details of these subject areas but peripheral to the reporting instructions should be moved to the appendix instead. For example, the legislative requirements can be tabulated and included as an appendix. The guidance would be easier to understand if it was more concise, used direct language and clearly listed the due dates/forms/topics required. A table listing these elements would be helpful.

2. Appendix G may be modified to only include an outline or checklist table of what to include in each required section of the annual report prior to submission and specific word or character limits for each section. The PowerPoint slides used in the AMCHP-sponsored webinar this August may be modified to accommodate the above recommendation. The original narrative found in Appendix G may be moved to the main document to minimize repetition.

3. The eight-page Needs Assessment instructions describe the level of detail that is essential in developing the narrative for a given population domain. With a 20-page Needs Assessment report limit and an organizing framework of the narrative by the six population domains, this translates to limiting 3-1/3 pages of narrative to describe the findings (strengths, capacity, needs) for each domain which may not be realistic, even if the report is written in a bulleted format devoid of context or headings and sub-headings.

4. The Guidance could incorporate instructions to include reporting using the Electronic Handbook interface. For example, the instructions for Form 1 were written if one is filling-in a hardcopy of the form. If it is to be completed as an electronic form, make mention of any drop down menus or radio buttons to select when completing the form in EHB. If certain line items in the form are to be automatically populated, that needs to be stated, too. Also, for Form 4, add to the instructions a list of all newborn screening tests available in the drop-down menu in the EHB. In the previous Guidance only 3 tests of the 29 were documented in the Guidance.

5. The changes in reporting requirements may be better presented in a bulleted format with changes for the annual application/report tabulated separately from the changes in the needs assessment report. Sometimes this simplest of features enhance the readability and understanding the most.

6. Provide a glossary to define all technical terms including the revised three levels of services pyramid and how structural measures may differ from process measures and how they differ from SPMs. Also, provide a glossary of terms for Forms 2a, 2b, 3a, and 3b.

7. Identifying the NPMs by a primary population domain is necessary to minimize duplication of narrative and action plan for the same measure.

8. Since the MCHB Pyramid of Services was revised from four to three levels, a cross-walk discussion to explain this change could be provided in the Guidance. Similarly, transformation has been mentioned in the Guidance and a bit more discussion to explain the difference between MCH Transformation 3.0 from 2.0 and 1.0 may be in order.

9. MCHB may consider identifying more evidence-based or promising practices that they want to promote to improve national collective impact and evaluate these programs.

10. Word or character limits should be mentioned for each section of the annual application/report based on what will be required in EHB. It would be helpful to have a comprehensive Guidance instead of having part of the instructions included in the Guidance and part of it only available when one accesses the EHB.

11. Age group cut-offs adopted should be consistent between Form 3 and 5 (up to age 22) and Form 11 (up to age 24)

12. Consider including the NPM framework and NPM detail sheets as part of Appendix E and the NHS/OM detail sheets only in Appendix F. Modify the table in Appendix E to include a column that identifies the NPM no and name/ title of the performance measure (e.g., NPM1- Percent of women with a past year preventive visit). Create a similar table for the NHS/OM in Appendix F. A copy of these tables developed by California's Title V Program is attached.

13. All lines to be filled for each form could be provided with an explanatory instruction for each form's standard set of instructions. "Self-explanatory" as a line instruction is not acceptable given the diverse audience using the Guidance.

14. Provide guidance or recommendations on how states could set annual objectives for Form 10a. Reference is made in the Instructions in Form 10A to Form 10b and 10c which have no additional guidance or instructions related to objective setting.

15. Include in the appendices a Letter of Transmittal form that states can complete and attach to their electronic report.

16. The statement on page 14 stating "A 5-year Needs Assessment Summary will be integrated into the State's Application/Annual Report and will replace the more comprehensive stand-alone 5-year Needs Assessment document that the state previously submitted" seem inconsistent with instructions to include a 20-page Needs Assessment report as an attachment.

17. The statement on page 20 of the draft Guidance is unclear why there is a need to nest the 6 population domains under the 3 defined MCH populations when three of the population domains match the defined MCH populations. Specifically, the Guidance states that "states shall present an overview of the health status of the state's MCH population for each of the six identified population health domains (i.e., maternal/ women's health, perinatal/infant health, child health, adolescent/young adult health, CYSHCN and crosscutting or life course) within the three legislatively-defined state MCH population groups (i.e., (a) pregnant women, mothers, and infants up to age 1; (bi) children; and (c) children with special health care needs.)"

18. The organizing framework should be consistent for both the needs assessment and the annual application narrative. The guidance states that the narrative for the needs assessment is to be organized by six population health domains (see above) yet the state action plan narrative is to be organized by 7 population health domains (page 28) which includes the "Other Programmatic Areas" domain. It will be helpful and less confusing if the template for the action plan table had all the required reporting elements as described in the narrative starting on page 31. It may be confusing to ask for narrative descriptions when the template does not address some of the narrative sections.

19. Provide clarification if states can select more than 8 NPMs and develop more than 5 SPMs. For the five SPM's each state develops, the guidance was unclear if an SPM should be developed for at least five of the six (or seven?) population domains.

20. It is unclear what "other" in Form 5 represents

21. Instructions for Form 4 do not include a defined age group for "older children" and "women". Older female teens and young female adults may be double counted to the overlap possible when no age-based definition is provided.

22. Instructions on Form 7 make reference to a line labelled State and to lines b1 through b6 which are non-existent in the actual form attached. Please clarify.

23. No instructions were provided for Form 8.

24 The instructions in Form 11 reference a non-existent Part Two, Section VIII. Please include a Part Two, Section VIII in the final Guidance.

25. The resource "Facilitating Public Comment on the Title V MCH Block Grant" on page 34 is dated material that does not include strategies that take into account the rapidly changing technological innovations and shift in cultural norms of the past 10 years that may facilitate/hinder public comment. More recent resources could be provided.

26. Please clarify if EHB will still automatically generate a "Table of Contents" listed under Part Two, General Requirements. There are no instructions provided to grantees if they are required to submit one as part of the reporting requirements.

27. It should be emphasized that the steps presented in Appendix D is not a linear progression but more of an iterative process between two or more steps in the cycle. It also needs to emphasize that stakeholders should be involved in all the steps listed from assessing the needs and identifying desired outcomes and mandates to monitoring progress for impact on outcomes. Development of an action plan is not a static activity as the narrative suggests but a continually evolving process. A discussion on continuous quality improvement may be included in describing the steps in developing and revising an action plan.

28. The statement "The Five-year Action Plan Table will provide a basis for the development of the State Action Plan. States will report on their five-year Action Plan in the narrative" on page 8 is unclear of what the difference is between a five-year State Action Plan and the State Action Plan referred to.

29. The way NPM 13 and 14 are worded seem to suggest that there will be two rates to be calculated for each NPM, i.e., a rate for children and a separate rate for CSHCN for reporting purposes. Otherwise, the current wording is wordy since CSCHN is a subset of the child population.

30. Similar to the MCH Transformation 3.0 presented by Dr. Lu, the Guidance could provide information on the national MCHB health priorities so that states, to the extent possible, align their surveillance efforts with those of the MCHB national priorities. Since it was not explicitly stated, it was unclear if the MCHB national priorities are those health priorities identified in the table listing the National Performance Measures (Appendix E). These national health priorities could then be linked to one and only one primary health domain for reporting purposes even if its impact may encompass one or more population domains, to avoid duplication of narrative for a particular priority across several population domains.

31. The listing of MCH Population Domains in Appendix E is unclear. "Families" was not listed in the population domains identified elsewhere in the Guidance but is listed multiple times in Appendix E. NPM 12A is defined as the "percent of women

who had a dental visit during pregnancy yet the population domain is listed as Children when the measure itself is for the Maternal/ Women health domain.

32. While Form 2b instructions are provided and the form will be pre-populated by MCHB, please provide a mock-up copy of Form 2b in the final Guidance. The EHB portal is not readily accessible at all times to view Form 2b.

33. It would be beneficial to have a required template for the proposed one-page Executive Summary (ES) so that all states ES's will be similar. As a business tool for marketing, the ES template to be developed by MCHB could have qualities that are consumer oriented, i.e., as a tool to help states engage the MCH community and stakeholders' for dialogue and input; and, as a tool which has the ability to communicate with the people who can create the conditions in which the MCH community can be healthy.

34. Unlike other forms or measures listed where each form or measure has a single data source, SDD #4A and SDD #4B is a compilation of data from 10 different data sources. For clarity, MCHB should consider numbering these 10 measures as SDD # 8 A&B to SDD #17 A&B, respectively.

35. Acronyms used for the first time in the Guidance could be defined or described (e.g., ACF, CDC, USDA, SNAP, WIC, TANF, CHIP, etc.) and a glossary of acronyms used in the Guidance be included as an appendix

36. As part of the appendix, provide a table listing all the data sources that MCHB used as data sources for the NPMs and NHS/Oms that will be calculated for the states, a brief description of the data sources, a list of indicators that were derived from the data source and limitations of the data source.

37. A list of FAQs can be provided as an attachment

Comments Regarding the use of Information Technology to Reduce Information Collection Burden

1. We recommend developing a "plug n' play" app which grantees can used to upload their documents saved as a word processing file and data spreadsheets that will interface with the Electronic Handbook (EHB) to upload grantees annual narrative, completed budget and data forms and attachments into the EHB. The current EHB is cumbersome and not user-friendly and adds a layer of logistical burden for states to use for uploading their annual report/ application.
2. The Guidance did not specify which NHS/OMs will be made available to states so the succeeding statements may be moot. With regard to infant mortality rate (HS/OM 1) can be derived by adding the neonatal morality rate (HS/OM 3) and post-neonatal mortality rate (HS/ OM 4) If states enter data for HS/OM 3 and HS/OM 4, have EHB automatically add these to auto- populate HS/OM 1 to lessen the state burden of data entry for HS/OM1 Similarly, EHB can auto-populate HS/OM 8.1, the % of preterm births by adding up data entered by states for % early preterm births (HS/OM 8.2) and percent late preterm births (HS/ OM 8.3),
3. Information collected can be better compiled and utilized if they are presented in the same way. Contrary to what is stated on page 30, CA believes MCHB is better served if the State Action Plan Table in Appendix B be used as a template for all states instead of making it an option for states to use. It would be more difficult to compile information submitted in different templates.
4. Most of the State Demographic Data can be pre-populated by MCHB using the NCHS database and ACS. For example, Poverty Levels data is collected by MCHB for annual budget allocation to states. The poverty data collected by MCHB for budget purposes can be used to populate Form 11, Table 6 and Table 7.
5. Some of the data reported in Forms 6 and 11 can be used to calculate some of the rates for the NPMs and NHS/OMs. For example, the no. of infants reported in SDD #01 can be divided by the no. of infant deaths reported in SDD #03 to derive the infant mortality rate (NPM 1). Taking this further, the EHB system can be programmed to calculate the post-neonatal mortality rate (NHS/OM 4) by subtracting the neonatal mortality rate (NHS/OM 3) from the infant mortality rate reported in NHS/OM # 1. The child death rate NHS/ OM 12 can be derived by using the data entered in SDD #03 as numerator and data from SDD # 01 as denominator.
6. Data entered in one form can be used to populate data required to be reported in other forms. For example, the no. of live births reported as denominator in in NHS/OM1 may be used to populate the denominator data for NHS/ OM2, 3, 4, 6,

7.1,7.2, 7.3, 8.1, 8.2, 8.3, and 8.4 without having states re-enter the denominator data over and over again in the different forms.

Other Comments

1. In generating the PDF version of the uploaded report in EHB, the pdf file generated should include a copy of the letter of transmittal submitted, completed SF-424 and the attachments uploaded by the state in the compilation and not just the narrative and forms completed.

2. The 20-page limit for the Needs Assessment report is a disingenuous way of reducing the reporting burden for states when the underlying processes and activities to complete the steps identified in the Needs Assessment conceptual framework (Appendix D), the framework logic model (Figure 2) and to address the scope and depth of discussion for topical issues described in the Guidance for inclusion in the Needs Assessment report is even greater than what was requested of states in their previous comprehensive needs assessment reports. It is conceivable that the onus will be for the reviewers during the annual face-to face review to gather more information from states to get the level of detail needed to fully comprehend the processes, findings and course of action that states will have to take based on their needs assessment findings, thus, shifting the reporting burden from the report submission to the face-to-face review and negating any decrease in reporting burden.

3. The Guidance may also provide information on the objectives, scope and structure of the annual review process and advise states on what reviewers expect or require from states at the review. It has been our experience that reviewers have suggested or recommended inclusion of more information (e.g. charts and tables) in our annual application/ report beyond what is stated as optional items in the previous Guidance.

4. The Guidance could cover areas such as programmatic audit and how long states are expected to keep documentation related to creating the annual application/report and five year needs assessment report.

Guardino, Taylor (HRSA)

From:	Michael D. Warren <Michael.D.Warren@tn.gov>
Sent:	Tuesday, August 26, 2014 5:45 PM
To:	HRSA Paperwork
Cc:	Brent Ewig
Subject:	Comments on proposed revisions to the Title V Maternal and Child Health Services Block Grant
Attachments:	TN Comments on Proposed MCH Block Grant Revisions 08.26.2014 1637.pdf

Please find attached our comments on the proposed revisions to the Title V Maternal and Child Health Services Block Grant.

Michael D. Warren, MD MPH FAAP
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Tennessee Department of Health
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August 26, 2014

HRSA Information Collection Clearance Officer
Parklawn Building
5600 Fishers Lane, Room 10-29
Rockville, MD 20857

Re: Comments on Proposed Revisions to the Title V Maternal and Child Health Services Block Grant

To Whom It May Concern:

Thank you for the opportunity to review and comment on the proposed revisions to the Title V Maternal and Child Health Services Block Grant. We appreciate the effort that went into meeting the three aims of the MCH transformation as stated by Dr. Lu: 1) reduce burden to states, 2) maintain state flexibility, and 3) improve accountability. We would like to offer comments or requests for clarifications on the four areas requested by HRSA:

1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions
2) The accuracy of the estimated burden (189 hours)
3) Ways to enhance the quality, utility, and clarity of the information to be collected
4) The use of automated collection techniques or other forms of information technology to minimize the collection burden

Necessity and utility of the proposed information collection for the proper performance of the agency's functions

- The required reporting on measures and narrative seems commensurate with the amount of funding provided to the state.
- The three-page limit for the executive summary may be insufficient for providing a concise but thorough summary of the Title V Maternal and Child Health Services Block Grant. As this section of the grant is one that is probably the most likely to be read by external stakeholders, including legislators, it may be beneficial to have additional pages

(maybe as many as 5 or 10) in order to allow for sufficient explanation of the myriad activities completed and services provided through the MCH Block Grant.

