Guardino, Taylor (HRSA)

From: Duckhorn, Jodi (HRSA) on behalf of HRSA Paperwork
Sent: Tuesday, August 26, 2014 9:28 AM
To: Wright-Solomon, Lisa (HRSA); Guardino, Taylor (HRSA)
Subject: FW: Comments on Draft Title V MCH Services Block Grant - FRN Doc No: 2014-15051
Attachments: Comments on Draft MCH Block Grant Guidance.docx

From: Nan Streeter [mailto:nanstreeter@utah.gov]
Sent: Monday, August 25, 2014 1:53 PM
To: HRSA Paperwork
Subject: Comments on Draft Title V MCH Services Block Grant - FRN Doc No: 2014-15051

Please accept my comments on the Draft Guidance in response to FRN 2014-15051. Thank you, Nan Streeter

--
Nan Streeter, MS, RN
Utah Department of Health
Deputy Director, Division of Family Health and Preparedness
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August 25, 2014

HRSA Information Collection Clearance Officer
Parklawn Building
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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

This letter is in response to the above cited FRN.

I have to extend my thanks to Dr. Lu in his leadership and vision in transforming MCH! He has been very receptive to input, ideas and suggestions; he has been willing to listen and hear the concerns of state leaders about the duplication of content and redundancy. He has been clear about the need to hold states accountable throughout the process, so changes made were in response to the duplication.

All in all, many of the changes are good changes. However, I believe that requiring a "full" Block Grant Application and Report annually as outlined in the draft guidance is still too much of a burden to states. My suggestion is the Annual Application and Report should consist of: 1) Five Year Needs Assessment Summary, 2) Description of what was accomplished the previous year and what will be accomplished in the year ahead, 3) financial reporting, and 4) summary of any changes in the various narrative sections. The requirement to report on what we are currently doing really shouldn't be needed as it is discussed in the previous year's grant. Reporting on what was accomplished (or not) in the next year ought to be sufficient. These changes would really reduce states' burden while providing a report and plan for the upcoming year, thus being accountable.

Positive Comments:

1. The draft guidance revisions address many of the issues that states have voiced for years without resolution until now. The new draft guidance does reduce the amount of redundancy and duplication in content in both the Needs Assessment and the actual grant application and report.
2. The Needs Assessment Summary is an excellent approach to the state identifying its priorities as it reduces the amount of reporting on health indicators for all three populations and allows states to summarize the important findings that actually need attention rather than a detailed description of many health indicators, significant or not. Incorporating the needs assessment with the annual application and report is helpful as it is accessible rather than being a stand-alone document that probably was never read by others.
3. The shift to a five year plan makes sense from a perspective of strategic planning and evaluation. However, it does add to the state burden for the grant, especially for the first year given the short amount of time between release of the guidance and the due date for the grant.
4. Reduction of the required number of national and state performance measures is helpful.

5. I like the revised pyramid as it simplifies the concepts and with definitions, it will clarify direct services and what these entail.

Other Comments:

1. The timing of this new guidance to be released January 2015 gives states very limited time to respond to the new requirements in the guidance, especially the five year plan.
2. Burden to states
   The July Federal Register Notice indicated that the "Burden per response (in hours)" is 123 hours for the annual application and report, and 189.3 hours for the application, report and Needs Assessment.

   - The estimate of 123 hours is equivalent to one FTE working an 8 hour day for 15.3 days for the annual application and report and the estimate of 189.3 hours is 23.7 days for one FTE for the Needs Assessment and annual report and application!!

   The estimate of state burden remains to be tremendously under- estimated, particularly for smaller states with very little Title V funding. Each state and territory is expected to accomplish the same amount of work with varied amounts of funding, resources and level of infrastructure capacity. The burden needs to be further reduced by shortening the narrative requirements that now have been expanded to include additional topics that were not required previously.

   In our state, we have more than 36 staff members who contribute to the grant each year, some spending more time than others. We begin work on the annual application and report in January and spend substantial amounts of time from then until July. In addition, we have a core group of approximately 5 staff who spend a substantial amount of time focused on the grant. Each one of them alone probably spends the estimated state burden time with the grant preparation.

   The state burden now will include the following activities:

   - Public input and inclusion of input received
   - Updates on narrative sections of grant application
   - Development of plans for the upcoming year for each National and State Performance Measure
   - Development of the narrative for the report, current activities and planned activities for each National and State Performance Measure
   - Updates on all data elements including performance and outcome measures, demographics
   - *New narrative sections, such as Workforce, health reform, etc.
   - *Development of five year action plan
   - *Development of S/PMs
   - *Needs Assessment Summary
   - *Executive Summary
   - Financial reporting, including
     - Overall financial reporting
     - Financial reporting by population served
     - Financial reporting by pyramid level

   *= new requirements

- It is misleading to say that the Health System Capacity Indicators have been eliminated when some have simply been incorporated into the NHS/OMs.
- Pre-population of data is actually only a slight relief in the burden of states. I personally would rather populate the data for the grant myself as it would be more current than any data MCHB has.
- The burden has been increased due to the additional requirement for the 5 year action plan AS WELL AS the report on past activities, current activities and future activities – it would be helpful to have these two combined to reduce overlap and repetition.

3. Definitions needed to be included with the draft guidance in order for states to adequately assess the burden more accurately as well as the meaning of the language in the draft guidance.

4. While the shift to 6 domains is good, it is not applied across the board consistently, e.g., reporting of numbers served, activities, etc. Some measures do not include women of childbearing ages, such as poverty and insurance which are interrelated with children's insurance and poverty. Lifecourse has to include women of childbearing ages or at least mothers and this is what lifecourse is all about, isn't it?

5. The age designation should be updated to be more accurate – birth to XXX, not 0 – XXX.

6. The Maternal Death definition should be expanded to include deaths that occur up to 12 months post delivery, fetal death, etc. Many women who die of pregnancy-related causes die much later than 42 days, especially if they have chronic diseases that were exacerbated by pregnancy. By limiting the definition to 42 days, we are missing deaths that need to be identified so that we have a true picture of our rates of maternal mortality, a huge under-reported and under-recognized issue in our country!

7. Financial reporting –
   a) Need clarification on what is meant by local funding – "total of MCH dedicated funds from local jurisdictions with the state and applied to state match plus overmatch for Title V". Does this mean that we only report local funds if we use them for match or overmatch?

   b) Why are we required to report all MCH funding that a state Title V Director administers? Each state is organized differently, so these numbers are comparing apples and oranges – one state MCH administers Title X, we don't. Another state administers Part C of IDEA, another doesn't. One state has different state agencies overseeing the MCH and the CSHCN separately. Some Title V Directors have oversight of chronic disease prevention programs that "touch" women and children, so does this matter? It is not an accurate representation of funding allocated to MCH populations and it overinflates Title V efforts as it has in the past. States' organizational structures vary. I am not sure of the relevance for reporting this information.

   c) On Form 2a – we should be asking state to report funding allocations for all three populations covered under Title V, i.e., mothers, children and children with special health care needs. I realize that the law only requires the 30-30-10 distribution, but reporting allocation of Title V funds without a category for mothers never conveys how we actually

use the Title V funds, because the amount of funding that states use to promote healthy pregnancy is not a reporting category on Form 2a. I thought that Title V was about mothers and children.... Reporting this way communicates to policy makers that funding going to improve maternal and infant health is irrelevant and that these efforts are not important. It doesn't reinforce "lifecourse" and which came first the chicken or the egg. It conveys mixed messages and fails to support lifecourse. It also communicates to policymakers that mothers are not a part of MCH.

8. Form 7 – instructions do not correlate with the specific line on the form, #7. There are two sets of numbers, "a" and b and the numbers don't specify which "a" or "b".

9. Proposed use of PRAMS data is not realistic at this point for two reasons:
   a. Not all states have PRAMS because CDC has not funded all states. In fact as CDC tries to expand to additional states, currently funded states get cut which further reduces their capacity to conduct PRAMS effectively.
   b. Current access to PRAMS data has been markedly delayed due to the newly developed PIDS "system" which has been problematic for many reasons. CDC has just now informed states that the data in the old PRAS system (PRAMTRAC) will finally be weighted for states that sued the old system the entire year of 2012, and last for states the used PIDS. It might be the case that CDC will not have data available for 2012 in time for the FY2016 Needs Assessment/Annual Application and Report.

10. It is not clear in the guidance how we will be transitioning from the current guidance to the new one, i.e., we currently have 18 National Performance Measures and 10 State Performance Measures. How will these fit in with the new requirements? In other words, will we be reporting on what we did for the previous year per old guidance and then present a plan of what we will be doing following the new guidance. This needs to be clarified.

Submitted by Nan Streeter, MS, RN
Utah Title V Director
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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: MCHB Block Grant Transformation Comments 08-26-14
Attachments: MCHB Block Grant Transformation Comments 08-26-14.docx

From: mary_aten@comcast.net [mailto:mary_aten@comcast.net]
Sent: Tuesday, August 26, 2014 11:10 AM
To: HRSA Paperwork
Subject: MCHB Block Grant Transformation Comments 08-26-14

The attached comments are provided, for your review.

Thank you very much.

Mary Castro Summers

mary_aten@comcast.net

Mary Castro Summers

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August 26, 2014

Via email: paperwork@hrsa.gov

Dr. Michael Lu, Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Lu:

As both a consumer of MCHB-funded services in the past and current parent-professional working on behalf of families in Massachusetts, may I offer congratulations on the herculean effort that you have overseen to affect a Transformation of the Maternal and Child Health Services Block Grant Process. My youngest son is now 26 years old, and it seems to me that the energy infused into caring for his special health care needs for over a quarter-century *pales* when compared to the effort you have inspired to streamline and improve the Block Grant process, on behalf of the US Government and the community that is served by the activities supported by a state block grant.

It is an honor to support MCHB's activities and raise awareness among Massachusetts residents of the healthy outcomes that result from your investment in our state. I have enjoyed numerous opportunities to provide feedback on services in my state (Massachusetts) and several others (as a Parent Reviewer for Rhode Island, Kentucky, and New Jersey in the past). For a number of years, I worked for a SPRANS-grant funded regional genetics network. Then, over the past 10 years I have been employed through MCHB block grant funds and oversee a program that supports families and professionals who support children and youth with special health care needs, birth to age 22. Attending the 2013 AMCHP conference raised awareness of this organization's efforts to positively support the efforts of MCHB. I have also served on the Massachusetts Newborn Screening Advisory Committee since 1999. These activities have helped me to see the important efforts that Maternal and Child Health Bureau continues, to assure healthy outcomes for women, children, and young adults throughout our nation.

Having completed a review of the new guidance and forms, below are general comments and then remarks to specific a Health Status/Outcome Measure or Performance Measures.

1. As a reviewer, I appreciate a more succinct application with fewer forms. On behalf of the Title V staff preparing the annual block grant application and updates, I would imagine that these changes will streamline the process for them. Additionally, the Review format used in Massachusetts is one I'd like to recommend as a standard. The Mass. Department of Public Health (DPH) prepares an overview PowerPoint to highlight its various MCHB programs, in the order they appear in the Block Grant Application. This presentation by relevant DPH staff streamlines the Review Process. By hearing the brief summaries on the program's structure, function, and activity, the Reviewers commented that their questions were addressed and thereby reduced the length of conversation needed. You may want to confer with Ellen Volpe of Region I, to receive a copy of that PowerPoint for further elucidation.

2. I had an opportunity to review the recommendations in a February 14, 2014 memorandum from the AMCHP Board of Directors. I enthusiastically supported its content, and am delighted that the Guidance incorporates a majority of them.

3. **The Vision of Title V is "a nation where all mothers, children and youth, including CSHCN, and their families, are healthy and thriving." The Mission of Title V is "to improve the health and well-being of the nation's mothers, infants, children and youth including children and youth with special health care needs, and their families."** I realize that an important aspect of the focus on women is related to their health prior to pregnancy, childbirth, and child-rearing. However, in acknowledgement of the transformation of the term "family" and as the relative of a family headed by an LGBT couple, how might MCHB ensure that families headed by two fathers can be specifically included in some of the service areas cited in the Pyramid of Services, as well as kinship families, such as the ever-growing number headed by grandparents or other relatives?

4. **The six population health domains create definition for MCHB's activities.** I wonder if it's possible to isolate data relative to children and youth to include subsets specifically for children and youth with special needs. This is the community with which I work on a daily basis. We need to monitor progress and systems improvements that help to assure access to health insurance, health care services (especially identifying access issues for primary and specialty care in rural, suburban, and city environments) , healthy lifestyles and outcomes, and acceptance and integration into the community at large for children and youth who have special needs, including complex medical conditions, nonverbal communication skills, and those children and youth affected by Autism Spectrum Disorder, behavioral and emotional health concerns, and severe mental illnesses.

5. **A general observation is the discrepancy in using only CSHCN throughout the document (not <u>CYSHCN</u>).** Children after age 11 are typically referred to as Youth. To highlight their inclusion, might you consider adjusting terms to use CYSHCN.

Referring to six (6) Health Status Outcome and Performance Measures, I'd like to share the following comments.

1. **Page 51, Health Status/Outcome Measure 18: % of children with special health care needs (CSHCN) receiving care in a well-functioning system:**
    a. To answer in the affirmative, must a child receive all 6 components (family partnership, medical home, early screening, adequate insurance, easy access to services, and preparation for adult transition), or a majority of the 6?
    b. This broad range of support would be optimal. However, how can MCHB systems help facilitate improvements with the complex systems of care? I am concerned that it will be difficult for states to achieve high percentages with so many factors, many of which are outside the realm of MCHB-funded services and systems.

2. **Page 52, Health Status/Outcome Measure 19.1: # of children with special health care needs:** This Measure references all children and youth with special health care needs – ages birth through 17 years. The subsequent Measures (19.2, 19.3, and 20; Pages 53-55) reference children ages 3-17 years. Would it be beneficial (for data collection) to report all 4 Measures with the same age range? This change may help to identify children between ages 0-35 months who are diagnosed with Autism Spectrum Disorder and infants who may be eligible for home-visiting programs as a result of maternal-infant depression. ADHD, Measure 19.3, may have no change in data, as I understand this condition is seldom diagnosed before age 3.

3. **Page 55, Health Status/Outcome Measure 20: # of children with a mental/behavioral condition who receive treatment:**
    a. I noted this measure does not differentiate between mental health/emotional challenges *and* behavioral conditions, such as ADHD.
    b. Do you intend to capture data only for children who are diagnosed and receiving treatment? How might MCHB determine how many children have a diagnosis but are not yet receiving treatment and related reasons: access to health insurance (including children who are undocumented), access to adequate services (due to lack of insurance benefits or availability of appropriate providers), or other issues (such as transportation, family concerns, case management, etc.)?

4. **Page 68, Performance Measure 8: % of children ages 12-17 who are bullied:**
    a. Do you intend for surveys to capture number of children and youth who are bullied with some indication, too, of who is the bully (another child or adolescent, an adult (18yo+), or a parent or guardian? These factors are important to develop meaningful strategies to stand up to bullies and identify and address bullying tendencies.
    b. Grammatically, Line 12 should read "likely to drop out" (remove hyphen) and Line 20, remove the space around the hyphen in the term "bully-victim."

5. **Page 76: Performance Measure 15A, # of women who smoke during pregnancy, and B: % of children who live in households where someone smokes, Page 76:**
    a. Will states track the smoking habits of women who are surrogates for GLBT couples?
    b. Should MCHB strive to quantify Mothers/primary caregivers vs. others who live in a household (grandparents, relatives, etc.) and smoke in the home; this may influence strategies to (1) reduce smoking by teaching the effects of second-hand smoke (including chronic health conditions in children/youth), and (2) improve family

relationships by fostering support, understanding, and treatments for those who wish to participate in cessation programs.

6. **Health Status Outcome Measure 23, % of eligible newborns screened for heritable disorders with <u>on-time</u> physician notification for out-of-range screens who <u>receive follow up in a timely manner</u>, Page 58 (note <u>suggested changes</u>):**
    a. Will states no longer report data related to infants who typically are among those lost to follow-up, such as infants born across state lines (and therefore potentially receiving follow-up in a state not covered by a border agreement) or infants whose mother does not have insurance coverage for the infant (such as born to an undocumented mother)?
    b. Will CCHD eventually be included in this data set, important to note as states follow up on the National recommendation for inclusion in screening panels.

In closing, I would like to comment on the importance of addressing the emotional needs of parents, particularly those who are caring for children and youth with special health care needs. As the Statewide Director of Family TIES of Massachusetts, I reinforce this message with our program staff, parents who contact our program for information and referral services and emotional support, and professionals who reach out in order to determine what resources we can offer to the families they serve. **My message is simple: Parents who feel supported and adequately address their emotional stress and strain report having more energy, time, and patience to provide the day-to-day support and caring that their children require *because* of their special health care needs.** Peer support is crucial to family success.

This emotional support can begin with effective parent-to-parent (P2P) contacts. These P2P contacts may come through (1) a local community of casual contacts and support groups, (2) the efforts of keenly attuned medical providers who acknowledge the breadth of family wisdom shared in peer support (particularly when caring for a child with a life-threatening, rare, or complex medical condition), and (3) state and national P2P programs, such as our own and those supported through Parent to Parent USA (P2PUSA). These programs can help parents to find others who manage similarly complex lives. When they realize *I am not alone,* parents can normalize what is truly not the norm for approximately 84% of families in the United States. The P2PUSA network expands the reach of parents receiving and giving support. Please assist P2PUSA and our state-run programs to build program standards, so this incredibly uncomplicated process can lighten the burdens of families such as my own.

Thank you again for your inspirational efforts at Maternal and Child Health Bureau, Dr. Lu. I look forward to continuing to support MCHB's Vision and Mission and ultimately, families across the country.

Sincerely,

Mary Castro Summers

Matthew's Mom

Cc: Ellen Volpe, MCHB Region I
Shirley Smith, MCHB Region II
Richard Robison, Executive Director, Federation for Children with Special Needs
Suzanne Gottlieb, Director, Office of Initiatives, Mass. Department of Public Health
Kathy Brill, Executive Director, P2PUSA

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: Public Comment - 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
Attachments: Title V Guidance - Iowa Response.pdf

Importance: High

From: Johnson-Miller, Marcus [IDPH] [mailto:Marcus.Johnson-Miller@idph.iowa.gov]
Sent: Tuesday, August 26, 2014 9:49 AM
To: HRSA Paperwork
Cc: Waldron, Debra B; Russell, Bob [IDPH]
Subject: Public Comment - 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
Importance: High

Good morning!

Attached you will find Iowa's response to the proposed Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172—Revision. This response is a culmination of feedback from staff and stakeholders of Iowa's MCH and CYSHCN programs.

If you have questions or need additional information, please feel free to contact me.

Thank you,

Marcus Johnson-Miller
1st Five Healthy Mental Development State Coordinator | Bureau of Family Health | Iowa Department of Public Health | Lucas State Office Building | 321 East 12th Street | Des Moines, Iowa 50319 | P: 515.473.4540 | F: 515.725.1760 | marcus.johnson-miller@idph.iowa.gov

"Promoting and Protecting the Health of Iowans"

August 26, 2014

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

RE: Public Comment – 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 Madam:

On behalf of Iowa's Title V Maternal and Child Health Program and Children and Youth with Special Health Care Program, we submit the following comments in response to the proposed revisions to the Title V MCH Block Grant. Iowa's response was developed around the strengths and areas of concern for each of the areas of the triple aim of the MCH transformation:

Aim 1: Reduce burden to states	
Strengths	**Areas of Concern**

• Streamlining the application and annual reporting process
  ○ Including a needs assessment summary vs. the former comprehensive document
  ○ Reducing the number of forms and NPMs(8) /NPMs(5)
  ○ The elimination of Health System Capacity Indicators
	• Conceptually and operationally identifying and delineating the NPMs, NHS/OMs, S&PMs, and SOMs and how they align. Clarification is requested.
	• Although Health Capacity System Indicators and Health Status Indicators were eliminated to reduce the burden to states; many were moved into National Outcome or National Performance measures. It appears that there is actually an increase in reporting elements.
	• Key populations are missing for the following national performance measures:
	  ○ NPM #8 Bullying – should also include the CYSHCN population
	  ○ NPM #10 Breastfeeding – should also include the Perinatal population
	  ○ NPM #12 Oral Health – should include all MCH and CYSHCN population
	• Definitions to key terms are important to understand what expectations are for the grant (e.g. MCH core competencies).

Aim 2: Maintain state flexibility	
Strengths	**Areas of Concern**
• Alignment of Title V MCH efforts in advancing public health ○ An overlay of the 10 essential services/public health standards with the MCH Pyramid • Addressing adolescent health as an MCH population health domain • Including crosscutting/life course measures • The ability to refine Action Plan items in interim years will keep activities relevant and current • Maintain Title V as a safety net program. Iowa's Title V program will still need to offer gap-filling services and essential public health services in the era of health reform. Due to Iowa's decision to institute a federal-state partnership for the insurance marketplace, MCH will have a limited impact on leading consumers to select a dental insurance plan, inclusive of children. As a result, Iowa's MCH program anticipates that there may be several low-income children, as well as adults without dental insurance for preventive care and treatment. Title V providers will likely need to continue to provide gap-filling preventive services to reduce disease.	• Enabling services are missing from the new pyramid. Enabling services such as transportation, translation, family support services do not clearly fit into one of the new three tiers, and are a large part of current Title V efforts. These critical services allow families to fully participate as valued members of their health care team, while also increasing efficiency and the quality of health care provided. Lack of transportation is a major barrier to care for families in rural areas, due to a shortage of health care providers, as well as limited numbers of providers who accept Medicaid. This results in the need for who some families to drive several hours to access services. Translation is an essential service to assuring family involvement in their child's care for Iowa's increasingly diverse population. • More guidance is requested on the definitions of direct services and access to care in the top tier of the new MCH pyramid. • Consider adding the CDC's Oral Disease Prevention Program within "Other Federal Investments" listed. • On Page 32: Recommend that the guidance includes a listing of potential MCH workforce examples, to include oral health professionals. • For NPM 8, Iowa suggests the performance measure be changed to: Increase the number of adolescents who have a trusted adult in their life. • In the Appendix, page 72: Although we believe that it is critical to maintain oral health performance measures as part of the Title V block grant, the proposed NPM 12 for oral health relies on visiting a dentist specifically and may not be a true measure of access to dental services for the MCH population. In Iowa, services provided within MCH and public health are considered part of a child's dental home and contribute to a child's ability to then be referred to a dental office for definitive diagnosis and treatment. As written, the two performance measure options do not recognize the preventive care that is provided outside of the traditional dental delivery system.