- The structural and process measures are a nice addition to aid in the "real-time" determination of program/activity progress. These measures should further support the work of agencies in addressing their SPMs and NPMs.

Accuracy of the estimated burden

- Based on previous experience with the MCH Block Grant, the estimate of 189 hours potentially seems reasonable. However, the guidance does not have any information about character limits for the various sections of narrative. Such information would help us better determine the accuracy of the reporting burden.
- Please include character limits for all sections in the final version of the guidance.

Ways to enhance the quality, utility, and clarity of the information to be collected

- As we anticipate being asked to report our budget by the levels of the new pyramid, it would be helpful to have a definition for each level of the pyramid with examples of the types of services that would fall within each category.
- The guidance (on page 35, section i) indicates that "states should primarily describe activities for which the Title V program provides primary leadership in administering the activity." Does this mean just those projects primarily funded by Title V? In our state, the same public health Division that administers Title V also administers Title V, WIC, and Chronic Disease. Please clarify the extent to which reporting on other activities (not funded by Title V) is required.
- On Form 10C (State Defined Structural and/or Process Measure Detail Sheet) on page 63, there is no space for related HP 2020 objectives but this is included in the instructions on page 64. Please clarify.
- For HSOM 11 (% of children and adolescents who are overweight or obese), there are multiple data source listed. Will multiple measures be reported, or just one? How will this be reported?
- For HSOM 13 (% of children without health insurance), there are multiple data source listed. Will multiple measures be reported, or just one? How will this be reported?
- For HSOM 21 (% of deliveries with associated morbidity), which ICD-10 procedure codes will be used to calculate the numerator?
- For NPM 3 (% of VLBW deliveries at appropriate facility): How will levels of care be determined if this is from a national source? Will data on hospital and level of care be matched at the national level?
- For NPM 11 (% of children physically active), two age groups (and two data sources) are described. Will both values be reported?
- For the various performance measures that will be pre-populated with data at the national level, when will the data be available so that we can set performance objectives?
- The guidance (on page 82) states that we should start reporting on SPMs in Year 3. Do we not develop these in Year 1 and start reporting in Year 2?

- Please clarify whether states will be required to submit both a structural and a process measure, or just select one of the two to report.
- Several of the measures reference external sources (such as an AAP list of hospitals by level of care or APHL standards for newborn screening follow-up). These sources may not be known to states or easily accessible. Please include direct links to these sources or provide the most up-to-date copies of the data sources on the HRSA/MCHB website.
- Regarding HSOM 23, related to newborn screening, the numerator defined in the measure does not appear to capture the construct referred to by the Healthy People 2020 Objective cited. The numerator currently restricts the population to a very small subset of the denominator (i.e., eligible infants who were screened, then had a positive screen, then had on time physician notification, then had timely follow-up relative to all eligible live births). The denominator for this measure should be redefined to align with the Healthy People Objective. Suggested definitions are below.
    - Numerator Option 1: Number of eligible newborns screened for heritable disorders with on time physician notification* for out of range screens who are followed up in a timely manner*.
    - Numerator Option 2: Number of eligible newborns screened for heritable disorders with timely follow-up after a positive screen.
    - Denominator: Number of eligible newborns screened for heritable disorders with out of range screens ("Screen positive").
    - *The numerator, as currently written, potentially features a so-called double barreled question.
    - In addition, definitions of "on time" physician notification and "timely manner" should be provided.

<u>Use of automated collection techniques or other forms of information technology to minimize the collection burden</u>

- In general, we applaud the effort to reduce the burden to states by pre-populating performance data where possible with data available from national sources.
- As one of the articulated goals of MCH 3.0 was to help better tell the Title V/MCH story, we have some concerns about the use of national data (which may lag several years behind data available at the state level) to tell the story about state activities and performance. We hope that the final version of TVIS will allow states to enter more recent (even provisional data) and describe the data source, so that legislators and others will have a more accurate understanding of the state's current performance level.
- Several measures rely on PRAMS. In some recent years, our state response rate has been lower than the threshold required by CDC for publicly releasing the results. In those circumstances, how will the state data be reported?
- For NPM 6 (rate of injury-related hospital admissions), our understanding is that this will come from state hospital discharge databases. Is this data aggregated nationally (and therefore will be pre-populated) or will states be responsible for entering this data?
- For NPM 10 (% of infants ever breastfed), we were told from CDC that the NIS breastfeeding data is being discontinued. Is this true? If so, how will this data be obtained?

- For HSOM 24 (% of children ready for school), both the numerator and denominator are listed as "under development." When will the specific parameters for this measurement be released? We recognize that many definitions exist for school readiness and states may measure this differently; if there is not a national-level measurement for this indicator, we suggest removing this measure and allowing states that choose to report on this to do so as a state performance measure.
- Several of the performance measures reference national surveys that are currently only collected periodically (ie every three or five years). We understand that there is a movement to collect this data more frequently. Until such time when that happens, we have some concern that the available data will be several years old and will not accurately reflect the states' current progress on the measure. We suggest considering adding these measures to the required reporting list once the current national data becomes available.

Thank you for the opportunity to provide comments on this proposed guidance. Should you have any questions for us or if you need more information, please feel free to contact me per the information below.

Sincerely,

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Tennessee Department of Health

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Guardino, Taylor (HRSA)

From:	Hale, Linda J - DHS <Linda.Hale@dhs.wisconsin.gov>
Sent:	Tuesday, August 26, 2014 7:53 PM
To:	HRSA Paperwork
Subject:	WI Response to Federal Register Notice (6/27) of planned changes to the Title V MCH Services Block Grant
Attachments:	AMCHP Guide to Reviewing Commenting on Revised Title V Guidance8_26_14.docx

Thank you for this opportunity. We look forward to the second round. Linda Hale

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Maternal and Child Health Hotline
1-800-722-2295
Twenty-four hours/day, 7 days/week
For current MCH resources please visit the Maternal Child Health website at http://www.dhs.wisconsin.gov/health/mch/

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WISCONSIN MCH/CYSHCN Program Comments on Proposed Revisions to the Title V Maternal and Child Health Services Block Grant

8/26/14

Wisconsin's MCH and CYSHCN Programs thank you for the opportunity to respond to the revised MCH Services Block Grant federal guidance.

*We look forward to the addition of the 5 year State Action Plan. It is a transition we had determined was needed within our state's MCH/CYSHCN work with our partners the past 5 years. Our CYSHCN Program has been using work/action plans the past several years and their partners have successfully been able to better share their stories of the systems work they are doing. Our MCH Program is looking forward to our move in that direction in 2015.

*From Wisconsin's Title V MCH/CYSHCN Program's experience, a 3 page Executive Summary isn't long enough to allow the detail being described in the guidance (pg. 7)—"serve as a standalone document for the state in marketing its Title V program's achievements to other state, community and family agencies and in soliciting programmatic input from families and other MCH stakeholders."

*Prefer the use of CYSHCN vs. CSHCN. If not then there needs to be clarification when using CSHCN and who is included in that definition.

*The reporting mechanism and ease of its use needs to be enhanced based on what the states need as well as what HRSA MCHB needs from the EHB and TVIS. Moving towards electronic grant reviews within our state Department of Health Services, the TVIS is not conducive for a readable and comprehensive version of the grant application/report. There is additional work needing to be done by state staff to have multiple versions (electronic as well as paper) and formats to include the budget and reporting forms, narrative, attachments, and ability for multiple administrative department sign offs as the grant is routed through our department for approval prior to submission to HRSA/MCHB.

*The 3 goals of the proposed guidance does not appear to substantially:

1) Lessen the burden to states—(Estimated @189 Hours) It appears that the Application/Annual Report is being reformatted and reporting requirement sections renamed. The expectation is still somewhat daunting with the number of NPM and SPM along with NHS/OMs, S&PMs. It does not appear to be reducing the burden to states for a data reporting perspective even with the federal pre-population of national data for the states.

* There are many health status/outcome measures. We are to be reporting on all of them, even if they don't relate to our activities or our priorities. Is this necessary?

*We have a question about the timing of the data becoming available to states during their grant writing/reporting. This data will be important to receive in a timely manner for the programs to be able to analyze their outcomes and plan for their next year's work.

*In Wisconsin, time working on the grant is much more than 189 hours. Our most intensive time is 4 months prior to the submission, but again in preparation for the face to face meeting as well as upon return to review recommendations and make updates and revisions as identified through the review process. There is the ongoing review and evaluation of the current year's activities and planning for the next year's work of the grant dollars; constant engagement, sharing, reporting, and soliciting input from our partners for the current and next grant writing and report production. Multiple very dedicated staff and partners across the state work year round on the actual "production" of the annual grant application and report.

2) Maintain state flexibility—It appears to remain at least the same from a perspective of reporting on required NPMs, SPM along with S&PMs, and NHS/OMs (which at our initial review many of the past measures have been integrated or those that were eliminated replaced with different and perhaps more relevant/updated measures.
We are hoping that there is a better connection between all of these measures and the work being done across the 6 identified population health domains within the 3 legislatively defined state MCH population groups.
We would suggest allowing states to choose "*up to* five state performance measures" rather than exactly five.

3) Improve accountability—
Standardization of definitions of: 3a) "Title V supported services" vs. direct reimbursable MCH Health Care Services, Non-Reimbursable Primary and Preventive Health Care Services, Public Health Services and systems for MCH Populations (on the new pyramid as well as the budget forms e.g. Form 3b). Possibly consider recommended definition used in MCHB's direct service survey; _"Definition of "Services"_

> *For this survey, a list of examples of "services" can be found in the following paragraph. Using your Federal Title V MCH Formula Block Grant funds, services would be paid for through a formal process similar to paying a medical billing claim. Federal Title V MCH Formula Block Grant funds <u>provided to a partner, such as a clinic or local health department, for salary or operations support **are not** considered services for the purpose of this survey.</u>*

Services include, but are not limited to:

- **primary care and specialty care doctor visits,*
- *emergency department visits,*
- *inpatient services,*
- **outpatient and inpatient mental health and substance abuse services,*
- *prescription drugs,*
- **occupational and physical therapy,*
- **speech therapy,*
- *durable medical equipment and medical supplies,*
- *lab services,*
- *radiology,*
- *medical foods,*
- *preventive care screenings,*
- *dental care,*
- *orthodontia,*
- *vision care,*
- **case management,*
- *transportation, and*
- *rehabilitative and habilitative services.*

Reimbursement for services using the Federal Title V MCH Formula Block Grant funds could be made for children or pregnant women who are uninsured or who exceed coverage limitations if they do have public or private insurance. For example, suppose your state's CHIP program

reimburses for 20 physical therapy sessions for a child. However, the child needed 30 sessions, so the Title V program paid for the extra 10 sessions using the federal portion of Title V MCH Formula Block Grant funds. In this case, physical therapy is a reimbursed service as defined for this survey."

Standardization of definitions--3b) demographics such as race; 3c) guidance and standardization on how to measure the reach of systems work; gap filling which infers direct services vs. complementing ACA which promotes the systems work at the base of the revised pyramid.

*One potential challenge will be SSDI's M/CDS alignment with MCH Services Block grant indicators. Since the vast majority of M/CDS indicators are not included in the revised MCH Block Grant guidance, it will be important to identify a strategy that does not dilute the data component of the Block Grant's newly streamlined format. This is especially true for M/CDS indicators with a close parallel in the Block Grant.

*Consider reframing Form 3a—rather than stating "types of individuals served" reflect the 6 domains.

Consider a 2 part Form 7—allowing for those programs that provide direct (top of revised pyramid) to fill out one part of the form; and the second part of the form to be completed by programs that are providing population based or systems of services for MCH populations.

*Clarity is needed on how the structural and performance measures differ from the state performance and outcome measures and the health status/ outcome measures?

*Direct Reimbursable MCH Healthcare Services—not sure how this is being tied to providing access to care (revised pyramid). This needs a clear definition of both the direct reimbursable MCH Healthcare services as well as "providing access to care". Is it the development of the system to assure access to care (complementing ACA) vs. providing direct access to care.

*In the "Overview of the State" Section (page15-16): "States should address how the healthcare reform efforts and ACA implementation are impacting the health status of its MCH and CSHCN populations and delivery of Title V supported services."

a) Concern with this request as it may be too political for states to answer.
b) What are Title V supported services?

*The guidance calls for states to report on "level of commitment to consistently engaging family / consumer partnership." How will states determine "level"?

*The Guidance indicates Title V "will continue to serve as a safety-net provider...by providing gap-filling safety net services." Yet, surveys indicate that close to half of all states are not providing any direct reimbursable health care services and the remaining states are serving very small numbers (i.e. <1% of population). We recommend the description specify, "will continue to serve as a safety-net provider *in some states...*" to more accurately reflect current use of resources. Possibly consider the mission description on page four that may provide a more accurate description. (p.2)

*Description of the Purpose of the MCH Block Grant (page 2 of appendix). Three of the first four bullets describe Title V as "providing comprehensive care…" and the fifth references "immunizing all children." It seems that fewer states are using Title V funds for these purposes. This can create a major disconnect between what policymakers think Title V does and how the funds are actually spent. Consider the new mission of Title V described on page 4-5 of the guidance.

*Interrelationship of measures. We would request clarity on the connection between how the NHS/OM measures relate back to the NPMs. Would there be an opportunity to map each of the NHS/OMs back at least to the six domains (as done with the NPMs) and even to individual measures? If this doesn't happen, most likely states will have to do this in their state action plans. Without this standardization, states will potentially map these differently (although flexibility is nice). This is added burden that could be reduced with some additions to the NHS/OM detail sheets.