Aim 3: Improve accountability	
Strengths	**Areas of Concern**
• The Five year Action Plan Table and Action Plan will help Iowa's Title V program to fully integrate the Five- Year Needs Assessment information into the Title V • Emphasis on how Title V MCH Block Grant serves to complement expanded coverage through the ACA (health reform) work and	• Increased emphasis on Family/Consumer Partnership as essential to the health of MCH and CYSHCN populations, consider the adoption of a S&PM or Outcome Measure around this topic. • Health Status/Outcome Measures 19.1, 19.2, and 19.3 (CYSHCN) do not provide useful information about whether progress is being made for the care of these children. For example, is it good

reporting each year. • Promoting family/consumer involvement/partnerships • Emphasis on Workforce development and capacity will require states to be proactive and plan ahead to address potential workforce shortages. • Emphasis on Family/Consumer Partnership aligns reporting requirements with best practices	or bad to have a higher or lower percent of CYSHCN in the state? A higher percentage of CYSHCN might indicate better early identification, while a lower percentage may indicate more effective prevention of special healthcare needs (i.e. prenatal/preconception care) Is an increase or decrease in these percentages indicative of progress? • For Health Status Outcome Measure 20, "Percent of children with a mental/behavioral condition who receive treatment," the denominator should be the number of children aged 3-17 years with a mental/behavioral condition. The number of children aged 3-17 years with a mental/behavioral condition who receive treatment out of the total number of children does not accurately capture this outcome. • Health status/outcome measure 24 "Percent of children meeting the criteria developed for school readiness," (still under development) might use literacy components like English alphabet 26-letter recognition and social emotional components. • There should be consistency on the age ranges for children and adolescents in the various NPMs. Also it is unclear if adolescence is <17 or <19 years. Most NPMs list <17 years, but the injury NPM has <19 years.

Other areas of concern:

- Typo in Performance measure 5 on page 65- children ages 9-17* months.

Thank you for the opportunity to provide input on the proposed revisions to the Title V Block Grant Guidance.

Sincerely,

Bob Russell, DDS, MPH
Interim Title V Maternal and Child Health Director
Division of Health Promotion and Chronic Disease Prevention
Iowa Department of Public Health

Debra B. Waldron, MD, MPH, FAAP
Title V Children and Youth with Special Health Care Needs Director
Child Health Specialty Clinics
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Guardino, Taylor (HRSA)

From: Duckhorn, Jodi (HRSA) on behalf of HRSA Paperwork
Sent: Tuesday, August 26, 2014 9:28 AM
To: Guardino, Taylor (HRSA); Wright-Solomon, Lisa (HRSA)
Subject: FW: MCH Block Grant Guidance and Forms comments
Attachments: CSN Block Grant Guidance comments.pdf

From: Fogerty, Sally [mailto:sfogerty@edc.org]
Sent: Monday, August 25, 2014 2:03 PM
To: HRSA Paperwork
Subject: MCH Block Grant Guidance and Forms comments

Here are the comments from the Children's Safety Network on the proposed revised Guidance and Forms for the MCH Block Grant State Program.

Sally

Sally Fogerty
Deputy Director, Center for Study & Prevention of Injury, Violence & Suicide
Director, Children's Safety Network
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Children's Safety Network

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August 25, 2014

HRSA Information Collection Clearance Officer
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Rockville, MD 20857

Re: Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report

Dear Dr. Lu,

The Children's Safety Network is pleased to provide comments on the revised Title V Maternal and Child Health Block Grant Guidance and Forms. Based on a review of the draft Guidance and forms, it is clear that MCHB heard and listened to the many comments provided over the last year. We commend the MCH Bureau in undertaking this effort and recognize the need to update and revise the National Performance and Health Status/Outcome Measures as well as the MCH pyramid. The linking of the pyramid to the Core Public Health Functions and 10 Essential MCH Functions is a major step in assuring the alignment of MCH with public health. The strong focus on increased accountability is a major step forward. The linkage of priorities, NPMs, SPMs and Health Status/Outcome measures will help states be more focused and targeted in addressing a smaller number of issues/areas which should allow for increased improvement in the selected areas. The alignment with six population groups should allow states to make sure they are continuing to focus on the specific issues related to age as well as cross cutting/life span issues. We do recognize the need for clear definitions and understand that MCHB will be developing a glossary which will be critical to assuring everyone is working towards the same purpose and goals.

The final list of National Performance Measures and Health Status/Outcome measures reflects the critical areas which, if addressed, should move the needle and further improve health outcomes for children and families, as well as reduce health care costs. We commend you for the inclusion of the following direct and indirect injury and violence measures and recommend that these continue to be part of the measures which are in the final document.

A. National Performance Measures
   #4: Percent of infants placed to sleep on their backs.

CSN (www.ChildrensSafetyNetwork.org) is funded by the Health Resources and Services Administration (U.S. Department of Health and Human Services).

#6: Rate of injury-related hospital admissions per population ages 0-19 years.
#7: Percent of adolescents with a preventive services visit in the last year. (Indirect)
#8: Percent of adolescents, ages 12-17 years, who are bullied.

B. National Health Status/Outcome Measures (as numbered in Appendix F)
#6: Rate of sleep-related Sudden Unexpected Deaths (SUID) to infants.
#12: The child death rate per 100,000 children aged 1 through 9. (Indirect)
#16: The rate of death to children aged 15-19 years caused by motor vehicle crashes per 100,000 children.
#17: Rate of suicide death among youths aged 15 through 19 per 100,000.

As you know, in the United States, unintentional injury, homicide and suicide are leading causes of death among children ages 1 through 19. For every child that dies due to unintentional injury another 25 are hospitalized (CDC Vital Signs, April 2012), and for every child that dies as a result of violence 9 are hospitalized. Motor vehicle crashes, suffocation, drowning, poisoning, fires and falls are the most common causes of childhood injury. Serious injuries place a heavy burden on the child, his or her family and society. Children and adolescents exposed to violence or who experience an injury can miss school days and require emotional and/or physical rehabilitation. The most severe non-fatal injuries result in lifetime disability. The family of a severely injured child will experience economic, emotional and health- related issues due to the need to provide care for the injured child/adolescent and pay long-term health care costs for acute and rehabilitation services, as well as possible mental health services for both child and family members. Society is affected as a result of the inability of the child/adolescent to reach their full potential.

Through the range of services they provide and the populations they serve, Title V programs are uniquely positioned to implement evidence-informed and promising practices for injury and violence prevention and "move the needle" on the number of infants, children and adolescents who die or require hospitalization due to an unintentional or intentional injury. The existing efforts of state programs in this area are integrated with other services and programs thus assuring non-duplication of efforts with other federal and state programs. The inclusion of the proposed national performance measures and health status/outcome measures in the area of injury and violence prevention

demonstrates that MCHB recognizes the significant toll that injuries and violence take in the lives of children and families, and reconfirms MCHB's commitment to ensuring that our nation's children and adolescents can reach their full potential. They will also assure a continued focus on injury and violence prevention at the state and local level. The improved accountability process outlined in the Guidance should allow for MCHB to better understand the level of effort in this area, as well as monitor the progress being made to reduce injury and violence-related mortality and morbidity.

With the exception of the safe sleep/sleep-related and bullying measures, the proposed measures are an update of earlier measures and thus there should not be additional burden to states. CSN recognizes that the inclusion of these measures will support the MCH Transformation goal of improving outcomes across the six MCH population domains.

Thank you for your attention to these comments. We look forward to working with the MCHB leadership and staff on the implementation of the Guidance and development of state plans which are evidence–based or evidence-informed and will move the needle, reducing both mortality and morbidity. Please do not hesitate to contact me at sfogerty@edc.org or 617-312-2771 should you have any questions or would like additional information.

Sincerely,

Sally Fogerty

Sally Fogerty
Director, Children's Safety Network

CSN (www.ChildrensSafetyNetwork.org) is funded by the Health Resources and Services Administration (U.S. Department of Health and Human Services).

A Project of the Education Development Center, Inc.

Guardino, Taylor (HRSA)

From: Duckhorn, Jodi (HRSA) on behalf of HRSA Paperwork
Sent: Tuesday, August 26, 2014 9:27 AM
To: Wright-Solomon, Lisa (HRSA); Guardino, Taylor (HRSA)
Subject: FW: Public Comment, Title V MCH Block Grant Guidance proposed changes
Attachments: Public Comment - MCH Block Grant Ltr.pdf

From: Spain, Kristina - CO 4th [mailto:SpainK@dhw.idaho.gov]
Sent: Monday, August 25, 2014 4:28 PM
To: HRSA Paperwork
Cc: Downing-Futrell, Sheri (HRSA); Gleason, Carolyn (HRSA); Watson, Jacqueline - CO 4th; Spencer, Dieuwke A. - CO 4th
Subject: Public Comment, Title V MCH Block Grant Guidance proposed changes

Hello,

Attached you will find the Idaho response to the Title V MCH Block Grant Guidance *proposed changes*. We appreciate the opportunity to comment.

Sincerely,

Kris Spain
Title V MCH Director-Idaho

Kris Spain, MS,RD,LD, Chief
Bureau of Clinical and Preventive Services
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spaink@dhw.idaho.gov

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF CLINICAL AND PREVENTIVE SERVICES
450 West State Street, 4th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE 208-334-5930
FAX 208-334-6581

August 25, 2014

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

RE: Public Comment, Federal Register Vol. 79, No. 124-Title V MCH Block Grant Proposed Changes

To Whom It May Concern:

This correspondence is to provide comment to the 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.

We are appreciative of the Maternal and Child Health Bureau (MCHB) efforts to transform the Title V MCH Block Grant to 1) reduce burden to states, 2) maintain state flexibility, and 3) improve accountability in order to assist states in the effort to "tell a more cohesive and comprehensive Title V story." However, we do wish to express concern for some of the proposed changes and associated timelines for implementing these changes.

- *Proposed State-level data for the National Performance Measures (NPM) will be provided by the MCHB from national data sources* (intended to reduce burden). We are interested in which data sources will be used and for which measure. There are several health surveys where the sample for Idaho is relatively small compared to other states in Region X. Concern exists due to the weighting scheme assumed for Idaho. For example, some national data sources, such as BRFSS, indicate Idaho has an 18% African American population, when it is actually 1.1%. We suggest identification of the data source and value be noted for each NPM, as well as year of data collection, for comparison and response by states.
- *The 15 NPMs represent six MCH population health domains. States are required to select 8 NPMs across each of the six domains; in addition, states are to develop State-Initiated Structure/Process Measures (S&PMs) plus State Performance Measures (at least 5).* We are concerned that within the six domains, there may only be two options for states to select a NPM. In some cases, it should be noted that states, such as Idaho, do not have hospital discharge data, thus further limiting states options.
- *As part of the first-year Application and Annual Report, states are required to develop a Five-Year Action Plan Table* as part of the first year Needs Assessment Summary. We are very concerned with the short

timeframe to complete this, along with the S&PMs. Many states will not have completed the Needs Assessment and have resulting summaries until late spring, 2015. The timeline and application due date allow approximately a 6-8 week window to evaluate, prioritize, select and subsequently develop State Performance Measures and Structure/Process Measures and associated Action Plans.

- General concern is expressed for states with limited workforce capacity specific to Title V MCH activities. In Idaho the Title V MCH Director and CYSHCN Director have additional roles/responsibilities. There are no additional FTE's to solely support MCH activities. The transformation activities, while of value, do not seem to take into consideration smaller state capacity to implement large scale change within a very compressed timeline. It is suggested that the timelines be extended, to allow for completion of the assessment and adequate evaluation and planning with existing workforce capacity.

We appreciate the opportunity to respond to the proposed changes and your consideration of our comments and suggestions.

Sincerely,

Kris Spain

Kris Spain, MS,RD,LD
State of Idaho MCH Director
Chief, Bureau of Clinical and Preventive Services

Cc Dieuwke A. Dizney-Spencer, Deputy Division Administrator
Jacquie Watson, CYSHCN Director, Program Manager MCH Programs

Guardino, Taylor (HRSA)

From: Duckhorn, Jodi (HRSA) on behalf of HRSA Paperwork
Sent: Tuesday, August 26, 2014 9:26 AM
To: Wright-Solomon, Lisa (HRSA); Guardino, Taylor (HRSA)
Subject: FW: Information Collection Request Title: Title V Maternal and Child
Attachments: OPHD MCH Section comments BG 3.0 guidance.docx

From: FISCHLER Nurit R [mailto:nurit.r.fischler@state.or.us]
Sent: Monday, August 25, 2014 7:28 PM
To: HRSA Paperwork
Cc: Wilcox Cate S; Gleason, Carolyn (HRSA); Marilyn Hartzell (hartzell@ohsu.edu); Downing-Futrell, Sheri (HRSA)
Subject: Information Collection Request Title: Title V Maternal and Child

Attached please find comments pertaining to 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.

Thank you for the opportunity to provide comments.

Nurit Fischler, MS
MCH Policy Lead and Title V Coordinator
Maternal and Child Health Section
Center for Prevention and Health Promotion
Oregon Health Authority
desk (971) 673-0344
mobile (503) 602-9447

Date: August 25, 2014
To: HRSA Information Collection Clearance Officer
From: Oregon Title V Program Co-Director Cate Wilcox, and Title V Program Coordinator Nurit Fischler
Re: Comments on draft MCHB Title V guidance revisions

Oregon's Title V program supports Dr. Liu and the MCHB's efforts to maximize effective use of the MCH Block grant by aligning the MCH Block grant activities with health and health system changes, while attempting to decrease the administrative burden on states, maintaining flexibility, and increasing accountability. In light of these objectives and our review of the draft guidance, we would like to address several areas in response to the draft guidance.

Reporting Burden:
While the intent of BG 3.0 is to decrease administrative and reporting burden on states, we do not see evidence that the new guidance will accomplish this, and may in fact increase burden on states. There are several reasons for these concerns:

- Although some national performance measures will have pre-populated data, it is not clear how many or how timely this data will be for use in the ongoing Title V planning and program implementation cycle. Furthermore, much of the burden associated with data is not associated with generating the data, but in analyzing and interpreting trends, disparities, etc. and developing plans in relation to these. While pre-populating some of the data will certainly help, it remains to be seen how much the pre-populated data will relieve the data burden on states.
- Although the Health System capacity indicators and some of the health status and outcome indicators have been eliminated, others have been added, along with the additional burden of developing and action plan, strategies, and structural/process measures for both the national performance measures and state selected measures. The actual number of reportable elements in the guidance appears to be greater once the new structural and process measures are accounted for, and as mentioned previously pre-populating the data for a sub-set of these data may not decrease the burden of reporting on these elements enough to offset the new data reporting requirements.
- Timing of availability of the pre-populated data will be key to its usefulness. In order for data to be useful for our state's Title V reporting and planning work, pre-populated data would need to be available by January each year. Please clarify the timeline for availability of the pre-populated data.
- Clarification of reporting expectations in the transition year are needed. Will states be expected to report on all of the old measures in addition to creating plans in relation to the new measures? This could create a double burden during the coming year and seriously handicap states' ability to address the new measures and requirements.

State and National performance measures

- The guidance states that states will be required to choose a minimum of 5 state performance measures in addition to choosing 8 of the 15 National Performance measures. We have concerns about states' ability to develop and implement action plans and strategies to "move

the needle" on so many performance measures with our limited Title V funds. It was our understanding from previous presentations of MCHB staff that states would be allowed to choose "up to 5 state performance measures" that they both the need and capacity to address and that did not align with in the National performance measures. We would strongly urge MCH to restore the flexibility in allowing states to choose how many state performance measures to develop and address.

- The guidance also requires development of an action plan and evidence-informed strategies for all state and national performance measures chosen in the first year, although process and structural measures are not required until the second year. Our state anticipates significant work with local implementing partners to develop appropriate and feasible strategies along with structural and process measures in year 2 of the grant. Therefore, any presentation of strategies in a first year action plan will need to be high level. Clarification of expectations around this portion of the action plan, as well as detailed lists of evidence-informed strategies that the Bureau intends for states to be considering for each performance measure would be very helpful.

Budgeting and fiscal accountability

Clarification is needed on revised budget and fiscal tracking requirements including:

- Requirements for state and federal funds expended to be reported separately.
- Expectations regarding tracking of expenditure of title V funds on identified state and national priorities versus, and other activities as appropriate.
- Tracking of Oregon's Title V match dollars. Do dollars that are used for Title V match need to be directly available to the Title V program and under the Title V Director, or are funds used to support services for the MCH population within State Public Health but outside the Title V program, such as for newborn hearing screening and tobacco prevention/cessation allowable for Title V match?

Thank you very much for the opportunity to provide comments and request clarification on the draft Block Grant Guidance.

Cate Wilcox, MPH
Maternal & Child Health Section Mgr
Oregon's Title V Director
Center for Prevention & Health Promotion
Oregon Public Health Division
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Guardino, Taylor (HRSA)

From: Sajak,Tammy (DSHS) <Tammy.Sajak@dshs.state.tx.us>
Sent: Tuesday, August 26, 2014 9:07 PM
To: HRSA Paperwork
Cc: bewig@amchp.org
Subject: Texas Feedback on New Title V Block Grant Guidance
Attachments: MCH 3.0 Feeback Texas.docx

Hello,
Please find attached the Texas Office of Title V and Family Health's feedback to the MCH 3.0 Title V Block Grant Guidance.
Thank you.

The Texas Department of State Health Services, Office of Title V and Family Health (OTVFH) would like to thank MCHB for the opportunity to comment on the Draft Proposed Title V MCH Block Grant Guidance.

Background and Administrative Information

Vision and Mission

The new pyramid showing the three level stratification of direct reimbursable, non-reimbursable and public health services is very useful especially with the crosswalk to the essential public health services. The strategies developed in regards to the crosswalk are very clear and provide an excellent framework for the attainment of the Title V mission.

The reporting implications for the new pyramid will create some additional burden to the State in terms of revising the program codes and how they are used to calculate expenditures in order for us to accurately complete financial reports to HRSA using the three stratifications. There is a need for clear and concise definitions for the pyramid services and examples to be provided.

National Performance Measurement Framework

The three-tiered framework including the national health status/outcome measures, the national performance measures and the state-initiated structure/process measures are logical, however there is some room for improvement in naming conventions and terminology. The acronyms used throughout the document to refer to these measures: NHS/OM, NPM, and S&PM are confusing especially when adding in state performance measures (SPM). It would be helpful to find another way to refer to these measures to facilitate communication as we become familiar with the new guidance.

National Performance Measures (NPM)

The new provision to enable states to choose 8 of the 15 NPM may result in the inability to compare data trends for the nation if states significantly differ in the NPM they select. The reduction in the total number of NPM is a welcome change.

The National Performance Measure 10 could be improved by focusing on exclusive breastfeeding at 6 months rather than "ever breastfed". In Texas and in the nation as a whole, breastfeeding initiation is high. We consider initiation of breastfeeding to be almost a proxy of intent to breastfed. We've already exceeded the Healthy People 2020 objective for this in the Texas WIC population. If we support continued and exclusive breastfeeding, initiation will also increase. But, while initiation is high, exclusive breastfeeding at 6 months is low.

The mission of Title V could be furthered by including a National Performance Measure for behavioral/mental health. The inclusion of Health Status Outcome Measure 20, the percent of children with a mental/behavioral condition who receive treatment is helpful.

State Performance Measures (SPM)

The selection of five SPM increases the ability to focus more attention on a narrower field and allows for increased efforts in these areas.

State Outcome Measures (SOM)

Although SOMs are not required to be reported and the guidance states these may be developed for SPM provided that the National Performance Measure/Outcome Measure is NOT the same, the SOMs may be needed to pinpoint the change in outcome for a specific population domain when an activity has been aimed at one domain but the NPM includes more than one domain. Therefore, SOMs may need to be developed for NPM because the NPM is inclusive of more than one population domain and the only way to capture that in an outcome measure is to break down the combined population into the separate domains.

State Narrative Application/Annual Report

The narrative reporting by the six population domains is a good way to reinforce the life course theory but it also introduces another layer of complexity because there is not a one-to-one correspondence with the three legislatively-defined MCH populations. The national performance measures also add more complication because some of the measures include more than one population domain. For example, if a state is working on national performance measure 6, rate of injury-related hospital admissions per population ages 0-19, then the state would have to look at each state-initiated structure/process measure to see if it pertains to infants, children, and/or adolescents in order to determine which population domain to report in the narrative and in order to determine what contributed to any changes in the performance measure. It is reasonable to speculate that several structure/process measures could be developed to address this one performance measure and that within each structure/process measure there could be more than one population domain targeted.

Five Year Action Plan

The new Five-year Action Plan is a good idea but it is very complex and there may be a need for technical assistance to implement this component. The replacement of the Application/Annual Report with the Action Plan has the potential for being an improved frame work; however it is essential that adequate space is allowed for the Action Plan.

Needs Assessment

The Needs Assessment Summary is an improvement over submitting the entire needs assessment every year, however if there is not ample space to reflect the essential information then it will not be an effective change. Although, there is the option to include additional information as a link or an attachment, it is not clear whether reviewers would include the additional information in their review of the State application.

Executive Summary

The Executive Summary is an excellent addition to the Title V application process, however given the list of required discussion points; it may not leave the State with much flexibility to include other key points. It is likely that three pages will not be sufficient to cover the required discussion points and other key points.