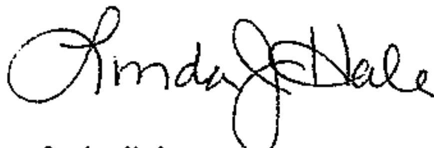
*Needs Assessment Expectations. A 20 page limit for submission may be difficult with all the expectations now included in the guidance.

*Action Plan Table format. Could the sample plan included on page 8 in the appendix be incorporated into the guidance directly so it is readily available?
It may be difficult to fit the level of detail needed (particularly for strategies) in the Five Year Action Plan Table format.

*State Action Plan Key Strategies / Activities. It would be helpful to include a strategy and a performance measure example to help differentiate the differences (p.30).

*State Support for Family / Consumer Engagement. Preference would be to use "education of policymakers" rather than "advocacy" to reduce a potential red flag in the list of strategies. (p.33)

Respectfully submitted,



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Guardino, Taylor (HRSA)

From: HRSA Paperwork
Sent: Monday, August 25, 2014 12:53 PM
To: Wright-Solomon, Lisa (HRSA); Guardino, Taylor (HRSA)
Subject: FW: Family Voices NJ/SPAN comments submitted on Title V due 8-26
Attachments: comments-Title V final.docx

From: familyvoicesnj@aol.com [familyvoicesnj@aol.com]
Sent: Friday, August 22, 2014 5:07 PM
To: HRSA Paperwork
Subject: Family Voices NJ/SPAN comments submitted on Title V due 8-26

Thank you for the opportunity to provide input. Our comments are attached.
Lauren Agoratus
Family Voices NJ

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SPAN & Family Voices NJ comments on Agency Information Collection Activities: Title V Maternal and Child Health Services Block Grant to States Program

August 22, 2014

Thank you for the opportunity to comment on the Title V Maternal and Child (MCH) Health Services Block Grant to States Program. The Statewide Parent Advocacy Network (SPAN) is NJ's federally designated Parent Training and Information Center. Family Voices is a national network that works to "keep families at the center of children's healthcare." The NJ State Affiliate Organization for Family Voices is housed at SPAN, which is also the home of the Family-to-Family Health Information Center, a chapter of the Federation of Families for Children's Mental Health, and the Parent to Parent USA affiliate. In addition to these comments, we also support the comments of Family Voices National. Our comments follow.

SUPPLEMENTARY INFORMATION:

We understand the purpose is "transforming the MCH Block Grant to States Program to better meet current and future challenges." This will be achieved in order to "(1) Reduce burden to states, (2) maintain state flexibility, and (3) improve accountability." While we agree that there should not be unnecessary burden placed on states, we are concerned that activities needed for accountability and transparency may be misinterpreted as "burdens." While we also agree that there should be flexibility for states to address their own state challenges and use strategies that are effective for their populations, we are concerned that "state flexibility" may also be misinterpreted as not requiring accountability and transparency. Finally, we strongly support efforts to improve accountability and engage MCH constituents more deeply in the accountability process.

We understand that specific changes include:

"(1) Narrative reporting...organized by six population health domains (i.e., maternal and women's health, perinatal health, child health, CSHCN, adolescent health, and life course); (2) Revised National Performance Measure (NPM) framework...(3) State-level data...provided by MCHB...(4) For each...NPM, the state will...report only on a Structural/Process Measure (S&PM); (5) Revised instructions for the State Application/Annual Report... (6) State Application/Annual Report will include a 5-year Action Plan... (7) An Executive Summary... included with ...Application/Annual Report... (8) A 5-year Needs Assessment Summary...(9) Health System Capacity Indicators will be eliminated... (10) Data for Health Status Indicators will be provided by the MCHB... (11) Federal and State Title V Program budget and expenditures will be reported separately by the state."

We can appreciate that MCH providing state-level data for NPMs will reduce burden. (However, we note that, for some of these data, the territories are not included in the national data sets and question how MCH will address this issue. We strongly recommend that the territories be included in all national data collections to ensure that they have access to the same pre-populated data as states). We understand that it will reduce burden for states to report only on Structural/Process Measures. We particularly support the development of a state 5-year Action Plan; we strongly recommend that additional provisions be added requiring the meaningful participation of family organizations and family leaders in the development, implementation, and evaluation of the Action Plan. We agree with the provision of an Executive Summary to highlight key points, which will be useful to MCH constituents and the general public. In addition, we agree that integration of the 5-year Needs Assessment Summary into the State's Application/Annual Report will reduce burden. We are concerned however with the elimination of the Health System Capacity Indicators as there must be measurement of capacity to address the needs identified in the assessment. We do agree that burden to states will be reduced by having MCH provide data for Health Status Indicators (but see concerns re; territories, above). We do think it will increase burden to report state and federal budget and expenditures but this action may enhance understanding of areas being addressed and identify areas for improvement.

Need and Proposed Use of the Information

We understand that "Each year, all states and jurisdictions are required to submit an Application/Annual Report." We further understand that Title V programs will be required to "conduct a statewide, comprehensive Needs Assessment every 5 years" and strongly support that one of the three areas of focus is the need for "services for children with special health care needs." We agree that the 5 year Needs Assessment would be less burdensome and allow for flexibility as different gap areas are identified longitudinally.

Likely Respondents:

We understand that the "MCH Block Grant Application/Annual Report must be developed by, or in consultation with, the State MCH Health agency." We would also strongly recommend inclusion and input from families served by Title V programs. In NJ, Title V and families do work in a collaborative manner, and Title V supports the work of our non-profit organization.

Burden Statement

We understand that this includes "time expended by persons to generate, maintain, retain, disclose or provide the information requested" but note that any quality improvement efforts requires generating, maintaining, retaining, reporting, and use of performance data.

Total Estimated Annualized burden hours

We agree with the estimated burden hours of the Application and Annual Report with and without the 5-Year Needs Assessment.

We understand that "HRSA specifically requests comments on (1) the necessity and utility of the proposed information collection… (2) the accuracy of the estimated burden, (3) ways to enhance the quality, utility, and clarity of the information… (4) the use of automated collection techniques." We do agree that this information collection is both necessary and useful. As mentioned above, we are concerned with the elimination of the Health System Capacity Indicators to address needs but do support the 5 year Needs Assessment. We agree with the estimated burden hours. Regarding enhancing data quality, as mentioned previously we think that this must include input from families being served in Title V programs. We agree that the use of technology will aid in the information collection process.

Recommendations on the full text document:

Pages 2-4 Vision and Mission
We are concerned, especially for children with special needs, that despite gains from the Affordable Care Act, adequate health care financing is still an issue. Even before the ACA, most children with special healthcare needs had insurance. The provisions of the ACA re: pre-existing conditions and elimination of lifetime caps have helped CSHCN, but have not solved all the problems of underinsurance, or the issue of children in undocumented immigrant families who are not only not eligible for Medicaid or SCHIP but whose families also cannot purchase more affordable health insurance on the exchange. The revised pyramid strategy of mobilizing partners including families is actually central to all of the strategies. Core partners include underserved populations, such as families from racially and ethnically diverse families, who are subject to health disparities. We strongly support "Conduct ongoing assessment of the changing health needs of the MCH population (as impacted by cultural, linguistic, demographic characteristics) to drive priorities for achieving equity in access and positive health outcomes."

Recommendation:
Include as a first strategy on page 4, a separate concept that "MCHB mobilizes and supports the engagement of families and family organizations in all aspects of MCH work at the federal, state and community level in order to promote and implement the MCHB vision, improve MCH systems of care, promote quality public health services and develop supportive policies."

Pages 5-6 National Performance Measurement Framework
We understand that MCH is providing guidance for states to report that they "work closely with family/consumer partnerships as they develop the S&PMs for their selected NPMs. "

Recommendation:
Guidance is needed on determining the level of work and should include working with the state Family-to-Family Health Information Center (F2FHIC) to identify the performance measurement framework and select national and state Performance Measures.

Pages 6-8 Changes to the Application/Report Guidance
We understand that the Executive Summary highlights key points of the guidance but should not be used for "soliciting programmatic input from families." Families and organizations serving them should provide input to the Executive Summary as well as the Block Grant application and this should be documented. This includes needs assessment and identifying priorities.

Recommendation:
Include in the elements required in the Executive Summary methods and levels of engaging diverse families and family organizations in needs assessment, priorities, action plans, and Performance Measures.

Page 14 Components of the application/annual report
We understand that states must report "Level of commitment to consistently engaging family/consumer partners in Title V MCH and CSHCN programmatic and decision making efforts." Guidance is needed on how this will be measured.

Recommendation:
Provide guidance on ranking "commitment to consistently engage family/consumer partners." All states need to use the same methodology. States should be required to include the self-ranking and average of rankings by family organizations.

Pages 25 & 33 Data Elements
We understand that states collect data on the elements described on page 25 and on page 33 about family/family organization engagement. We suggest that states should be required to report on qualitative and quantitative data and this should also be required for data collection from families and family organizations.

Recommendation: Require states to measure effectiveness in engaging families at the individual level of care by reporting survey data from populations served through Block Grant funds. Title V programs should work with family partners, especially F2FHICS, in designing and undertaking such surveys. In addition, in order to reach diverse families, surveys must be available in a variety of formats including translations, online, hard copy, telephone interviews and focus groups. Non-traditional outreach will assure input for culturally and linguistically diverse families. Potential sources/tools for data collection include:

- Questions from the Family Voices Family-Centered Care Assessment
- Questions from the National Survey on Children's Health
- Adapt the NCSEAM (National Center for Special Education Accountability and Monitoring) survey
- Consistent data elements across states for comparability

National Performance Measures and New Measurement Framework
We are concerned that few of the measures pertain to children and youth with special health care needs (CYSHCN). Regarding 36 National Health Status (NHS) and Outcome Measures (OM), there are only 5 measures for CYSHCN, and 2 are disability specific (autism and ADHD.) Regarding the 17 National Performance Measures, only 2 apply to CYSHCN. In addition, only one measure for CYSHCN is required to be reported by states, despite the mandate that 30% of the funding is allocated for this population.

Recommendation
Re-examine the number of identified NHS/OMs and National Performance Measures applicable to CYSHCN, include measures on each of the six components, and require states to report at minimum 2 measures.

Thank you again for the opportunity to comment on the MCH Block Grant.

Sincerely,

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Guardino, Taylor (HRSA)

From:	Messenger, Kathy (DPH) <kathy.messenger@state.ma.us>
Sent:	Tuesday, August 26, 2014 5:21 PM
To:	HRSA Paperwork
Cc:	Benham, Ron (DPH); Downs, Karin (DPH)
Subject:	Comments on draft MCH Block Grant Guidance InformationCollection Request
Attachments:	MCH BG Guidance Comments_Massachusetts.docx

Please find attached comments and suggestions from Massachusetts related to the HRSA Information Collection Request, as published in the Federal Register on June 27, 2014.

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Massachusetts Department of Public Health
Bureau of Family Health and Nutrition (State Title V Agency)

Comments on Information Collection Request:
Draft Maternal and Child Health Block Grant (MCH BG) Guidance, Forms, and Appendices

Overall we support the streamlined and revised Guidance and Application/Annual Report Process proposed by MCHB. The new National Performance Measures and National Health Status/Outcome Measures seem realistic and well-targeted to capturing the breadth of state MCH programmatic and policy efforts to improve the health of all mothers, children, and families.

We cannot comment definitively on the burden aspects of the application/annual report process. While the overall estimates of time required seem to be underestimates, based on our lengthy experience with the Block Grant, this is not new. In particular, the impact of the new measures and forms on changes in existing data collection and analysis cannot be fully assessed without a new glossary and without a working TVIS interface.

We do commend the Bureau for their efforts at streamlining the process, eliminating a number of forms and other redundancies, and for their commitment to provide states with much of the data required each year. This latter approach will not only make the comparisons among the states (and the accumulation of national data) more accurate, but will also relieve states of some often time-consuming efforts.

We also strongly support the effort to separate out federal and state / match funding in the annual budget presentations. This is an approach which we in Massachusetts have voluntarily taken for a number of years (as supplemental tables attached to our Application/Annual Report) to respond to questions raised in review sessions about shifting funds from year to year. It is the only way to accurately depict the use of federal MCH funds.

We do, however, have a number of major critiques of the draft and suggestions for improvements.

1) **Replace National Performance Measure # 10 (% of infants ever breastfed) with the more robust and valuable % of infants exclusively breastfed at 3 months.** The measure for breastfeeding should focus on duration/exclusivity vs. initiation. Exclusive breastfeeding at 3 months would be a more appropriate metric than the current proposed measure. Our state, along with many others, has already surpassed the HP2020 goal for initiation – the national average is 79.2% and the HP2020 target is 81.9%. Exclusive breastfeeding at 3 months is also captured on the NIS survey (and thus data will be available from a national source) and is a metric better correlated with improved health outcomes than initiation.

2) **Consolidate the "Children" and Adolescent/ Young Adult" domains.** The split seems both unnecessary and confusing. Together, they coincide with the required 30% expenditure requirement. In addition, there seems to be only one National Measure which relates solely to children (# 5 – Developmental screening) and two that relate only to adolescents (#7 – adolescent well visit and #8 – bullying). On the other hand there are 3 measures that by definition include persons in both age groups (#6 – child injury hospitalizations ages 0-19, #9

– adequate insurance coverage ages 0-17, and #11 – physical activity ages 6-11 and 12-17). In addition, 2 other cross-domain measures (#13 – medical home and #14 – transitions to adult health care) both reference all children as well as CYSHCN. Based on the measures selected, there seems to be no compelling reason to keep the two domains separate. Since state action plan reporting appears to be focused by Domain, it will be potentially redundant or confusing for state's to report on unified activities in support of the measures as the domains are currently defined.

3) **Clarify the distinction between the "Maternal/Women's Health" and Perinatal/Infant Health Domains.** National Performance Measures #2 (low–risk C-sections) and #3 (perinatal regionalization) are listed in Appendix E as being related to the "Maternal, Perinatal" Domains, which in fact is correct. But if states must choose at least one measure from each domain, and the same measure cannot be used for two domains, does it make a difference where the state places it? The distinctions between Women's Health (e.g. NPM #1) and Infant Health (e.g. #4) are clear. Clarifying the distinction may be particularly important as states consider creating state-based measures in these domains. Since "perinatal" includes pregnancy, there does not seem to be a clear reason to include "Maternal" with Women's Health rather than with Perinatal Health. We suggest having the two domains as follows: 1) Women's Health and 2) Maternal, perinatal and infant health. Again, the lack of a Glossary and complete definitions leaves this area unclear.

4) **Clarify and modify National Performance Measures so that each measure either measures a single unique item or formally subdivide the single measure into two distinct submeasures, each with its own reporting on the TVIS forms.** At the moment, there are several measures with two components. It is not clear how these would be entered in the application software, as it appears from the forms shown that there is one target, numerator, denominator, etc. for each. Thus a state would not be able to enter both but would be expected to do so. There are other "Cross-cutting" measures (e.g. #12 and 15) that contain two quite different dimensions and specifically reference an A and a B submeasure that we assume will have separate data entry points in TVIS. The problematic measures are as follows:

   # 11 – Physical Activity. Requests separate data for children ages 6-11 and adolescents ages 12-17. This appears to be related to the fact that data for the entire age group will not be available from the NSCH until 2017 so until then there are no data for the younger children but data for the older group can come from the YRBS. We prefer the YRBS when available, as the self-report for the older children is probably more accurate than parental report (per the NSCH) and would therefore recommend splitting the measure into 2 measures for the 2 age groups. If distinct data are desired for the two subgroups, the measure must be divided.

   #13 – Medical Home. Requests separate data for all children and for the subset of children with special health care needs. We strongly support collecting data on both groups, but to do so requires splitting the measure into a 13A and a 13B. If states select the measure, they would be required to report on both parts.

   #14 – Transitions to Adult Health Care. Requests separate data for all children and for the subset of children with special health care needs. We strongly support collecting data on both groups, but to do so requires splitting the measure into a 13A and a 13B. If states select the measure, they would be required to report on both parts.

5) **Make Appendix E (Performance Measure Framework) consistent with Appendix F (National Performance Measure (NPM) Detail Sheets) and with the defined six Domains.**
Almost all of the labels in the Table in Appendix E that reference the MCH Population Domains do not use the same names for the Domains as specified on p. 28 of the Core Guidance document. The terms "pregnant women and "families" are used, although they do not appear in the Domain names. NPM #12 (Oral Health) is labeled "children" when in fact this is a two-part measure that includes women and children and falls into the "Cross-cutting/Life course" Domain. The confusion between the three sources in the documents highlights some of the confusion and lack of clarity highlighted earlier as to the distinctions between some of the Domains and the multi-variate nature of some of the NPMs.

The video by Dr. Lu that was shown at this year's state review sessions helped clarify this situation by showing that several measures could "count" toward more than one of the domains, but that a single measure could not be used to meet the requirement of more than one domain. [E.g. one could use #11 as either a Child or Adolescent domain measure but would have to select a different measure for the other domain.] We would suggest incorporating the graphics and explanatory information from his presentation into the Guidance, replacing the Table in Appendix E and making sure that all labelling and categorizing language throughout the Guidance and the Appendices is consistent and clear.

6) **Provide thorough mapping of the relationships between the NPMs, the National Health Status/Outcome Measures (NHS/OMs), and the Domains.** This will both be of assistance to states who will otherwise have to do this themselves and will highlight some of the discrepancies and inconsistencies mentioned above.

7) **Clarify the relationship of the NHS/OMs and NPMs to the 43 Minimum/Core Data Elements referenced in the new SSDI Guidance and Application.** We are not clear why data elements are listed and highlighted for SSDI that do not appear anywhere in the overall MCH BG Guidance. If the Minimum and Core Data Elements are required for states in their SSDI reporting, they should either be the same as the National Health Status/Outcome Measures (NHS/OMs) or at least clearly referenced in the MCH BG Guidance as additional reporting requirements for the states. Or the SSDI Minimum and Core Data Elements should be revised to correspond to the NHS/OMs. To add to the additional and unreferenced reporting burden, there are numerous instances where there are similar but not identical measures and data elements, with no explanation why one is a national performance measure (or NHS/OM) and the other a minimum/core data element. There should be consistency in those cases, no repetitions, and an explanation of why many of the SSDI data elements are not included here. Many of the Minimum Data Elements are the old NPMs. Since there are some good reasons why they have been dropped as NPMs, it seems an unnecessary burden to the states to continue to require reporting through a different MCHB grant.

8) **Eliminate State Demographic Data items #04A and 04B from Form 11.** We can find no reference in the Title V legislation that requires reporting on this assortment of service utilization and child statistics, either overall or in the detail required by race and ethnicity. It takes a great deal of time to assemble the data from a wide variety of sources, as most of the programs are not administered by the Title V program and are in fact generally run by other state agencies. Overall, the most reliable sources are national databases, including the

Annie B. Casey Foundation. Several of the data sources do not have data available by race/ethnicity. All of the items are useful factors that states should consider in their needs assessments and in the coordination of services at the community level for families (and they could be mentioned as such in the needs assessment guidance), but the point of the annual Tables is absolutely not clear. Since the data do not seem to be required by law (and there is no reference cited in the Table), they should not be required. It is interesting to note that the Application does not require race/ethnicity breakouts for all those receiving MCH Partnership funding (only for deliveries and infants on Form 6), so it is particularly aggravating to complete these tables for other programs.

9) **A three –page Executive Summary is not adequate space.** Even just listing the measures, let alone commenting on 'Major accomplishments and significant challenges" for each, will require more space. This is an area when an excessive effort to reduce burden will in fact create more burden. AMCHP has suggested that states might instead choose which things to highlight. We would agree with that, but even then 5-7 pages or even 10 would seem to be a more realistic framework that would enable states to really explain what is happening in MCH. Slightly expanding the space allowed would also be more likely to produce a valuable stand-alone document with enough context (and fewer abbreviations) to use with state and local leaders and other audiences. This is something that is sorely missing in the current format and would be a great improvement.

10) **A 20-page limit for the Needs Assessment submission is totally inadequate.** By our count, the description in the Guidance of the points and topics that are to be addressed in the Needs Assessment section runs to almost 9 pages! We like the idea of submitting only the summary and results of the Needs Assessment process, but more space is needed (perhaps a limit of 50 pages). Again a longer format will better allow for a thorough stand-alone document with multiple uses, a great benefit to the state.

11) **Allowance for additional attachments to the Needs Assessment Summary.** One major loss with not having a separate Needs Assessment document will be the ability to present any tables, graphs, charts, or other visual presentations of data that can most effectively and efficiently convey findings, highlight disparities, and otherwise really enhance the value of the needs assessment summary. If TVIS continues as it is now, with absolutely no capacity for formatting text attractively, let alone inserting figures and tables, states should be encouraged to supplement their summary with an attached document. We would recommend that such a graphic attachment be specifically encouraged and cross-referenced in the state's Needs Assessment summary.

12) We are concerned that the complete redesign of the TVIS system seems scheduled to be completed shortly before the states will need to use it to prepare the next application. In particular, the method by which states will report their narratives on the Domains and selected measures is not clear in the Guidance. The timelines proposed for both the final Guidance and then release of the new TVIS software put a burden on the states late in the application process. It is also not clear what if any narrative reporting will be required in the first year (application due 7/15/2015), as the State Action Plans will not be due until the next year. Will any reporting from the current measures be expected?

13) We understand the rationale for the revised MCH Pyramid and the incorporation of references to essential public health functions. However, the attempt to depict the 3 MCH Block Grant levels as related to discrete essential public health functions is misleading and inaccurate. For example, promoting evidence-based practice can be part of direct health care services and almost all of the functions pointing to the middle of the pyramid (non-reimbursable and preventive services) are equally related to the bottom level of Public Health Services and Systems. Perhaps a diagram that shows arrows from the essential functions to several of the pyramid levels would make the point that MCH plays a critical and extensive public health role without implying that there is a one-to-one relationship between the two frameworks. In addition, the label of the middle level does not seem quite right. States may be working hard to turn what is non-reimbursable today (e.g. care coordination) into a covered service for a more sustainable program. We understand why "Infrastructure" had to go as a label (and we like the new language for the bottom level) and did find the term "enabling" tricky to define, but the term "population-based" seemed to work well. Again, there is a need for a new Glossary and more examples for states to work from.

Thank you for the opportunity to review and comment on these significant documents.

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Guardino, Taylor (HRSA)

From:	HRSA Paperwork
Sent:	Monday, August 25, 2014 12:52 PM
To:	Guardino, Taylor (HRSA); Wright-Solomon, Lisa (HRSA)
Subject:	FW: Title V Block Grant OMB No. 0915-0172 Information Request
Attachments:	Title V Block Grant comments 2014.docx

From: Marsha Walker [marshalact@gmail.com]
Sent: Monday, August 25, 2014 8:55 AM
To: HRSA Paperwork
Subject: Title V Block Grant OMB No. 0915-0172 Information Request

See below and attached for comments

Information collection request title: Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172-Revision.

The United States Lactation Consultant Association (USLCA) is a non-profit membership organization comprised of lactation consultants, nurses, physicians, dietitians, peer counselors, nutritionists, public health providers, and related professionals. USLCA is pleased for the opportunity to respond to the Maternal and Child Health Bureau's (MCHB) call for public comments regarding the Title V Block Grant process.

Breastfeeding is a public health imperative, positively affecting more than 10% of the Healthy People 2020 objectives for the nation. Breastfeeding affects health outcomes across the lifespan for mother and baby and it is important that state MCH programs consider breastfeeding promotion and support across funding streams. USLCA wishes to offer the following recommendations to achieve this end:

A performance measure for exclusive breastfeeding at 3 months of age should be adopted

- **Change performance measure number 10 from "Percent of infants who are ever breastfed" to "Percent of infants who are exclusively breastfed for 3 months."** Eleven states have already surpassed the Healthy People 2020 goal for breastfeeding initiation with many more coming very close. While breastfeeding initiation provides the foundation for lifelong health, *optimal outcomes are achieved only when breastfeeding duration and exclusivity are considered.* Six months of exclusive breastfeeding is considered optimal, but 3 months of exclusive breastfeeding provides a substantial boost to the immune system, helps populate the infant gut microbiome with flora that reduces inflammation, aids in gut closure, and contributes to reductions in both acute and chronic diseases and conditions. Lactation exerts its influence on maternal health with reduction in risks for type 2 diabetes, obesity, and reproductive cancers.

Access to an International Board Certified Lactation Consultant (IBCLC) should be available through performance measure number 9

- **Adequately insured children should have access to the level of lactation care and services needed to breastfeed exclusively for 6 months in performance measure 9.**

A large number of mothers with breastfeeding infants lack access to the level of support needed to overcome challenges for their infant to be exclusively breastfed for the first 6 months as recommended by the American Academy of Pediatrics. This results when third party payers reimburse licensed providers only. The IBCLC is not a license but a certification denoting healthcare providers with the requisite expertise to provide lactation care and services throughout the childbearing continuum from prenatal through weaning and from routine to complex medical situations.

Title V programs and MCHB would benefit from having on staff an International Board Certified Lactation Consultant (IBCLC) who is responsible for assessing and assuring that comprehensive lactation care and services are available within Title V activities.

- It is important that the IBCLC expert be involved in MCHB's improvement efforts for maternal and child health. While breastfeeding is a cross-cutting issue that should be addressed by a variety of professionals and lay supporters, a great need exists for specially trained individuals versed in lactation and breastfeeding from the prenatal period through weaning. The IBCLC brings science-based knowledge of lactation and breastfeeding as well as clinical expertise in the administration of lactation care and services.

The starting point for a state's needs assessment as well as implementation of its performance objectives is to engage relevant stakeholders in the process. State identified needs should include measures to increase the exclusive breastfeeding rate at 3 months. States can collaborate with state chapters of USLCA and state breastfeeding coalitions to strengthen community partnerships and improve MCH outcomes. It is requested that MCHB incorporate breastfeeding and the IBCLC into relevant performance measures as well as structural and process measures to support collaboration, ensure technical assistance, and integrate best/promising practices.

Thank you for the opportunity to provide comments. USLCA looks forward to working with MCHB and Title V funded programs in the upcoming years.

Respectfully submitted,

Alisa Sanders, RN, IBCLC

President

United States Lactation Consultant Association

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Thank you for the opportunity to provide comments. USLCA looks forward to working with MCHB and Title V funded programs in the upcoming years.

Respectfully submitted,

Alisa Sanders, RN, IBCLC
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Guardino, Taylor (HRSA)

From:	HRSA Paperwork
Sent:	Wednesday, August 20, 2014 1:06 PM
To:	Guardino, Taylor (HRSA); Wright-Solomon, Lisa (HRSA)
Subject:	FW: Title V MCH Services Block Grant to States Program: Guidance and Forms (OMB No. 0915-0172)
Attachments:	CDHP Title V PM Comments 8_20_14 Final.pdf

From: Meg Booth [mbooth@cdhp.org]
Sent: Wednesday, August 20, 2014 9:24 AM
To: HRSA Paperwork
Subject: Title V MCH Services Block Grant to States Program: Guidance and Forms (OMB No. 0915-0172)

Please find attached comments from the Children's Dental Health Project regarding the Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Form for the Title V Application/Annual Report OMB No. 0915-0172.

–

Meg Booth, MPH
Director of Policy
Children's Dental Health Project

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children's dental health project

August 20, 2014

Michael C. Lu, M.D., M.S., M.P.H.
Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration
U.S. Department of Health and Human Services

Dear Dr. Lu:

Thank you for the opportunity to provide feedback on the Title V Maternal and Child Services Block Grant to States Program Guidance and Appendix. We applaud the efforts in this new guidance to increase accountability and ease the burden on states to report uniform data and tell the "story" of Title V. We also commend your leadership in addressing the oral health of families with a focus on preventing early childhood tooth decay. Oral health is essential to the health of all pregnant women and children and this guidance provides the opportunity to track the progress of the strategies states choose to address the oral health of their communities.

The Children's Dental Health Project (CDHP) has reviewed the new guidance and presents the following recommendations to ensure that the outlined measures produce accurate and reliable data to evaluate state and national efforts to improve the oral health of women and children.