National Health Status/Outcome Measures

The provision of National health status/outcome measures by MCHB will result in data being used that is several years old when states have access to more recent data and may result in the Title V performance measures not being utilized because other reports the state produces will contain more recent data.

There are inconsistent references to children and adolescents in Health Status Outcome Measures. The noted age range does not always match the reference to children or adolescents. In some cases, the age range is within the adolescent years, but the reference is to children. In others, the age range crosses both children and adolescents but the reference is solely to one or the other. It would be helpful to clearly indicate age ranges that relate to children, adolescents, or both.

Child maltreatment is included in the definition of CYSHCN, but is absent for children who do not have special needs. There are insufficient reimbursement mechanisms for treatment or family support for child maltreatment among children without special needs.

Legislative Requirements

The 30% requirement remains unchanged which does not reflect the changes to health care delivery or the increases in the population of children with special health care needs (CSHCN). Therefore we may experience a drop in preventive and primary care services due to changes with health care delivery while we are seeing an increase for needed CSHCN services. The request for a waiver must be included in the Application letter of transmittal which does not allow for the unforeseen changes in the health care delivery system that our country is undergoing now. States should be allowed to submit a request for waiver when it becomes apparent there is a justifiable need during the fiscal year.

Budget

There is a need for significant re-tooling of the underlying agency budget reports that have been created for the former Title V Block Grant in order to report for the new pyramid categories and the population domains. It is difficult to align program codes that may be used for one population or multiple populations with the budget forms asking for population expenditures for children that include ages 1 to 22 years because this includes children and adolescents. It would be an improvement if there was consistency throughout the application in the definition of the populations so that programmatic activities could easily be mapped to the appropriate population.

Guardino, Taylor (HRSA)

From:	Dalbec, Barb (MDH) <Barb.Dalbec@state.mn.us>
Sent:	Tuesday, August 26, 2014 10:40 PM
To:	HRSA Paperwork
Subject:	OMB No. 0915-0172-Revision comments
Attachments:	MN Comments Title V Guidance.pdf

Please see our comments regarding the proposed Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report on the attached document.

Thank you.

Barb Dalbec, RN, PHN
Section Manager, Children & Youth with Special Health Needs

Minnesota Department of Health
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MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

August 26, 2014

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

Re: 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

To Whom It May Concern:

Thank you for the opportunity to comment on the Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172-Revision. The Minnesota Department of Health would like to thank Dr. Lu and the HRSA staff for providing additional information regarding the proposed Title V Maternal and Child Health Services Block Grant to States Program: Guidance and Forms for the Title V Application/Annual Report and carefully considering how the changes will impact the state work.

We respectfully submit the following comments for consideration in response to the Federal Register /Vol. 79, No. 124/Friday, June 27, 2014:

1. Provide definitions for each level on Figure 1, Public Health Services for MCH populations the Title V MCH Services Block Grant. As is, it is not clear what is meant by Non-reimbursable primary and preventative health care services for MCH population. This could also be enhanced by additional examples listed on right of the diagram. This is of significance since we are expected to breakdown our budget by this new 3-level Pyramid of Services.
2. Evidenced based or informed practices pose challenges for those populations most impacted by health disparities since there is little or no research on best practices for many populations especially new immigrants. To move forward in reducing health disparities, the language should be more inclusive.
3. It is hard to estimate the burden to reporting, in part because the degree to which the state will need to separate out and report on Block Grant expenditures as distinct from overall MCH expenditures could make the reporting requirement much more difficult for county public health agencies. Along these same lines, by way of example, the language in the MCH Population Needs area, which asks for TitleV-specific programmatic approaches, would be difficult as neither the state nor local public health agencies think about their MCH programmatic approaches in terms of Title V vs. non-Title V. Rather, needs assessments address, broadly, all MCH needs, then determine what sources of funding may be available to meet those needs.

4. The approach of organizing the reporting, summarizing, throughout the guidance according to the three legislatively-defined MCH populations in the context of the six population health domains seems to make sense in theory. However, in fact this will result in much of the same duplication across areas that the current Block Grant reporting creates.
5. The proposed measure for newborn screening goes beyond the current measure to include percent of infants screened, presumptive positive screens, confirmed and treated (broken out by every core and secondary screened condition). However, this proposed measure has more to do with the quality of the biochemical testing and lab practices than maternal and child health. A more appropriate MCHB measure regarding newborn screening would address what happens after an infant is identified as having a newborn screening condition: How quickly is treatment commenced? How do these infants and children fare? What are the benefits of early identification through newborn screening? While few states track these data, such a measure would be more meaningful in addressing the long term outcomes of infants and children with newborn screening conditions, and would move states towards addressing long term follow-up, a component of newborn screening that both cuts to the heart of maternal and child health, and is recognized by Health and Human Services as a critical component of state newborn screening programs.
6. Regarding NPM's and Outcome Measures that identify the targeted age ranges as 0-17, 0-18, or 0-19, these age ranges are very broad and encompass differing developmental stages and needs. There is concern that states may select interventions that only address a few years within the full range. We strongly encourage MCHB to provide clear guidance that indicates the need to implement multi-pronged approaches that are developmentally appropriate for all stages of development for youth and young adults ages 0-24 years.
7. Consider adding "Adolescents" to the Population Domain for NPM#9 "Children age 0 - 17 years with adequate insurance." Currently, it only states "children" even though the age range addressed extends to age 17 (adolescents). This will draw attention to the adolescent specific needs regarding insurance coverage.
8. Guidance should be very clear throughout as to when the information or measure is expected to encompass the state's MCH work in its entirety versus only work funded by the MCH Block Grant. These will be extremely different answers since the MCH Block Grant represents an important but small portion of MCH funding in the state.

On behalf of the Minnesota Department of Health, we would like to again thank you for the opportunity to comment on the Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172-Revision. We look forward to the next round of review and final release of the new guidance.

Sincerely,

Barb Dalbec
CYSHN Director

Susan Castellano
MCH Director

Guardino, Taylor (HRSA)

From: Brent Ewig <bewig@amchp.org>
Sent: Tuesday, August 26, 2014 4:30 PM
To: HRSA Paperwork
Cc: Lori Freeman
Subject: Federal Register Notice (FRN) Doc No: 2014-15051 - Title V Maternal and Child Health Services Block Grant to States Program
Attachments: AMCHP Final Comments to the FRN Draft.pdf

Dear Sir or Madam:

The Association of Maternal and Child Health Programs (AMCHP) applauds and commends the Maternal and Child Health Bureau, Health Resources and Services Administration (MCHB/HRSA) for its leadership and efforts to transform the Title V Maternal and Child Health (MCH) Services Block Grant. Attached please find our comments in response to Federal Register Notice (FRN) Doc No: 2014-15051. Thank you for this opportunity and for your consideration.

Brent Ewig

Brent M. Ewig, MHS

Director of Policy and Government Affairs

Association of Maternal & Child Health Programs
2030 M Street NW, Suite 350, Washington DC 20036

MAIN 202 775 0436 **DIRECT** 202 266 3041 **FAX** 202 775 0061

bewig@amchp.org

AMCHP
ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

SAVE THE DATE!

2014 AMCHP Annual Conference

Jan. 24-27, 2015
Washington, DC

ASSOCIATION OF MATERNAL & CHILD HEALTH PROGRAMS

August 26, 2014

HRSA Information Collection Clearance Officer
Parklawn Building
5600 Fishers Lane, Room 10-29
Rockville, MD 20857
Via Email: paperwork@hrsa.gov

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 Madam:

The Association of Maternal and Child Health Programs (AMCHP) applauds and commends the Maternal and Child Health Bureau, Health Resources and Services Administration (MCHB/HRSA) for its leadership and efforts to transform the Title V Maternal and Child Health (MCH) Services Block Grant (herein referred to as the MCH 3.0 Transformation), including changes to the Title V Block Grant Guidance and reporting forms. AMCHP has been actively engaged in working with the MCHB for over a year to provide state input, guidance and recommendations to the MCH 3.0 Transformation to ensure that the priorities, interests, and needs of states are reflected in this initiative. We thank the MCHB/HRSA for actively seeking and engaging the input of states.

Our comments to this FRN reflect the input of the AMCHP Board of Directors and in particular, the Future of Title V Work Group. Many of the recommendations that AMCHP has provided to the MCHB over the past year have been addressed and are reflected in the proposed Title V Block Grant Guidance and reporting forms as outlined in the Federal Register Notice (FRN). Additionally, AMCHP has encouraged its members to provide comments to the FRN and trust that those comments will reflect more specific recommendations and questions that states continue to have with regard to the proposed guidance and forms. As such, AMCHP's comments to the FRN are focused in four overall areas and outlined below.

1. Glossary of Terms and Definitions for the Title V Block Grant Guidance and Reporting Forms: A glossary of terms and definitions is needed 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 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, and
e. public health services and systems for MCH populations.

Perhaps most important in this regard, information about these terms and definitions would help to ensure that states have a full understanding of how the new Title V data requirements will assist the MCHB, states and others committed to the Title V program in telling and conveying a clearer story of Title V expenditures and their impact on MCH populations. This is particularly true for the definitions related to the three levels of the new proposed Title V pyramid: 1) 'direct reimbursable MCH health care services', 2) 'non-reimbursable primary and preventive health care services for MCH populations, 3) 'public health services and systems for MCH populations.'

2. Title V and Its Role as a Safety Net Program: The proposed guidance indicates that 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 state Title V programs are not providing any direct reimbursable health care services and the remaining states are serving very small numbers (i.e., <1% of population). A more accurate statement would be to indicate that the Title V program "will continue to serve as a safety-net provider *in some states*..." to better reflect current use of resources and Title V investments.

3. Limitations of Use of National Data Sets: States support the MCHB for working to streamline the data reporting forms and the process whereby the forms will be pre-populated with national data, where available. However, states remain concerned about the reliance on or use of certain "national" data sets, such as the Pregnancy Risk Assessment Monitoring System (PRAMS), which is not currently a national data set. In addition, PRAMS at this point does not have an available current or provisional data set, is experiencing reduced financial support to states for this important monitoring system, and some states do not have a PRAMS system at all. Only 40 states, for example, are funded or have a functional PRAMS data surveillance system. These data will not be comparable or available across all 50 states and the territories.

4. Number of National and State Performance Measures: The new proposed Title V guidance and reporting forms, and approaches to the reporting (e.g., pre-populated form) will significantly improve state reporting on the Title V MCH Services block grant in many areas. However, states remain concerned with the numbers of national and state performance measures that would be required for reporting under the new guidance. The total reportable measures (national, state, outcome and structure/process) under the new proposed guidance range from 57 – 61 measures, depending on measurement selection. The reportable measures required under the current guidance ranges from 52 – 55 reportable elements, depending on measurement

selection. Toward this end, AMCHP recommends that states be allowed to select '*up to five*' state performance measures rather than being required to select five state performance measures.

In closing, AMCHP again applauds the MCHB/HRSA for its leadership in the MCH 3.0 Transformation and for actively engaging states in providing input throughout the process of these changes. We look forward to continuing to work with the MCHB/HRSA in the implementation of the new Title V guidance and reporting forms, and in assuring the health of our nation's women, children and families.