Health Status/Outcome Measure 14
Percent of children ages 1-6 who have decayed teeth or cavities in the past 12 months

Recommendation:
Percent of children 0-5 who have experienced a toothache or a cavity in the past 6 months.

Understanding the caries incidence in young children is essential to identifying and assessing early prevention and community prevention strategies. CDHP supports reporting the incidence of cavities as an outcome measure; however we are concerned with the accuracy the data the current measure would yield. Dental caries is a chronic disease in which a cavity is the outcome of the disease process and as such prevalence of tooth decay in primary teeth increases until those teeth begin to exfoliate, generally after age 6. Parent reporting has limitations for data source. A parent can most accurately report: 1) symptoms of a cavity (toothache) and 2) treatment by a dentist (filled cavity) or ever had a cavity filled. However, parents are unlikely to accurately report: 1) recall of symptoms or problems longer than 6 months, 2) new unfilled cavities, and 3) subtle symptoms of tooth decay (discoloration, developmental disturbances).

Recognizing the limitations of the data collection, CDHP believes the occurrence of toothaches severe enough to get the attention of a parent is an important measure of the success or failure of primary prevention and timely intervention (secondary prevention), and one that parents can accurately provide within a 6 month period. Similarly, parents should be able to accurately report whether their child has had a new cavity filled. Therefore we recommend MCHB revise the current measure: *the percent of*

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children 0-5 who have experienced a toothache or a cavity in the past 6 months to provide the most reliable data through parent reporting on the incidence of tooth decay in young children.

However, if MCHB is seeking to measure disease prevalence, we recommend revising the measure to *"The number of children ages 0-5 whose parents report that they currently or have ever had a decayed tooth or a cavity filled"* to better understand dental caries disease burden and to be consistent with the Healthy People 2020 objectives and data collected by NHANES. The occurrence of a cavity is stable regardless of whether that cavity remains untreated, is filled, or the tooth is pulled. Any reduction in age-specific prevalence over time can be useful to determine disease prevalence in a given community/state.

National Performance Measure 12
A) Percent of women who had a dental visit during pregnancy and
B) Percent of infants and children, ages 1 to 6 years, who had a preventive dental visit in the last year

Recommendations:
NPM 12A: Revise to reflect PRAMS Phase 8 core question on teeth cleaning by dentists or dental hygienist during the most recent pregnancy;
NPM 12B: Revise data source to clarify preventive dental service are those provided by any member of the oral health team

MCHB's commitment to the oral health of women is exceptional, both in the funding of three states to address the systematic issues that pregnant women face in accessing dental care and NPM 12B to measure Title V's ability to improve access. Recognition of the importance of access to oral health care during pregnancy to improve the long-term overall health of both mother and infant has also been supported by CDC through PRAMS. PRAMS has a long-standing question on preconception access to dental care and, more recently, a question was added on access to care during pregnancy. In Phase 7 (2012-2015), as a result of language in the Affordable Care Act, CDC included oral health questions to the PRAMS core set that provided more details on the oral health of the woman, insurance status, and unmet needs for dental care.

However, PRAMS Phase 8 questions are currently in development and are scheduled to eliminate many of the oral health questions previously added in Phase 7 from the core set. Our current understanding is that the two existing oral health questions that will remain that include teeth cleaned by a dentist or a dental hygienist (1) in the 12 months prior to their most recent pregnancy and (2) during their most recent pregnancy. CDHP recommends MCHB change NPM 12A to reflect data available in the PRAMS Phase 8 core question that determines the percentage of women who had their teeth cleaned by a dentist or dental hygienist during their most recent pregnancy. While many dentists are reluctant to provide routine dental care during pregnancy, current recommendations developed in many states and nationally by the American Congress of Obstetricians and Gynecologists, American Academy of Pediatric Dentistry, American Academy of Periodentology, and MCHB's own consensus statement on oral health during pregnancy encourage care during pregnancy. that having teeth cleaned during pregnancy is a marker that the woman received oral care other than an episodic visit to address an oral health problem and thus is a good marker for whether their relationship with their dentist has the potential to assure receipt of routine primary dental care.

Similarly, NPM 12B provides critical information to understand access to preventive care for young children. The dental community is in agreement that preventive services need not be solely provided by a dentist but can include services provided by other members of the oral health team. Therefore, CDHP recommends clarifying NPM 12B to include preventive services provided by any member of the oral health team (such as dental hygienists, dental therapists, and others as permitted by the state's practice act). Establishing the data source to include all members of the oral health team will more accurately reflect the comprehensive approaches Title V programs can or have taken to address the oral health of young children. We recommend modifying the question previously asked in the National Survey of Children's Health to include providers other than dentists, which would be consistent with how the National Health Interview Survey addresses this issue. The specific question on NSCH could be: *"During the past 12 months/since [his/her] birth, did [CHILD] see a dentist, dental hygienist or other oral health professional for preventive dental care, such as a cleaning or fluoride varnish?"*

National Performance Measure 9
Percent of children 0 through age 17 years who are adequately insured

Recommendation:
Revise the data source for NPM 9 to determine insurance adequacy that includes dental coverage and affordability.

Affordable, accessible health insurance is essential to maintaining and improving access to preventive care and necessary treatment. Longstanding and new federal policies alike support the inclusion dental care as part of health coverage, regardless of whether it is provided as part of health insurance or through a separate arrangement with a stand-alone dental plan. Medicaid, CHIP, and Marketplace coverage all require coverage of pediatric dental services. Consistent with the Healthy People 2020 Access to Health Services Objective 6, the ability to obtain necessary dental care is essential to the health of a child or adolescent. Prior to Marketplace coverage, dentally uninsured children outnumbered those covered by health insurance almost 3 to 1. With the implementation of ACA in conjunction with Medicaid and CHIP, near universal access to dental coverage is available for children. However, affordability of dental coverage and services within a dental plan remain unsettled and may be a barrier for many children to adequately access necessary care. Tracking the progress of states to enroll children in comprehensive and affordable coverage will require revisions to the NSCH to include both Marketplace coverage and dental-specific coverage to the existing questions regarding the source of medical coverage. CDHP recommends the data source for NPM 9 be revised to determine insurance adequacy that includes dental coverage and affordability.

We appreciate the opportunity to provide feedback on the Title V Block Grant guidance and would be happy to discuss our recommendations in greater detail, including specific recommendations for revising the National Survey of Children's Health. Please do not hesitate to contact me at mbooth@cdhp.org or at (202) 417-3598.

Sincerely,

Meg Booth, MPH
Director of Policy

Guardino, Taylor (HRSA)

From: HRSA Paperwork
Sent: Monday, August 18, 2014 11:15 AM
To: Wright-Solomon, Lisa (HRSA); Guardino, Taylor (HRSA)
Subject: FW: Comments-Title V Application/Annual Report OMB No. 0915-0172--Revision
Attachments: 3 0 comments FR final.pdf; unknown.tiff

From: Sandy Perkins [sandy@asphn.org]
Sent: Friday, August 15, 2014 1:31 PM
To: HRSA Paperwork
Subject: Comments-Title V Application/Annual Report OMB No. 0915-0172--Revision

Information Collection Request Title: Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172--Revision. **Comments specifically Address -** The necessity and utility of the proposed information collection for the proper performance of the agency's functions.

The Association of State Public Health Nutritionists (ASPHN) is a non-profit membership organization comprised of public health nutritionists and related professionals. ASPHN appreciates the opportunity to contribute the attached comments regarding the Maternal and Child Health Bureau's (MCHB) Title V Block Grant.

Please let me know if there are any questions regarding these comments. ASPHN looks forward to working with MCHB and Title V funded programs as this transformation continues. We remain committed to improving the health of women, children and families.
Sandy

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August 15, 2014

Information Collection Request Title: Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172--Revision. **Comments specifically Address** - The necessity and utility of the proposed information collection for the proper performance of the agency's functions.

The Association of State Public Health Nutritionists (ASPHN) is a non-profit membership organization comprised of public health nutritionists and related professionals. ASPHN appreciates the opportunity to contribute comments regarding the Maternal and Child Health Bureau's (MCHB) Title V Block Grant. We have called upon the expertise of our members to prepare these comments.

ASPHN supports the many positive changes included in this proposal, which should achieve the aims of: (1) reduce burden to states, (2) maintain state flexibility and (3) improve accountability. The changes should also better target MCH resources to meet state identified needs leading to the improved health of women, children (including those with special needs) and families. It is gratifying to have exclusive breastfeeding and physical activity as performance measures.

ASPHN strongly disagrees with the decision not to include nutrition within a performance measures or to have a measure dedicated to obesity prevention. A previous straw measure included both nutrition and physical activity. Given the current obesity epidemic, it is necessary to address both healthy eating and physical activity. Also, nutrition is a key component in reducing infant mortality, an area of great concern to MCHB.

Healthy eating and good nutrition habits are essential for health. It is likely that if nutrition is not specifically identified as an important element of MCH programs it will not be addressed. The research is clear that nutrition is vital to the healthy development and wellbeing of infants, children, youth and adults. The nutritional well being of the MCH population is currently inadequate as evidenced by current statistics on the increase in obesity, poor eating habits and chronic diseases. Nutrition problems among the nation's women and children contribute to widespread health issues, intellectual and developmental problems, reduced productivity and higher health care costs.

Over time, there has been erosion in public health nutrition's ability to engage in population-based activities to improve the health of women and children. Historically, the Maternal and Child Health Bureau (MCHB) had a strong focus on ensuring the nutritional wellbeing of these populations. As stated in page 4 of the Appendix of Supporting Documents "One of the purposes of the Title V MCH Services Block Grant Program is to create federal/state partnerships in all 59 states for developing service systems that address MCH challenges, such as.... - Meeting the nutritional and developmental needs of mothers, children and families." Reduction in funding for the MCH Block Title V grant has forced states to prioritize the services they can offer and the positions they can fund. Additionally, the focus on addressing key performance measures and a movement away from a discipline-based focus has reduced the

visibility of nutrition within Block Grant-funded programs. This change is often coupled with a misunderstanding that programs, such as WIC, can cover all aspects of public health nutrition, which is not the case.

It is still important that state MCH programs consider the nutritional wellbeing of vulnerable women, children and families across funding streams. ASPHN offers the following recommendations to achieve this end.

- ***A performance measure that addresses nutrition and exercise and/or one that addresses healthy weight or obesity prevention throughout the lifecourse should be adopted.***
  - ***Include nutrition in performance measure 11 that addresses physical activity.*** The measure can be formatted to have two components: one related to physical activity and the other to nutrition. Promotion of healthy eating and preventing overweight and obesity are a lifecourse approach that will positively impact every generation. A focus on nutrition and physical activity supports a public health and social determinants of health approach and is consistent with existing federal health guidance. ASPHN strongly supported MCHB's previous intention to use fruit and vegetable consumption as a measure and recommends this be included in this measure. The ASPHN Fruit and Vegetable Nutrition Council is pleased to work with MCHB on how to impact fruit and vegetable consumption in the MCH population. Although fruit and vegetable consumption has been a priority in chronic disease prevention health programs, the CDC-funded health programs have shifted focus to increasing access to healthy food environments. As a result, there are no specific state-based health programs focused on diet quality across the lifespan.
  - ***Include a measure on healthy weight or obesity prevention throughout the lifecourse.*** While resolution of this measure is beyond the scope of MCH, obesity is a national public health priority. A unique role for a Title V public health system is identifying needs and convening partners to improve healthy weight among women and children or alternately to reduce obesity. Title V cannot independently impact obesity, but can assess, assure and develop policy for the MCH population. Title V could convene partners, integrate an MCH focus into existing services and support the development of needed interventions. No other federal program has this role. USDA programs are typically focused on low-income families and cannot take a broad public health approach. The CDC engages in broad efforts, but often lacks an MCH focus. Title V has the ability to work across public and private sectors as well as clinical and public health systems. Several measures have been suggested: healthy weight during the preconception period, entering pregnancy at a healthy weight, gestational weight gain and weight measurement during adolescent well visits.
- ***ASPHN strongly supported MCHB's original intention to use several nutrition related measures to track health status in the MCH population.*** We recognize and support the inclusion of Health Status/Outcome Measure 11- Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile). We recommend that additional Health Status / Outcome Measures should include:

- **The proportion of women entering pregnancy at a healthy weight.** The most recent National Health and Nutrition Examination Survey found that in the United States, more than one third of women are obese, more than one half of pregnant women are overweight or obese and eight percent of reproductive-aged women are extremely obese. Obesity among pregnant women is associated with increased risk for multiple pregnancy complications, including gestational diabetes, preeclampsia, chorioamnionitis and postpartum hemorrhage. The National Center for Health Statistics is gathering information about maternal prepregnancy body mass index (BMI) that can be used to track entering pregnancy at a healthy weight. By 2015, national data will be available via the 2003 U.S. Standard Certificate of Live Birth.

- **Gestational weight gain.** Women who gain more than the recommended Institute of Medicine guidelines range have increased risks of adverse pregnancy outcomes, including gestational diabetes, prolonged labor, preeclampsia and cesarean birth. Also, for the woman, weight gain during pregnancy predicts postpartum weight retention, which may have implications for her long-term health and future pregnancies. Gestational weight gain also aligns with infant mortality prevention. Evidence shows that counseling about diet, exercise and weight gain is inadequate in many prenatal and primary care settings. Title V can reinforce the importance of the Institute of Medicine's guidelines for gestational weight gain.

- ***Integrate nutrition into other performance measures such as: Well woman care, oral health, safe sleep, developmental screening, adolescent well-visit, adequate insurance coverage and medical home.*** When the new guidance is adopted, ASPHN requests MCHB provide information about how to incorporate nutrition into relevant performance measures, as well as using structural and process measures to support collaboration, ensure technical assistance, integrate best/promising practices and use resources such as Bright Futures.

- ***Title V programs and MCHB will benefit from having a public health nutritionist on staff who is responsible for assessing and assuring comprehensive quality public health nutrition within Title V activities.*** It is important that public health nutritionists be involved in these transformation efforts. While nutrition is a crosscutting issue that should be addressed by a variety of professionals, a great need exists for specially trained individuals versed in public health nutrition. Nutritionists bring science-based knowledge of public health coupled with expertise in food and nutrition.