We appreciate your consideration of these comments and thank you again for your work

Guardino, Taylor (HRSA)

From: Akeah, Kathryn (DOH) <Kathryn.Akeah@DOH.WA.GOV>
Sent: Tuesday, August 26, 2014 3:12 PM
To: HRSA Paperwork
Cc: Bardi, Janna (DOH); Peters, Riley M (DOH); Joyner, Pama (DOH); Nandi, Paj (DOH); Chapman, Kathy Ann / PCH/ACCS (DOH); kvan@amchp.org; Wilson, Beth (DOHi)
Subject: Washington State Comments on MCHBG Guidance Changes
Attachments: WA_Comments_MCHBG_Guidance(final).pdf

HRSA Information Collection Clearance Officer,

Attached are comments from Washington State Department of Health's Office of Healthy Communities.

Please feel free to contact us with any questions or concerns you may have.

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Washington State Department of Health

Healthy Communities Washington
Partners promoting healthy people in healthy places
www.doh.wa.gov/healthycommunities

Comments on the Planned Changes to the Maternal and Child Health Block Grant Guidance and Appendix – August 26, 2014

Washington State Department of Health's Office of Healthy Communities, Maternal and Child Health (MCH) Block Grant recipient reviewed the proposed changes to the guidance. The overall effort to focus on a Life Course approach while increasing efficiency in preparing both applications and reports is positive and we appreciate the direction.

We recognize the need to tell the Title V story and see that reflected in the guidance. The graphic on page three is excellent, making the explicit connection between the MCH Pyramid and the Essential Public Health Services and Public Health standards. Additionally, we appreciate the continued attention to both intentional and unintentional injury prevention in the National Performance Measures (NPM) and National Health Status/Outcome Measures (NHS/OM).

The five year needs assessment and connection to the State Performance Measures (SPM) and Structure & Process Measures (S&PM) is complex. The graphic logic model helps us understand the connection, but states may need some technical assistance. Furthermore, we would welcome opportunities to address the workforce capacity for population-based initiatives as well as reimbursement strategies for areas including home visiting and care coordination.

The pre-population of the data for the Block Grant will make interstate comparisons much easier. As part of the Block Grant application our state runs trend data and special data on many of the measures using our own vital statistics data as well as other sources. We will probably continue using the sources we use now to conduct our additional analyses.

To improve clarity we suggest HRSA/MCHB:

- Clarify the definitions and the differences between "maternal health" and "perinatal health" in the population domains.
- Clarify the alignment between NPM and NHS/OM.
- Clarify the rationale for choosing NPM. In some instances the NPM appear to be sub-measures rather than overall measures of performance. For example, NPM 7 could be a measure that all children get their preventive Early and Periodic Screening, Diagnostic and Treatment visits and then measured by age group.
- Increase the consistency of the terminology "CYSHCN" throughout the guidance document. For example, NHS/OM 18 and 19 include CSHCN in the title, but youth in the description. Clarifying the terminology will help us determine when populations are specifically included or left out.
- Clarify the timeline and state expectations for creating S&PM.

To improve inclusion of CYSHCN and demonstrate the diverse needs of this population, we recommend HRSA/MCHB:

- Separate data for CYSHCN in NPM 6, 7, 8, 9, 10, 11 and 12.

- Add "with and without special health care needs" to NPM 5, 7, 8, 9, 11 and 12B. We would like to increase the focus on CYSHCN as they are identified in NPM 13 and 14.

To improve population health we recommend:

- An increased focus on preventing and mitigating adversity and building resiliency among families and communities, informed by the Adverse Childhood Experiences (ACE) Study, brain science and resiliency research. Research increasingly shows the impact ACEs have on the health of people across the lifespan. This is a critical issue for many of our local communities and we are engaged in the work to reduce the incidence and impact of trauma in childhood. We have many contracts with local health that include statements of work to focus efforts on preventing and mitigating ACEs.
- A stronger emphasis on Life Course throughout the document. We will continue to align our work with the Life Course approach.

Additionally we make the following suggestions:

- **NPM 4:** Back to Sleep is one of several interventions for reducing infant mortality. We would like to see expansion for this measure of which.Back to Sleep is just one of many interventions.

- **NPM 8:** We agree that bullying is important, but would like to see the inclusion of other age ranges to increase the emphasis on the whole child and Life Course.

- **NPM 10**: We recommend the measure of "6 month duration" rather than "ever breastfed." In Washington State we need to increase the percentage of mothers meeting the 6 month mark. We have good rates for "ever breastfed" (91.8%) but the rates decline by the 6 month mark (64.2%).[1] Much of our work supports women that have chosen to breastfeed to continue breastfeeding. Additionally, local communities in Washington are gaining traction on this important issue. To be able to track these changes over time, it will help to have consistent measures.

- **NPM 11**: We are excited to see this NPM and know that our contractors and local health are interested in this as well. However, Washington State does not participate in the National Youth Risk Behavior Survey; instead we do the Healthy Youth Survey for 6th, 8th, 10th, 12th graders. We would like to know if that data source is usable between now and 2017 when the revised National Survey on Child Health will be conducted. Our office has similar concerns for obesity measurement (NOM 11.1).

We thank HRSA and MCHB for their revisions of the guidance and look forward to telling the story of Title V funds and the impacts on Maternal and Child Health.

Sincerely,

Janna Bardi
Director, Office of Healthy Communities
MCH Director
Washington State Department of Health

[1] Data from CDC's 2014 Breastfeeding Report Card accessed 8/21/2014 at http://www.cdc.gov/breastfeeding/data/reportcard.htm

Guardino, Taylor (HRSA)

From: Nora Wells <NWells@familyvoices.org>
Sent: Tuesday, August 26, 2014 4:33 PM
To: HRSA Paperwork
Cc: Cristy Marchand; Lynda Honberg; Bev Baker; Smalley, LaQuanta (HRSA); Manning, Leticia (HRSA)
Subject: Comments submitted by Family Voices National Center for Family Professional Partnerships-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.
Attachments: Family Voices NCFPP comments on MCHB Block Grant Guidance_8 26.2014.pdf

Comments submitted by Family Voices National Center for Family Professional Partnerships in response to Information Collection Request: *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.*

These comments represent input endorsed by 53 family-led organizations serving families across disabilities and other special healthcare needs including Family Voices State Affiliate Organizations and Family-to-Family Health Information Centers (F2F HICs) across the country. Together this network constitutes a powerful "voice" of families of children and youth with special needs and disabilities from every section of this country.

We recognize the very large undertaking and critical purpose that the revisions of the MCH Block Grant Application/Annual Report Guidance represent and greatly appreciate this opportunity for public comment. The following comments bring perspectives from experienced and diverse family leaders, actively engaged with State Title V programs in every state including the District of Columbia. The comments focus on overall aspects of the revisions, requirements to measure performance around family and consumer engagement, measuring care for CYSHCN, the necessity and utility of the proposed information collection for the proper performance of MCHB's function and ways to enhance the quality, utility and clarity of the information to be collected.

A. ***Pages 2-4: Vision and Mission***

As family leaders with a long history of partnership with MCH, we know first-hand the enormous impact that MCH has had on the health and well-being of children with special health care needs. Based on years of partnerships we also know that MCH has had a great impact on all the country's most vulnerable mothers, infants, children and youth. We have concerns, however, that this impact is not sufficiently visible and may be overshadowed in the context of ACA implementation. This is particularly true for children with special healthcare needs for whom ACA added critical protections but did not solve issues of adequate healthcare financing. We recognize the critical need for documented evidence of the impact of MCH work at the State and federal levels and believe that partnership with families served at all levels is essential to demonstrating quality, satisfaction and impact on health outcomes. The revised pyramid and strategies outlined in this MCHB Guidance capture the essential roles of MCH work. However we believe that the first listed strategy, "mobilize partners, including families, at the federal, state and community levels ...." is actually central to all of the other strategies listed under the vision and to all of the MCH essential services/public health standards listed under the pyramid. MCHB's partnership with families including families from diverse racial and ethnic populations must be viewed as unique and different from its partnership with other groups. These are MCHB's core and most critical partners, as these are the partners for whom MCH services are designed.

Recommendation I: Include as a first strategy on page 4, the 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."

B. *Pages 5-6: National Performance Measurement Framework*

We appreciate that the guidance requires that states report that they work with families/consumers, but request that MCHB provide specific guidance for how state Title V programs report that they "work closely with family/consumer partnerships as they develop the S&PMs for their selected NPMs "(pg. 6).

Recommendation II: Provide guidance on how to determine level of work and require each state at a minimum to work with their federally-designated Family to Family Health Information Center around identifying the performance measurement framework and selecting NPMs and developing S&PMs.

C. *Pages 6-8: Changes to the Application/Report Guidance*

The required Executive Summary is a key element of the new guidance. We do not think that his document should be thought of as a tool for "marketing" Title V achievement to "family agencies" or for "soliciting programmatic input from families" (pg. 7), but rather that each state be required to work with families/family organizations in developing the elements of this Executive Summary as well as the entire application. There should be a requirement that the summary include a brief description of how families were involved in the work that led to the Executive Summary of the Block Grant application-- including the needs assessment, identification of priorities, and development of plans to address identified needs. Engaging families from the full diversity of populations and family organizations in the work of the Block grant -- its development, implementation, and evaluation is the most effective way to ensure that families and family organizations truly understand and value Title V.

Recommendation III: In required elements of the Executive Summary (pg. 7), include as a 5th bullet *a description of methods and levels of engaging families/consumers/family organizations in assessing and developing needs, accomplishments, priorities, action plans, NPMs, SPMS and S&PMs

D. *Page 15: Components of the application/annual report*

The guidance requests on page 15 that in the interim year reports, states report on their "Level of commitment to consistently engaging family/consumer partners in Title V MCH and CSHCN programmatic and decision making efforts" but does not provide specific guidance for how to rank their level of commitment. MCHB must provide specific guidance to states on how to arrive at this description of a "level of commitment" so that this ranking will provide meaningful information.

Recommendation IV: Provide guidance for the ranking of "commitment to consistently engage family/consumer partners." Require all states to use the same methodology to establish a self-ranking and require them, in addition to self-ranking, to gather the same information on ranking from family organizations representing the populations served by their MCHB Block grant funds. Require states to include in their Block grant report both their self-ranking and the average of rankings by family organizations as well as a description of their methodology for arriving at the rankings.

- Require States to report both qualitative and quantitative data collected internally on the elements described on page 25 and on page 33 about family/family organization engagement at the program and policy level. Require states to collect information from families/clients/family groups on these same elements.