Thank you for this opportunity. ASPHN looks forward to working with MCHB and Title V funded programs as this transformation continues. We remain committed to improving the health of women, children and families.

Sincerely,

Karen L Probert, MS, RD
ASPHN Executive Director

Guardino, Taylor (HRSA)

From: HRSA Paperwork
Sent: Friday, August 15, 2014 8:59 AM
To: Wright-Solomon, Lisa (HRSA); Guardino, Taylor (HRSA)
Subject: FW: NYS Comments on Title V Draft Guidance Materials
Attachments: NYS Title V Comments 081514.pdf

From: deLong, Rachel (HEALTH) [rachel.delong@health.ny.gov]
Sent: Thursday, August 14, 2014 3:26 PM
To: HRSA Paperwork
Cc: bewig@amchp.org; Shaw, Wendy M (HEALTH); Kacica, Marilyn A (HEALTH)
Subject: NYS Comments on Title V Draft Guidance Materials

Please accept the attached comments in regard to the Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/ Annual Report OMB No. 0915-0172.

Thank you for the opportunity to comment.

Best wishes,

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NEW YORK
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HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

August 15, 2014

HRSA Information Collection Clearance Officer
Room 10-29
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

The following comments are being submitted on behalf of the New York State Department of Health, pursuant to The Title V Maternal and Child Health Services Block Grant Guidance, Forms and Appendices published in the Federal Register Volume 79, No. 124, June 27, 2014.

General comments

The proposed changes are positive, and we appreciate the thoughtful approach that HRSA has taken to transform the Maternal and Child Health Services Block Grant (MCHSBG). Specific strengths of the proposed changes that we support include:

- The adoption of six population health domains as the organizing framework for the guidance;
- Clearer and stronger emphasis on logical development of an action plan based on linkages between needs, priorities, strategies, outcomes and performance measures; and,
- Flexibility built into the framework for states related to the selection and development of performance, structural and process measures.

We have some concerns about the proposed changes. Key concerns include:

- Significantly underestimated burden for annual application/reporting process;
- Revisions to the MCH Pyramid that do not adequately encompass the breadth and unique value of the MCHSBG;
- Timeliness of pre-population of selected data fields by HRSA;
- Missed opportunity to more substantially restructure and streamline several key narrative sections of the annual application;
- Continued requirements for numerous reporting forms that contribute significantly to state burden without identifiable value to the states;
- Heavy reliance on the National Survey of Children's Health for both outcome and performance measures, in light of survey characteristics that limit its utility for meaningful performance improvement work;
- An increase in the number and complexity of Health Status/Outcome (HS/O) measures without clear rationale;
- Weaknesses, inconsistencies and technical issues for selected HS/O and National Performance Measures; and

- Lack of information about what improvements, if any, will be made to the Title V Information System (TVIS) to accommodate the revised application/report and reduce the burden of the data entry process related to annual updates.

Section-specific comments and accompanying recommendations are detailed below.

Section-Specific Comments

Burden estimate – *Federal Register, pg. 2*

- The burden estimate is unrealistically low. While the re-organization of the framework is significant, the overall application burden does not appear to be have been reduced. In particular, the time to complete the Needs Assessment, which necessarily precedes the development of the Needs Assessment Summary and Action Plan, is substantially underestimated. In a state the size of New York, it will take an estimated 600 hours to develop the FFY16 application.
- We believe there are opportunities for further streamlining which will both reduce the burden and result in a better quality application for states and reviewers (*see below*).

Vision and Mission – *Guidance & Forms, Background and Administrative Information, pp 2-5*

- The proposed revisions to the longstanding MCH pyramid raise significant concerns. We presume the pyramid was revised to make it clear that there are essential services supported through the MCHSBG that will not be reimbursed through health insurance even under the Affordable Care Act (ACA). However, the proposed tiers do not adequately encompass the breadth and unique value of the MCHSBG.
- Of particular concern is the new middle tier titled "non-reimbursable primary and preventive health care services for MCH populations", which appears to replace the current "enabling" and "population based" services. Characterizing this new tier as "health care services" will create further confusion about the overlap of Title V and ACA and does not accurately reflect the role of public health. Many of the supportive services delivered under Title V, including evidence-based programs and interventions, are better characterized as health promotion or community prevention services that address the wide range of behavioral, physical, interpersonal, environmental and socio-economic factors that impact health - i.e., a set of strategies that include but go well beyond "health care" services. We strongly recommend that this tier be re-named to more accurately reflect this public health approach.
- We also recommend that HRSA provide specific definitions and examples of MCH services/ strategies for each tier. We have found that concrete examples are needed to effectively communicate with diverse stakeholders about the relevance and importance of MCHSBG.
- The cross-walk between the pyramid tiers and 10 essential public health services is helpful.

National Performance Measure (NPM) Framework - *Guidance & Forms, Background and Administrative Information, pp 5-6*

- We endorse the concept of re-organizing priorities, outcomes and measures within the framework of population health domains. Reporting by population domains, rather than by

individual measure, is a major improvement over the current application/report format which was characterized by fragmentation and duplication of information across measures.

- The sixth proposed population health domain ("cross-cutting life course") seems superfluous and redundant, as none of the priorities or measures later defined in the guidance appear to fit exclusively in this domain and many outcomes and measures impact more than one domain, consistent with a life course orientation. We recommend this be removed in the interest of eliminating redundancy, streamlining the application and reducing the reporting burden.

Changes to the Application/ Annual Report Guidance - *Guidance & Forms, Background and Administrative Information, pp 6-8*

- We support the elimination of the health system capacity and health status indicators and the new flexibility allowing states to focus on 8 of 15 NPMs.
- While we appreciate that HRSA will now pre-populate selected data fields in an effort to reduce state burden, we have concerns about the timeliness of this. If data are not provided to states early enough, waiting for "pre-populated data" will become a barrier rather than a support. We start working on our interim year applications in January and on the initial five year applications with the needs assessment in September; we will not be able to wait for data from HRSA to begin this work. Please provide further detail about plans for providing data, including the timeline and process for timely follow with HRSA when states have questions regarding the data provided.

Executive Summary - *Guidance & Forms, Application/ Annual Report Instructions, pg 13*

- We endorse the addition of an Executive Summary and recommend that a template be provided to states for this summary.

Overview of the State and Five-Year Needs Assessment Summary - *Guidance & Forms, Application/ Annual Report Instructions, pp 15-16; pp 16-25*

- The "Overview of the State" section of the annual application has not been significantly revised from the current guidance, and it appears that current application sections "Agency Capacity", "Organizational Structure", "Other MCH Capacity" and "State Agency Coordination" have been incorporated within the new Needs Assessment Summary - calling for the same or even increased level of proscriptively detailed narrative responses as in the current guidance.
- We have found these sections of the annual application to be lengthy, time-consuming and not especially useful, contributing significantly to the burden of annual application development for states.
- We believe the lack of substantive revisions to these collective sections of the annual application/report is a significant missed opportunity at this juncture. We recommend that this section of the guidance be dramatically restructured by eliminating the narrative format and replacing it with a stylized "state profile" template that provides a snapshot of key information about each state's population demographics, health insurance programs (including ACA-related reforms), governance and organizational structure and very brief tailored points about specific issues, strengths or other aspects of state, agency and program capacity. We believe this could be accomplished through a standardized template that would be much more useful for HRSA, states and other stakeholders. *We would be happy to participate in developing a template for use by states.*

- We endorse the submission of a Needs Assessment Summary (60,000 characters or 20 pages) to replace the more comprehensive, standalone document previously submitted by States. While the use of the summary document will streamline the final application/annual report and reduce redundancy with other relevant strategic planning initiatives, it will not reduce, and may actually increase, the overall effort (burden) needed to complete, document and now summarize the Needs Assessment process.
- Page 22 of the guidance *MCH Workforce Development and Capacity* indicates that– "States should also report on the number of parent and family members, including Children and Youth with Special Health Care Needs (CYSHCN) and their families, who are on the state Title V program staff and their roles (e.g., paid consultant or volunteer." We believe this focus is too narrow and is not consistent with the broader array of approaches states may use to effectively involve families – such as through representation on state and local advisory councils, workgroups and committees; focus groups and surveys; and other strategies for engaging and obtaining ongoing family input. Large and diverse states like New York typically do not provide direct services to families, have limited options for employing individuals outside the Civil Service system, and require more statewide systematic approaches to represent the diverse needs of families than can effectively be gained through employing one or two individuals at the state level

State Selected Priorities, Linkage of State Priorities with Performance and Outcome Measures - *Guidance & Forms, Application/Annual Report Instructions, pp 26-27*

- We strongly endorse the proposed changes to this section of the annual application to more clearly support logical and coherent linkages between needs assessment findings, priorities, outcomes, measures and strategies.
- We also endorse the proposed new flexibility for states to select eight of the fifteen national performance measures, to develop tailored state-specific structural and process measures and to develop additional state performance and outcome measures.
- It is not clear from the draft guidance where in our application we will demonstrate these linkages – i.e., within the five-year action plan table and narrative, or in another stand-alone section. We recommend this be integrated within the action plan to reinforce the linkages and reduce unnecessary redundancy.

Five-Year Action Plan - *Guidance & Forms, Application/ Annual Report Instructions, pp 28-34; Appendix of Supporting Documents pg 80)*

- We support the proposed Five Year Action Plan Table as a framework for organizing and documenting the State Action Plan. The sample Action Plan Table presented in Appendix B is a clear and useful tool to support this new requirement.
- In contrast, the guidance for the content and structure of the Action Plan narrative (*Guidance & Forms pp 31-34)* and *Appendix of Supporting Documents p 80*) is not as clear. As written, it appears that information regarding MCH Workforce, family/consumer partnerships, Title V involvement in health reform, other significant emerging issues and the state's process for publicly sharing the action plan are intended to be repeated for each of the six population health domains, which would be redundant and burdensome for state applicants and HRSA reviewers. This needs to be clarified, and we recommend that these topics be addressed once across all domains, not separately for each domain.
- In addition, the Action Plan narrative appears to be very lengthy and open-ended, with many elements described in the guidance and appendix sections referenced above. We recommend that the "narrative" elements of the action plan be integrated within the structured format of

the action plan table, rather than having two separate sections. This would have the advantage of being more streamlined, less burdensome for both writers and reviewers and would reinforce the strong data-driven/ performance-based logical framework that underlies this revised guidance.

- If a separate Action Plan narrative is retained in the final guidance, we recommend that it be shortened to brief bulleted highlights and summary points, and that a template be provided to states to clarify expectations and ensure some consistency for ease of review and updates.

Reporting Forms – *Guidance & Forms, Reporting Forms, pp 36-73*

- We request clarification as to how HRSA uses the data collected from states in Forms 2b through 11.
- It is extremely difficult and time consuming for states the size of New York to obtain consistent and accurate client- and service-level data across the large number of public health initiatives supported through MCHSBG. Many hours of staff time are spent trying to estimate and extrapolate this information across programs, with no identifiable value for the state. We recommend that these forms be revisited to ensure that only the minimum data needed are collected, and that the value/use of these data are defined for states.

Appendices E: Performance Measure Framework and F: Detail Sheets for the National Health Status/Outcome Measures and National Performance Measures – *Appendix of Supporting Documents, pp 17 – 19, pp 20-77*

- We request that HRSA provide states with a more complete rationale for the selection of the fifteen national performance priority areas listed in the table on page 17, along with the rationale for eliminating other longstanding MCH priorities. Clear communication with states about both the process for revising outcome and performance measures, and how the final set of measures reflects changes in national MCH priorities, is important.
- The heavy reliance on the forthcoming revised National Survey of Children's Health (NSCH) as the data source for both health status/outcome and national performance measures is a concern. While the current NSCH provides valuable and unique information, the reliance on parent self-report and the sporadic and delayed nature of the data are critical limitations for its use in meaningful "real-time" performance management work that is key to the annual needs assessment and action plan updates. We understand generally that planned changes will include both new/revised questions and annual data updates, but at this time we have not received any specific details about the timeline or process for these changes. We would greatly appreciate further information from MCHB about these planned changes as this will be pivotal to successfully implementing the revised Title V guidance.

Health Status/Outcome (HS/O) Measures

- Overall, the set of HS/O Measures is somewhat improved in terms of reflecting major health outcomes. However, the burden associated with reporting these measures appears to have increased, from 12 to 21 HS/O measures and increased complexity of e data requirements for selected measures (e.g., obtaining series of specific ICD-10 and procedure codes to calculate HS/O #2 and #21).
- The HS/O measures for maternal and women's health are weak compared to the other domains. Given the increased emphasis on life course and especially preconception and interconception health, it is surprising that additional measures of women's health are not included – e.g., measures of general health and wellness (comparable to HS/O #9 for

children); measures of the prevalence and morbidity of common chronic diseases (hypertension, diabetes, obesity, depression) among women of child bearing age (comparable to HS/O #11, 14, 19.2, 19.3); and measures of reproductive health (unintended pregnancy rates, birth spacing).

- The HS/O measures for adolescent and young adult health are also weak compared to other domains and compared to the current Title V measures. Most notably, there are no HS/O measures related to reproductive health, e.g. adolescent pregnancy rates or STD rates. Given the significant burden of these health outcomes among adolescents and their impact on future maternal and child health, their omission is concerning.
- While we recognize that states will have the flexibility to establish additional State Outcome Measures, we view this as an important gap in terms of representing national MCH priorities.
- It is not clear how the specific set of HS/O measures for CYSHCN were chosen. The decision to highlight the prevalence of two specific sets of health conditions (ASD, ADD/ADHD) but not to include other common and emerging chronic health conditions with serious public health impact (asthma, diabetes) is concerning. We recommend that if condition-specific measures are to be included, that others be added for a more well-rounded picture.
- There is substantial internal inconsistency in how "health status/outcome measures" and "performance measures" are respectively defined and classified. Specifically, we identified five measures classified as HS/O measures that would be more accurately classified as performance measures, and one NPM that we believe would be more accurately classified as a HS/O measure:
    - HS/O #8.5 Percent of non-medically indicated early term deliveries among singleton term deliveries
    - HS/O #13 Percent of children without health insurance
    - HS/O #18 Percent of CSHCN receiving care in a well-functioning system
    - HS/O #20 Percent of children age 3-17 years with mental/ behavioral conditions who receive treatment
    - HS/O #23 Percent of eligible newborns screened for heritable disorders with on-time physician notification for out of range screens who are followed up in a timely manner
    - NPM #6, Rate of injury-related hospital admissions per population age 0-19 years

In light of the strong focus on demonstrating clear linkages between outcomes, strategies and measures within State Action Plans, we recommend that these six measures be re-classified.

National Performance Measures (NPM)

- The NPMs for Maternal and Women's Health are weak compared to the other domains, and do not appear to adequately encompass the key drivers of maternal morbidity and mortality highlighted as priorities in the related HS/O measures #21 and 22. Notably, all performance measures related to timely and adequate use of prenatal care have been eliminated which is puzzling. While we recognize that states will have the flexibility to establish additional State Performance Measures, we view this as an important gap in the national performance measures as important reflections of national MCH priorities
- *NPM 2: To reduce the number of cesarean deliveries among low-risk first births.* The definition of term as 37+ weeks gestation does not reflect the significant improvement work done in states such as New York and nationally to ensure an understanding of term as 39+ weeks. The definition should be revised to include the correct terminology: early term (37/0 – 38/6), term (39/0 – 40/6) and post-term.

- *NPM 5 – Percent of children age 9-71 months receiving a developmental screening using a parent-completed screening tool.* We fully support the addition of a measure on developmental screening, but do not think the NSCH is the best measure/source of this information. This measure should be consistent with the American Academy of Pediatrics (AAP) recommendation for Developmental Screening, which include Developmental Screening at 9-, 18-, and 30-months and Autism Screening at 18- and 24-months. We suggest instead aligning with the measure that is used for the Children's Health Insurance Program Reauthorization Act Quality Reporting which has been endorsed by the National Quality Forum (NQF): *Developmental screening in the first three years of life* / HHS: 004822 – metrics for this have already been developed nationally and would help align Title V with other health systems sectors.
- *NPM 8 – Percent of adolescents, ages 12-17 years, who are bullied.* We recognize the importance of bullying but question the decision to include this measure to the exclusion of other critical measures of adolescent behaviors and relationships such as risky sexual activity, contraceptive use, interpersonal violence, substance use and/or supportive adult relationships. If this is truly a new national priority for MCHB, we believe more information and technical assistance for states is needed.
- *NPM 10* – Percent of infants who are ever breastfed. We fully support the inclusion of a measure on breastfeeding, but believe that "ever breastfed" alone is weak as a performance measure and too vague to drive meaningful public health intervention strategies. Consistent with other multi-dimensional performance measures (e.g., *NPM12* and *NPM15*), we recommend this be expanded to a suite of measures consistent with the measures collected through the National Immunization Survey and Vital Statistics, including: 1) Ever breastfed; 2) Exclusively breastfed in hospital; 3) Exclusively breastfed at 3 months and 4) Exclusively breastfed at 6 months. This would allow states to critically review breastfeeding data and target improvement activities accordingly.

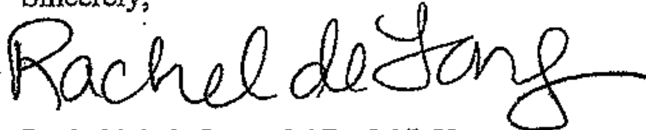
Technical Formatting and Submission Requirements

- The guidance does not reference how TVIS will be modified to support the significant changes in application/report format and structure. We strongly recommend that adequate attention be given to this key aspect of the process as it contributes significantly to the burden of annual application/reporting. For example, the sample Action Plan format (Appendix B) should be incorporated within TVIS for ease of reporting.
- Throughout the guidance, there are references to states "updating" various sections of the initial 5-year and subsequent interim year reports (see for example *Appendix of Supporting Documents pp 81-82)*. Conceptually, this sounds positive and hopefully signals an intention to reduce very burdensome duplication and formatting issues that have plagued the current interim application process. However, because there are no specific details provided regarding what the technical mechanism and format will be for doing this, we cannot determine the extent to which such improvements actually will be accomplished.
- Under the current format and TVIS system, there are sections of the application that are pre-populated, thus not allowing previously submitted information to be deleted. This makes the document unwieldy and difficult to update as information changes year to year. Conversely, there are sections that do not change drastically from year to year. We recommend that the pre-population of sections within TVIS be discontinued, and instead that states be permitted to either indicate "no change", submit brief summary updates to key information (e.g., a new Commissioner of Health) or submit revised replacement text for a given section.

- Clarification will be needed specific to the FFY16 application, in the context of transitioning from current to new set of performance measures. Because each year's submission includes a report from the previous year as well as an application for the next year, it is unclear how FFY16 will be structured. We recommend that the FFY16 application focus on the new framework and measures going forward, with a brief summary of the past five year accomplishments if needed, rather than detailed measure-specific narratives.

Thank you for the opportunity to comment on this draft guidance. We look forward to our continued partnership with HRSA MCHB to support the health and well-being of women, infants, children and families in New York State and nationally.

Sincerely,



Rachel M. de Long, M.D., M.P.H.
Director, Division of Family Health/ Title V Program
New York State Department of Health

Guardino, Taylor (HRSA)

From:	HRSA Paperwork
Sent:	Monday, August 25, 2014 12:53 PM
To:	Guardino, Taylor (HRSA); Wright-Solomon, Lisa (HRSA)
Subject:	FW: FRN) Doc No: 2014-15051. Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual ReporFW: New MCH Draft Guidelines reply from Virginia Title V/MCH program
Attachments:	MCH New Guidance Questionsmasterfinal.docx

From: Kalanges, Lauri (VDH) [Lauri.Kalanges@vdh.virginia.gov]
Sent: Sunday, August 24, 2014 11:33 PM
To: HRSA Paperwork
Subject: FRN) Doc No: 2014-15051. Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual ReporFW: New MCH Draft Guidelines reply from Virginia Title V/MCH program

Resending with the FRN notice in subject line thank you.

Lauri Kalanges, MD MPH
Deputy Director, Office of Family Health Services
Virginia Department of Health
109 Governor Street
Richmond, VA 23219-2448
Office: (804) 864-7170

From: Kalanges, Lauri (VDH)
Sent: Sunday, August 24, 2014 11:11 PM
To: 'paperwork@hrsa.gov'
Subject: New MCH Draft Guidelines reply from Virginia Title V/MCH program

Good evening,
I have attached the response to the new MCH Draft Guidelines from Virginia.
Please let us know if you have any questions.
Thank you,

Lauri Kalanges, MD MPH
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Title V/MCH Direcotr
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Draft MCH Guidance Reply from Virginia Title V/MCH

HRSA specifically requests comments on: "(1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions, (2) the accuracy of the estimated burden [**set at 189 hours**], (3) ways to enhance the quality, utility, and clarity of the information to be collected, and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden."

1. Does the proposed guidance achieve the overall aims of the MCH transformation:
   - To reduce burden to states?
     - Yes Unanimous
     - No
   - To maintain state flexibility?
     - Yes Unanimous
     - No
   - To improve accountability?
     - Yes Unanimous
     - No
2. Is it realistic to expect progress on at least 13 performance measures (8 selected national measures plus 5 state performance measures) at current funding levels?
   Mixed response from respondents
   Of those who said no, would you suggest allowing states to choose "up to five state performance measures" rather than five exactly?
     - Yes- Unanimous
3. Forms for budget and expenditures by type of service (pg 44) Does this form need additional definition to allow states to accurately estimate burden?
   - Yes unanimous
   - No
4. Structural and performance measures- Is clarity needed on how they differ from the state performance and outcome measures and the health status/outcome measures?
   a. Yes unanimous
   b. No

<u>**Direct Reimbursable MCH Health Care Services**</u>

Direct Reimbursable MCH Health care Services is proposed as 1st level of the revised pyramid of services. It is not clear how this differs from the "direct services" using the previous four levels of MCHB pyramid of services. One recommendation is the following definition developed by MCHB in 2013 for a survey :

"Definition of Services" proposed definition
*For this survey a list of examples of services can examples of "services" can be found in the following paragraph. Using your Federal Title V MCH Formula Block Grant funds, services would be paid for through a formal process similar to paying a medical billing claim. Federal Title V MCH Formula Block Grant funds provided to a partner, such as a clinic or local health department, for salary or operations support **are not** considered services for the purpose of this survey.*
Services include, but are not limited to:

- *primary care and specialty care doctor visits,*

- *emergency department visits,*
- *inpatient services,*
- *outpatient and inpatient mental health and substance abuse services,*
- *prescription drugs,*
- *occupational and physical therapy,*
- *speech therapy,*
- *durable medical equipment and medical supplies,*
- *lab services,*
- *radiology,*
- *medical foods,*
- *preventive care screenings,*
- *dental care,*
- *orthodontia,*
- *vision care,*
- *case management,*
- *transportation, and*
- *rehabilitative and habilitative services.*

Reimbursement for services using the Federal Title V MCH Formula Block Grant funds could be made for children or pregnant women who are uninsured or who exceed coverage limitations if they do have public or private insurance. For example, suppose your state's CHIP program reimburses for 20 physical therapy sessions for a child. However, the child needed 30 sessions, so the Title V program paid for the extra 10 sessions using the federal portion of Title V MCH Formula Block Grant funds. In this case, physical therapy is a reimbursed service as defined for this survey."

5. Is the above definition of the **Direct Reimbursable Health Care Services** acceptable to you?
   - Yes Unanimous with one additional comment below
   - No
   - Comments: This would be a significant change in the day to day operations Title V dollars to the 35 Virginia health districts. Also, there remains concern about how the ACA will affect this population

6. Non-reimbursable **Primary and Preventive Healthcare Services** for MCH Populations. Would a list of examples suffice?
   - Yes
   - No
   - Comments: There was one concern that primary services are different than preventive services. There needs to be either a clear definition for each OR if they are the same than one clear definition phrase/term used

7. **Public Health Services and Systems for MCH Populations-** Would a list of examples suffice
   - Yes near unanimous
   - No
   - Comments :

- Again public health SERVICES are different than public health systems and require different infrastructure supports, resources and inputs and measures. Language needs to be clear and definitions need to be consistent. "Services' are generally defined in terms of direct are to patients and "systems" is used more broadly in terms of linkages and multiple points of care that touch patients
- If states are allowed flexibility to add to the list through conversation with HRSa/MCHB

IMPORTANT: Please note that definition or the items in question 5-7 are significant since we expect states will be asked to breakdown their budget by the new 3 level pyramid of services. How they are defined will dictate changes needed to implement how we calculate and report our budgets.

Overview of the proposed Performance Measurement Framework

Outcome Measures. The proposed guidance eliminates Health System Capacity Indicators and incorporates some of the health status indicators into the NHS/OMs, and yet there are statutory requirements to report on the following that are not included:

- the proportion of infants born with fetal alcohol syndrome,
- the proportion of infants born with drug dependency,
- the proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy

8.Would you recommend including these issues as well?

- o Yes near unanimous
- o No
- o Comments:
  - Although some of these conditions are not found at delivery, the drug dependency issues also related to lack of or little PNC. There is concern about the monitoring of these issues in the context of a healthy family. As the same time, how would Virginia be able to use Title V dollars to improve care of these families?

Family/Consumer partnership

9._The guidance calls for states to report on "level of commitment to consistently engaging family/consumer partnership."

How do you recommend that states determine level?

- Require documentation of involvement, not just attendance at meetings, but outcomes of work.
- The guidance should list and define 4-5 "levels of commitment" and then the states can identify with their justifications how they fit into which "level". If there isn't a standard definition in the guidance, there is a concern about consistency in expectations and outcomes.
- Virginia can determine the level off family engagement in our CYCSHN program with our CCCs and CDCS as well as family representatives on committees, boards, etc.

- A process measure could be developed that reports the number of P2P group, advocacy groups or other family/consumer groups that Title V programs interact and participate with on an ongoing basis.
- Percentage of activities that consumers are involved with or participate in.
- Identification of family/consumer partnerships that exist and form of interaction i.e. public meetings, online trainings.

Title V as a safety net program

Guidance indicates Title V "will continue to serve as a safety-net provider…by providing gap-filling safety net services." Yet, surveys indicate that close to half of all states are not providing any direct reimbursable health care services and the remaining states are serving very small numbers (i.e. <1% of population). Should this description therefore specify "will continue to serve as a safety-net provider *in some states…*" to more accurately reflect current use of resources?

10. Should the guidance describe Title V as a safety net program?

No
Comments:
- It should describe what it actually is doing therefore it should specify "some states" versus appearing to be used by all states in that manner.
- However, it is not set up in Virginia as a primarily safety net program but may be a safety net program in other states.\

Description of the Purpose of the MCH Block Grant (page 2 of appendix).

Three of the first four bullets describe Title V as "providing comprehensive care…" and the fifth references "immunizing all children." In reality states seem to be using few Title V funds for these purposes. This can create a major disconnect between what policymakers think Title V does and how the funds are actually spent.

11. Do you Is the new mission of Title V as described on page 4-5 of the guidance more accurate?
Yes

Availability of Data For Pre-Population.
As noted, a large portion of the anticipated reduction in burden of reporting will be achieved by pre-population of reportable elements with state data where available at the national level.

12. Do you recommend that MCHB provide a proposed timeline to maek available to states which data they will be pre-populating?
- Yes – near unanimous
- No

Interrelationship of measures.
There may be an opportunity to map each of the NHS/OMs back at least to the six domains (as they did with the NPMs) and even to individual measures. Otherwise, states will likely have to do this themselves in the state action plan, and the potential concern is that states will map these differently

(although flexibility is nice), and this is added burden that could be reduced with some additions to the NHS/OM detail sheets.

13. Do you need additional clarity on the connection between how the NHS/OM measures relate back to the NPMs?

- Yes Unanimous
- No

Feasibility of Three Page Executive Summary. The guidance calls for a three page summary that describes "major accomplishments and significant challenges" for the state's performance on each of the measures under the new framework. When including submeasures there are 36 NPM/OMs, 8 state selected NPMs, 5 SPMs and at least 13 S&PMs supporting each of the NMPs and SPMs, for a total of at least 62 reportable measures.