Recommendation V: In addition, require all states to measure their effectiveness in engaging families/consumers at the individual level of care by themselves collecting directly from a selection of the populations served through MCHB Block Grant funds:

- Title V programs should be required to annually collect survey data from a selection of families served by activities/programs undertaken by the program or contractors funded through Block Grants. This requirement should be undertaken for whatever form of service to families is provided within a state be it direct or indirect. Title V programs should work with family partners, specifically including the federally-designated Family to Family Health Information Center and the Family Voices State Affiliate Organization within their state, in designing and undertaking such surveys. MCHB should provide guidance as to the amount of data a program needs to collect to represent the perspective of the populations served by the programs. In addition, because underserved families are less likely to complete surveys, even if they are in their language or are in easy-to-understand language, especially if they are on-line, states should be required to utilize varied methods of obtaining survey results such as hard copy surveys and focus groups. Summaries of survey findings will give programs direct annual feedback from families they serve for quality improvement. Findings should be required as part of the annual State Block Grant Report and should be compared across years to track yearly progress. Potential sources/tools for such state level data collection:
  1. Questions about family-centered care from the Family Voices Family-Centered Care Assessment for Families.
  2. Questions from the NSCH or other questions related to the topic and appropriate to the situation.
  3. State special education and early intervention programs are required to report on family engagement and family outcomes, respectively, as part of their annual State Performance Plan/Annual Performance Reports. The survey developed and validated by the National Center for Special Education Accountability and Monitoring for Part C early intervention family outcomes, in use by early intervention systems across the country, may be adaptable by state Title V programs. This survey contains questions leading to results on specific measures of hope/optimism, problem-solving and sense of resourcefulness, empowerment, and links to the community, among others.
  4. MCHB Guidance regarding administration of surveys must include requirements regarding representativeness of the families surveyed and families responding as well as requirements to use strategies to secure feedback from culturally and linguistically diverse families that often do not respond to surveys.
  5. At least some data elements should be consistent across states, if possible, so that data would be comparable across states.

E. ***Pages 5-7, Page 17 of Appendix: National Performance Measures and New Measurement Framework:*** Family Voices recognizes the critical importance of having valid sources for performance measures to document the impact of MCHB funding and clear guidance as to measurement protocols. However we are deeply concerned that the measures identified in the draft Block Grant Guidance include so few specifically focused on CYSHCN, while the federal funding requirement legislates that 30% of the federal dollars be allocated to this population. Of the 36 NHS/OMS, only 5 specifically focus on CYSHCN and two of those focus on a subset of CYSHCN with a specific diagnosis. Of the 17 identified draft NPMs, only two focus specifically on CYSHCN. While we believe that it is valuable that stratified data around CYSHCN be provided to states for any measures where this data is available, we are concerned that only one measure on CYSHCN is required to be reported on by all states. This seems inadequate to document the impact of the significant federal dollars invested in serving CYSHCN and their families through the MCHB Title V Block Grants. It sends a message to those who will be reporting on these measures that, despite the mandate to spend 30% of the federal dollars on CYSHCN and their families, CYSHCN are not really that important. In reality, nearly 20% of children ages 0-17 in the US have special health care needs, and more than one in five families (23%) has at least one child with special health care needs (see http://www.familyvoices.org/admin/miscdocs/files/One-in-Five_05-01-2014.pdf).

Recommendation VI: Revisit the # of identified NHS/OMS and NPMs that focus on CYSHCN and reconsider including measures on each of the six components identified by MCHB as indicators of an effective system of services for CYSHCN. At a bare minimum, require all states to report on at least two national measures related to CYSHCN.

The above recommendations are respectfully submitted by the following 53 organizations.

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Nora Wells, Co-Director, National Center for Family Professional Partnerships (NCFPP)
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twitter

Guardino, Taylor (HRSA)

From: Rooney, Laura <Laura.Rooney@odh.ohio.gov>
Sent: Tuesday, August 26, 2014 2:14 PM
To: HRSA Paperwork
Subject: Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172-Revision
Attachments: RESPONSE- Title V ApplicationAnnual Report OMB No. 0915-0172-Revision.pdf

The National Network of State Adolescent Health Coordinators (NNSAHC) has attached comment regarding the Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172-Revision.

Thank you,

Laura Rooney, MPH
President-Elect
National Network of State Adolescent Health Coordinators
Laura.rooney@odh.ohio.gov
614-466-1335

August 26, 2014

Re: 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

Attn: HRSA Information Collection Clearance Officer

To Whom it May Concern:

Thank you for the opportunity to comment on the Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172-Revision. The National Network of State Adolescent Health Coordinators (NNSAHC) would like to thank Dr. Lu and the HRSA staff for identifying Adolescents/Young Adults as a priority population among the Domains. In addition, we are pleased with the inclusion of the language "children with and without special health care needs" in regards to health care transition and medical homes.

We respectfully submit the following comments for consideration in response to the Federal Register /Vol. 79, No. 124/Friday, June 27, 2014:

- Regarding NPM's and Outcome Measures that identify the targeted age ranges as 0-17, 0-18, or 0-19 - These age ranges are very broad and encompass differing developmental stages and needs. There is concern that states may select interventions that only address a few years within the full range. We strongly encourage MCHB to provide clear guidance that indicates the need to implement multi-pronged approaches that are developmentally appropriate for all stages of development for youth and young adults age 0-24 years.
- Consider adding "Adolescents" to the Population Domain for NPM#9 "Children age 0 - 17 years with adequate insurance." Currently, it only states "children" even though the age range addressed extends to age 17 (adolescents). This will draw attention to the adolescent specific needs regarding insurance coverage.
- Continue to include analysis of data for youth without special health care needs in regards to transition as this is an issue that impacts all adolescents regardless of health care needs. Further data analysis will allow states to more effectively implement targeted strategies that will reduce barriers to care for all youth transitioning into adulthood.
- Not all states implement YRBS. For those that implement a state specific survey, will data be included or will they only use the NSCH?
- The data source noted for NPM 11 (physical activity) implies the YRBS will not be used after 2017 (as noted on p. 71 of Appendix F in the "Title V MCH Services Block Grant to States Program - Appendix of Supporting Documents" publication). The NNSAHC feels that YRBS

should continue to be used where identified across all NPMs because it provides self-reported behavior by the adolescent. As we know in adolescent development research, young people do not always share specific details of their behavior with their parents. Therefore, including self-report data will provide a more accurate reflection of behavior.

On behalf of National Network of State Adolescent Health Coordinators, we would like to again thank you for the opportunity to comment on the Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172-Revision. We look forward to the next round of review and final release of the new guidance.

Sincerely,

Laura Rooney, MPH
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Guardino, Taylor (HRSA)

From:	Mertz, Kim N. <kmertz@nd.gov>
Sent:	Tuesday, August 26, 2014 4:33 PM
To:	HRSA Paperwork
Cc:	'Brent Ewig'; Gallup-Millner, Tammy L.; Muccatira, Devaiah M.; Wagler, Debra (HRSA)
Subject:	ND Comments to the Proposed Revisions to the Title V MCH Block Grant Guidance
Attachments:	ND MCH Grant Guidance Feedback 8-26-2014.docx

Thank you for the opportunity to provide feedback to the Title V Maternal and Child Health Services Block Grant to States Program – Guidance and Forms for the Title V Application/Annual Report.

Attached are comments from North Dakota.

Please feel free to contact us for any questions or clarification.

Kim

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Thank you for the opportunity to provide feedback to the Title V Maternal and Child Health Services Block Grant to States Program – Guidance and Forms for the Title V Application/ Annual Report. Below are comments from North Dakota.

What we like about the proposed guidance:

- The Logic Model is helpful in organizing processes.
- May assist with targeting priorities more effectively.
- Could assist with increasing comparability between states.

What could be improved about the proposed guidance:

- CSHCN and family involvement appears much weaker than previous guidance; requires a continual "call out" to assure inclusion; story for this population is marginal.

Does the proposed guidance achieve the overall aims of the MCH Transformation:

- Reduce burden to states
  - It is helpful to have data pre-populated into the grant; however, this will only be helpful if the data is entered in a timely manner. We start analyzing data by October of the prior year of when the grant is due in order to complete narrative sections of the grant (i.e., annual report).
  - With our current funding levels, the selection of 13 performance measures (8 selected national measures plus 5 state performance measures) may not realistically achieve the results of "moving the needle." We suggest you consider a reduced number of performance measures based on a state's funding and capacity. For example, allow states to select between 5-8 national performance measures and 3-5 state performance measures. This will allow states with less resources to select fewer measures, thereby reducing burden; but still allows for more selection for states with greater funding and capacity.
  - The estimated time to complete the Block Grant application is 189 hours. In reviewing the proposed guidance, we feel this is an under-estimate.
- Maintain state flexibility
  - The proposed guidance allows states to select state priorities, thereby maintaining flexibility.
- Improve accountability
  - We feel the current grant guidance already addressed accountability; however, the proposed guidance appears to improve accountability in targeted areas. While we support and recognize the need for accountability, it feels like there will be so much work effort put into "accountability", that time to actually complete work activities may be reduced.

Definition of key terms:

- Having key terms defined in this first draft of proposed guidance would have been very useful.
- Forms for budget and expenditures by type of service (Form 3b)
  - Additional definition and examples are needed for the new pyramid – "Types of Individual Services."
  - Definitions for the "Types of Individual Services" were provided in the MCHB's direct service survey. It may be useful to use these same definitions. Note: We have

not received a summary report from the MCHB direct services survey and would be interested in receiving one.
    - "Reimbursable" definition needs to be clarified as it could be used to inaccurately misrepresent what is really "gap-filling" for Medicaid, private insurance, and other payers.
    - Budget breakdown by pyramid is not useless for state use/management.
- Reporting instructions/number of individuals served under Title V (Form 5)
    - In ND, a significant portion of MCH funds are granted to local entities to carry out MCH functions. As a contract requirement, grantees report on the number of individuals served. However, in order to do this accurately, they need to be provided with "definitions" for collecting and reporting the data. Since definitions are not currently available and the guidance will not be finalized/released until March 2015, there will not be adequate time to expect grantees to adjust how they report on the number of clients served; hence the data entered for the 2016 grant may not be accurate with the new pyramid and definitions.
    - Need detailed instructions on "how to" if both direct and population-based services are reported. There is also a "cost" to reporting on these in relationship to systems (i.e., informational technology) and staff resources.
- Structural and performance measures
    - Clarity is needed on how structural measures differ from performance and outcome measures. Several examples for *all domains* will be needed for clarity.
- Direct reimbursable MCH healthcare services
    - This may be misconstrued. In ND, we pay what isn't being covered by insurance or other payers. There is concern that policymakers will think there is duplication or that gap-filling is not needed. States are not equal with what Medicaid reimburses for Title V services.
- Non-reimbursable primary and preventive health care services for MCH populations
    - Specialty care for CYSHCN's in MCH 3.0 seems to be missing. Small rural states often support access to specialty care. Definitions and examples are always help.
- Public health services and systems for MCH populations
    - Assuring direct services should not be excluded as it is a core public health function. Definitions and examples are always helpful.

<u>Does ND recommend reporting on infants with FAS/ born with drug dependency and women who deliver who do not receive prenatal care during the first trimester of pregnancy</u>:

- Yes, however; what are the data sources other than Vital Records? Vital Records data on FAS and drug dependency may not be useful/accurate as a population measure.

<u>Level of commitment to consistency engaging family/consumer partnership</u>:

- Tools to measure engagement are helpful for all of Title V, not just CYSHCN's.