14. Is it feasible to think an executive summary could include this level of reporting?

- Yes
- No – near unanimous
- Comment: One could not report 62 measures in 3 pages.

If not, would it be better to suggest states choose which measures to highlight in the summary?

- Yes near unanimous with comment: If states are expected to report on the "major accomplishments and significant challenges" of up to 62 in only a three page space, little if any meaningful content could be presented. Opting instead for being able to select specific measures in priority areas may encourage a more fruitful discussion of successes and challenges and ultimately render a better view into the landscape around tee priority.
- No

Needs Assessment Expectations.

15. Are the expectations clear regarding the level of detail expected in the needs assessment?

- Yes – near unanimous
- No

16. Is a 20 page limit for submission acceptable?

- Yes near unanimous
- No

Action Plan Table format.

17. Will states be able to fit the level of detail needed (particularly for strategies) in the Five Year Action Plan Table format?

- Yes near unanimous
- No

State Action Plan Key Strategies / Activities.

18. Would it be helpful to request inclusion of examples to help differentiate between a performance measure and a strategy? (p.30).

- Yes -near unanimous
- No

State Support for Family / Consumer Engagement.

19. Should "advocacy" be replaced with "education of policymakers" to reduce a potential red flag in the list of strategies?

- Yes Unanimous
- No

20. Open comments related to any question (please designate question)

- The changes reflect the reality of how title V has been used in many states. Changes to population groups vs performance measures will better represent the collaboration that is occurring and in some cases support more collaboration.

- 1 – Percent of women with a past year preventive visit – NEW –good!

- Other performance measures for consideration:

  - Percent of adolescents that receive the HPV vaccine
  - Percent of women that receive baseline mammogram screening by age 40
  - Percent of women that receive cervical cancer screening age 21 and older
  - Percent of women that are overweight or obese
  - Percent of women who exercise 3 or more time/week

Guardino, Taylor (HRSA)

From:	Wrightsman-Birch, Stephanie G (HSS) <stephanie.wrightsman-birch@alaska.gov>
Sent:	Tuesday, August 26, 2014 7:31 PM
To:	Wright-Solomon, Lisa (HRSA)
Cc:	HRSA Paperwork; Guardino, Taylor (HRSA)
Subject:	RE: Alaska's response to the federal register notice 2014-15051
Attachments:	Alaska response to federal register notice2014-15051.pdf

Let's try again

Stephanie.Birch@alaska.gov
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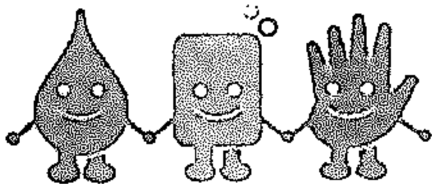

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Alaska Division of Public Health
Prevention Promotion Protection

From: Wright-Solomon, Lisa (HRSA) [mailto:LWright-Solomon@hrsa.gov]
Sent: Tuesday, August 26, 2014 10:52 AM
To: Wrightsman-Birch, Stephanie G (HSS)
Cc: HRSA Paperwork; Guardino, Taylor (HRSA); Wright-Solomon, Lisa (HRSA)
Subject: Alaska's response to the federal register notice 2014-15051

We received your e-mail but don't see your comments.

Thank you!

Lisa Wright-Solomon
Deputy Division Director
Health Resources and Services Administration
Maternal and Child Health Bureau
Division of Services for Children with Special Health Needs
5600 Fishers Lane
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Rockville, MD 20857
301-443-0985

From: Wrightsman-Birch, Stephanie G (HSS) [mailto:stephanie.wrightsman-birch@alaska.gov]
Sent: Monday, August 25, 2014 6:57 PM
To: HRSA Paperwork
Cc: Brent Ewig
Subject: Alaska's response to the federal register notice 2014-15051

Please accept Alaska's response to the federal register notice entitled Title V MCH Block grant to states program application and annual report guidelines and forms.

Thank you.

Stephanie.Birch@alaska.gov
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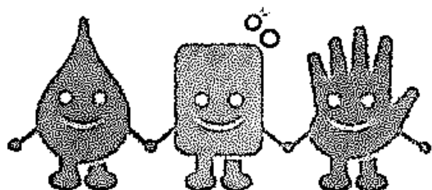

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THE STATE of ALASKA

GOVERNOR SEAN PARNELL

Department of Health and Social Services

DIVISION OF PUBLIC HEALTH
Section of Women's, Children's and Family Health

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Main: 907.269.3400
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August 26, 2014

HRSA Information Collection Clearance Officer
Parklawn Building
5600 Fishers Lane, Room 10-29
Rockville, MD 20857

Re: Federal Register Notice (FRN) Doc No: 2014-15051. Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172—Revision

Dear Sir or Madame:

Thank for the opportunity to comment on Federal Register Notice (FRN) Doc 2014. To follow is a list of comments regarding the current proposed changes to the Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172—Revision:

1. As noted by the Association of Maternal Child Health Programs, a glossary of terms and definitions is a foundational need in order to fully estimate the level of burden that will result from the proposed Title V guidance and forms, and to understand federal expectations for reporting on essential elements of the Title V program especially in relationship to the three levels of the new proposed Title V pyramid. Definitions are needed in areas including but not limited to:
    a. number of individuals served by the Title V program,
    b. forms for budget and expenditures by type of service,
    c. direct reimbursable MCH health care services,
    d. non-reimbursable primary and preventive health care services for MCH populations,
    e. primary leadership in administering an activity and
    f. Public health services and systems for MCH populations.

2. While the proposed guidance and reporting forms propose to reduce the number of reportable measures from 52-55 measures (depending on the current number of state performance measures chosen), in reality the proposed plan has actually increased the number of national and state reportable elements to a range of 57-61 depending on the measure selection. While we applaud the Maternal Child Health Bureau for focusing the measures on the six MCH population health domains, the number of measures to report on will continue to cause an undue burden especially in small states such as Alaska where the block grant received is just slightly over 1 million dollars per year. Currently the state spends well over 1.5 FTEs in time (3120 hours per year) in preparing and reporting the block grant application. In the years where a 5 year needs assessment is conducted, the amount of FTE increases to over 2.0 FTE's worth of time (4160) to accomplish all of the requirements. This amount of time far exceeds the amount of time put into writing other annual reports for some federal grants whose awards are at least as much if not more than that of the Title V MCH Block grant. This translates into 20-25% of the Alaska's grant award dollars is spent collecting, analyzing and reporting data and writing an application which requires extensive detailed reporting of work done. While we appreciate the intense scrutiny the MCH Bureau has experienced, we do not feel that more data and reporting requirements are necessarily better, nor with increased reporting will it translate into more effective or more efficient program delivery in our state. We strongly request that the reporting requirements be reduced by reducing the number of national and state performance measures that states will select

to report on annually during a 5 year cycle. An additional possibility for reducing the burden of writing the annual report and application is to consolidate the requested information about MCH program capacity and partnerships into single sections, rather than asking states to describe these in multiple parts of the application/annual report.

3. We appreciate that HRSA has indicated in the proposed guidance that some performance measure data will be pre-populated, as a way of reducing reporting burden on the states. Will there be an opportunity for states to include more recent data if we have it available to us before it is available at the federal level, or will we only be able to report the data pre-populated by HRSA?

4. The proposed guidance requests that states will report on the "level of commitment to consistently engage family/consumer partnerships". Please provide more guidance on what this really means. How will we as a state determine or assess the "level of commitment"?

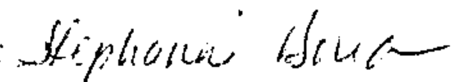
5. Five Year Action Plan Table-p.8 of the FRN. While the example of the table is helpful and provides a nice way to demonstrate the link of national outcome and performance measures with the state performance measures, it may be misleading to think that the amount of detail required to be addressed on 'strategies' will fit into a table format. We would also suggest removing the requirement to report on the structural and process measures in this table for ease of reading. We request that SMART objectives be substituted as the required framework with limited narrative required describing the activities. This would improve the reporting, assure consistency and measurement as well as reduce the narrative reporting burden. Finally, examples would be helpful in the guidance to assist states to differentiate between performance measures, strategies, and structural and process measures.

6. Additional guidance on what information to include in the cross-cutting or life course domain for example, when asked to describe MCH population needs (p.20 of the FRN) or Title V program capacity (p.22) would be helpful.

7. Regarding the Outcome and Performance Measures, we have a few questions that need clarifying:
    a. Will we receive more detailed guidance about how to combine the data sources for Outcome measure 11 (Percent of children/adolescents who are overweight or obese)? It is not clear from the information on the detail sheet (p. 44 of Appendix) how to combine the data from these sources to get one measure. Alternatively, are states supposed to report three different percent's?
    b. For PM#10 (ever breastfeeding) can states that have a PRAMS survey choose to use PRAMS data rather than NIS? We believe the PRAMS data are more valid and reliable than NIS for Alaska for this particular indicator.
    c. Please clarify how states are expected to report on the performance measures with two data sources (PM#12 – dental visits, and PM#15 – exposure to smoking). Are states supposed to calculate one number/percent that incorporates the data both for women and infants, or are we supposed to report two different numbers for a single performance measure?

In closing, we appreciate the significant work the leadership at the Maternal Child Health Bureau has put forth in redesigning the guidance and forms to match MCH 3.0 Transformation and their collaboration with state leaders who provided input throughout the redesign process. We hope these comments will be helpful to clarify the guidance and forms and assure states are identifying the most important outcomes and reporting on strategies and data that will improve outcomes for women and all children in the United States.

Thank you,



Stephanie Birch RNC, MPH, MSN, FNP

Section Chief, Women's, Children's and Family Health

Guardino, Taylor (HRSA)

From: Duckhorn, Jodi (HRSA) on behalf of HRSA Paperwork
Sent: Tuesday, August 26, 2014 12:48 PM
To: Wright-Solomon, Lisa (HRSA); Guardino, Taylor (HRSA)
Subject: FW: Florida comments on draft MCH Title V Guidance
Attachments: FL Comments on Proposed Title V BG Guidance.docx

From: Peck, Bob [mailto:Bob.Peck@flhealth.gov]
Sent: Tuesday, August 26, 2014 9:36 AM
To: HRSA Paperwork
Cc: 'bewig@amchp.org'
Subject: Florida comments on draft MCH Title V Guidance

Per request, attached are comments from the Florida Title V MCH program on the draft guidance for the Title V MCH Block Grant.

Please feel free to contact me if you have any questions. Thank you for the opportunity to comment on the guidance.

Bob Peck
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MCH Comments on the Proposed Revisions to the Title V Maternal and Child Health Services Block Grant Guidance

1. Presently the revised guidance calls for states to select eight national performance measures and five state performance measures. While this is a reduction in the number of measures states were required to track in previous years, if the aim of the transformation is to reduce the burden to states and to maintain state flexibility, perhaps states should be allowed to choose "up to" five state performance measures.

2. Without a clearer definition of "direct reimbursable health care services" and "population-based services" it will be difficult for states to estimate and report the numbers served using these two levels. This is especially important if states will also be required to use these definitions when calculating and reporting their budgets on Form 3b.

3. We would like to see a clearer definition for structural performance measure. It is not clear how the structural performance measures differ from the state performance measures, outcome measures, and the health status/outcome measures.

4. Better definitions are needed for the three pyramid levels in Figure 1. For each of the three levels, it would be helpful if the guidance included a list of examples of the types of services examples that correspond to each level.

5. We noticed that there were some reporting requirements in the federal Title V law that were not included in the new guidance such as:

   The proportion of infants born with fetal alcohol syndrome,
   The proportion of infants born with drug dependency, and
   The proportion of women who deliver who do not receive prenatal care during the first trimester of pregnancy.

6. The guidance describes Title V as a "safety net" program, which is interpreted to mean that states are using the Title V funds to provide "gap-filling safety net services" in the form of direct reimbursable services. However, we would surmise that not all states are actually using significant portions of their Title V funds for direct reimbursable services. Therefore, it is recommended that the guidance take this into consideration by specifying that the Title V funds will continue to serve as a safety net provider in "some" states. This would more accurately reflect how the funds are actually being used.

7. The bullets describing the purpose of the Title V Maternal and Child Health Services Block Grant contained on page 2 of the appendix are very prescriptive in their specificity as to how the Title V funds are to be used by states. By being so prescriptive states might be prohibited from using these dollars for state identified priorities. The Title V mission as written on pages 4 – 5 of the guidance is a more accurate description of how the Title V funds are actually spent and provides greater flexibility to states in tailoring strategies to address the needs of their maternal and child health populations.

8. The plan to reduce the state burden related to the annual performance data by pre-populating data for the NHS/OMs and the NPMs is greatly appreciated. However, of particular concern is the timeframe in which the data will be available. It is important that the data be available in the HRSA Electronic Handbook (EHB) by at least April 1st so states will have sufficient time to assess and incorporate the data into their development of the application and annual report. At the latest, all data should be pre-populated in

the EHB when it opens in early April, or better yet at an earlier date in another format if available.

9. Presently the guidance maps the NPMs to the six population domains, which is very helpful. It is suggested and would be helpful if a similar mapping were done relating the NHS/OMs to the six population domains as well. This would provide for consistency among the states in how they relate the NHS/OMs to the domains which is important especially if the objective of the transformation is to "move the needle."

10. The revised guidance limits the newly required Executive Summary to three pages used to briefly describe major accomplishments and significant challenges of the state's Title V program, as well as the state's performance on the various performance measures (e.g., the NHS/OMs, NPMs, SPMs and the S & PMs) specific to each of the six population health domains. There is concern as to whether three pages is sufficient to cover so many reporting elements and areas. To help states maintain the brevity desired in the Executive Summary and at the same time create a standalone document that could be used to help market the state Title V program, perhaps it would be better to allow the states to choose which measures to highlight based on their successes and challenges.

11. Examples of the action plan key strategies and activities would be helpful to states in differentiating between performance measures and strategies.

12. We suggest that the term "advocacy" be replaced with "education" to reduce the potential of misinterpretation.