<u>Should the guidance describe Title V as a safety net program</u>:

- Yes, as over half of states are providing direct health care services, albeit small numbers of them. Consider adding to "where needed to assure access."

Description of the purpose of the MCH Block Grant:

- ND still uses Title V funds to provide comprehensive care. Perhaps this is a small, rural state issue, especially for the CYSHCN population. The mission/description of pages 4-5 is fine as services to address unmet needs covers the comprehensive care issue.
- "Partnering" to immunize all children would more accurately reflect how ND utilizes Title V funds.

Availability of data for pre-population:

- Current and timely data is a huge issue. It has potential to critically hamper coordinated work efforts required to complete the application.

Interrelationship of measures:

- We would suggest mapping be done for states rather than by states.

Feasibility of three three-page executive summary:

- A three page summary would be extremely challenging with the current scope of reporting.

Needs assessment expectations:

- Based on past experience, we expect a 20 page summary will be difficult to achieve.

Action plan template format:

- Please provide examples for all domain groups regarding level of detail expected. The table requires a great deal of information.

State action plan key strategies/activities:

- Examples would be helpful for all domain groups.

Describe activities for which the Title V program provides primary leadership in administering the activity:

- Primary funding vs. leadership provides a clearer reference.

State support for family/consumer engagement:

- If the word "education" is chosen to replace advocacy, we would not support adding "education *of policymakers*," as education goes far beyond that group.

Proposed reportable elements (from 52-55 to 57-61):

- Yes, there is an increased reporting burden.

Proposed Performance Measurement Framework:

- Unsure on data availability for new measures for CSHCN, especially in small rural states. Will data be available or will the numbers be too small for needed analysis?
- Why are only mental/behavioral health measures included, as this does not reflect the full CSHCN population.
- Why is early hearing, detection and intervention (EHDI) excluded?
- Limited national performance measures for CYSHCN's in MCH 3.0.

- Provide examples for all measures and relational mapping.

Health Status and outcome measure (HS/OM):

- Annual data populated for all health status and outcome measures – at what point in time during the application year and for which calendar year during the grant application will the data be made available? A lag time could impact the state grant narrative, annual plan, and reporting of structural and process measures.
- For states like ND, will the revised NSCH capture ample sample size for minority populations that address both CSHCN and non-CSHCN? Consider a category specific to American Indian (AI) rather than including them in the "other" category. Capturing AI data is very useful for the state for program planning and targeting disparity and equity.
- Specify the age groups using "through" or "to", not a dash (-) to avoid confusion.
- Clarity of definition of children, adolescents and youth usage in the health status and outcome measures. In some measures, both children and adolescents have been used. Should it be consistent across the measures?
- HS/OM #10.2-Percent of children 6 months to 17 years who are vaccinated annually against seasonal influenza. The denominator indicates 'through' for age and the numerator indicates 'to'.
- HS/OM #15-Rate of death in adolescents ages 10-19. Children and adolescents in the title of the measure? The measure has 10-19 years (Which is supposed to be 'to') but the numerator and denominator is mentioned as "through."
- HS/OM #18 -Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system. Which measure will be used from the old survey as a baseline that is referenced for the source in the detailed sheet?
- HS/OM #19- The rate of deaths to children aged 15-19 years caused by motor vehicle crashes. The title of the measure refers to "children" and the example referred to in HS/OM #15 refers to it as "adolescents." It's also in the numerator and denominator definitions.
- HS/OM #19.2- Percent of children diagnosed with autism spectrum disorder. There is no baseline state specific data from the referenced source which is the NSCH. Any solutions and/or recommendations?
- HS/OM #19.3- Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD). The age group in the old survey for baseline data is 2-17 and not 3-17 as in the new measure. Will that be changed in the revised survey?
- HS/OM #20- Percent of children with a mental/behavioral condition who receive treatment. Which measure will be used from the old survey for baseline? Is the age group 3-17 correct, or is it the new age group in the revised survey?
- HS/OM #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. Is the American Public Health Laboratories data set the universal data set for this measure, or are there other alternative sources?

National Performance Measure (NPM):

- Consistent usage of " through" or "to" among NPM measures to avoid confusion.
- NPM#4 -Percent of infants placed to sleep on their backs. ND does not have PRAMS data. Providing recommendations on alternative data sources will be very helpful.

Thank you again for the opportunity to provide comments. Please feel free to contact us for any questions or clarification.

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- NPM #5 -Percent of children, ages 9-71 months, receiving a developmental screening using a parent-completed screening tool. The baseline source has a different age group from the old survey.
- NPM #6- Rate of injury-related hospital admissions per population ages 0-19 years. ND does not have state hospital discharge data. Providing recommendations on alternative data sources will be very helpful.
- NPM # 10- Percent of infants who are ever breastfed. There is lag time in NIS data. Consider using the revised NSCH data (if question is included).
- NPM # 8 & 11- there are two recommended sources for data –YRBS & NSCH- state collected data versus national survey data. Why? Which data set would you recommend? Can the state choose the data source that it feels best reflects accurate data?
- NPM # 12- 12A Percent of women who had a dental visit during pregnancy. ND does not have PRAMS data. Providing recommendations on alternative data sources will be very helpful.

North Dakota also supports the comments presented by the National Network of State Adolescent Health Coordinators (NNSAHC):

- Regarding NPM's that identify the targeted age ranges as 0-17, 0-18, or 0-19 - These age ranges are very broad and encompass differing developmental stages and needs. There is concern that states may select interventions that only address a few years within the full range. We strongly encourage MCHB to provide clear guidance that indicates the need to implement multi-pronged approaches that are developmentally appropriate for all stages of development for youth age 0-17+ years.
- Consider adding "Adolescents" to the Population Domain for NPM#9 "Children age 0 - 17 years with adequate insurance." Currently, it only states "children" even though the age range addressed extends to age 17 (adolescents). This will draw attention to the adolescent specific needs regarding insurance coverage.
- Continue to include analysis of data for youth without special health care needs in regards to transition as this is an issue that impacts all adolescents regardless of health care needs. Further data analysis will allow states to more effectively implement targeted strategies that will reduce barriers to care for all youth transitioning into adulthood.
- Not all states implement YRBS. For those that implement a state specific survey, will data be included or will they only use the NSCH?
- The data source noted for NPM 11 (physical activity) implies the YRBS will not be used after 2017 (as noted on p. 71 of Appendix F in the "Title V MCH Services Block Grant to States Program - Appendix of Supporting Documents" publication). The NNSAHC feels that YRBS should continue to be used where identified across all NPMs because it provides self-reported behavior by the adolescent. As we know in adolescent development research, young people do not always share specific details of their behavior with their parents. Therefore, including self-report data will provide a more accurate reflection of behavior.

Guardino, Taylor (HRSA)

From: Foster, Jessica <Jessica.Foster@odh.ohio.gov>
Sent: Tuesday, August 26, 2014 3:26 PM
To: HRSA Paperwork
Cc: Mchugh, William; Seagraves, Theresa; bewig@amchp.org
Subject: Title V MCH Block Grant to States Program: No. 0915-0172-Revision comments
Attachments: Document.pdf

Dear Sir or Madame,

Please see attached letter from the Ohio Department of Health Title V Maternal Child Health Program. Thank you for the opportunity to comment on the Guidance revision.

Dr. Foster

Jessica Foster MD, MPH, FAAP
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Richard Hodges/Director of Health

AUG 26 2014

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

Re: 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 you for the opportunity to comment on the Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172-Revision. Overall Ohio applauds the efforts of Dr. Lu and the HRSA staff to reduce reporting burden to states, maintain state flexibility and to improve accountability. We are pleased with the improved alignment of the state priority needs with national outcome and performance measures as well as structural/process performance measures and state performance measures. The format of the 5-year State Action Plan, 5-year Action Plan Table as well as the new Executive Summary requirement will assist states in telling a more cohesive and comprehensive story and will improve accountability across MCH population domains.

We respectfully submit the following comments for consideration in response to the Federal Register /Vol. 79, No. 124/Friday, June 27, 2014:

Reporting Burden to States

- Overall it seems the new proposal will streamline the block grant reporting process. It is unclear if the hours of burden will actually be reduced. The planned pre-population of state-level data fields and reduced number of measures may yield a reduction in burden.

- As reflected in the burden estimate which compares the initial 5-year needs assessment year with future years, there will be a substantial investment of hours, likely initially increased from past investment of hours as states develop state priorities, select the 8 NPMs, create the 5 SPMS and make sure they clearly align demonstrating accountable outcomes. Creation of the related State Action Plan Table and narrative and then, by the second year, development of the structure and process activities and documentation will also require an initial heavy time investment. Once this initial work is completed by states, it is possible that future reporting burden will be somewhat reduced.

- The page limits for the Executive Summary and Needs Assessment description are appreciated; however, both limitations (3 page limit for the Executive Summary and 20 page limit for the Needs Assessment description) might be too restrictive to ensure states can include all necessary components and adequately cover each component in each document. States are often criticized in current Block Grant reviews for not being able to adequately tell their story with the document. The new organization of these documents will greatly improve this concern, but states will need adequate space to respond to each component as well.

- Overall, we are very pleased with the creation of the new Executive Summary as the document will be useful for sharing to educate our legislators, state partners, etc. regarding our MCH work. We agree that a shorter document better holds the attention of our audience, but we also want to be certain that states are adequately able to reflect their work in this brief document.

New MCH Pyramid

- The statement under "Direct Reimbursable MCH Health Care Services" (payment for direct services not covered by public or private insurance) is appreciated and will help clarify the role of Title V at this level of the pyramid. The formal definition of each of the pyramid levels will be critical and we understand will be available for review in the second round of public comment.

- The title "Non-Reimbursable Primary and Preventive Health Care Services for MCH Populations" is somewhat misleading when the corresponding MCH Essential Public Health Services are considered. Perhaps a better title for this category would be, "Non-Reimbursable Population-Based MCH Services".

New Mission Statement

- Consider revising the new mission statement to reflect Title V role of "state infrastructure building" to ensure the state has the capacity to conduct the MCH strategies (p. 4 of the guidance) from the 10 Essential Public Health Services.

Improve Accountability

- The new guidance provides more emphasis on partnerships, collaboration and coordination. This emphasis is greatly needed and will reduce duplicate efforts within a state. It will also likely drive improvement of internal partnership/collaboration within Title V programs.

- In general, the grouping of the priority needs, NOM's, NPM's, SPM's by the 6 population groups is an excellent approach to assist states in reporting and being accountable for impact in each population group. It is important that CYSHCN continues to be called out as a population due to the unique needs faced by this vulnerable population. However, the CYSHCN population spans infants, children, and adolescent/young adults, so a caution is that this grouping of measures could make it tough to group for collaboration. This concern should be addressed in guidance regarding implementation and tracking to the states.

- Related to the comment above, suggest continued analysis of data for youth without special health care needs in regards to transition as this is an issue that impacts all adolescents regardless of health care needs. Further data analysis will allow states to more effectively implement targeted strategies that will reduce barriers to care for all youth transitioning into adulthood.

- Further clarity in the instructions for Form 5, Number of Individuals Served Under Title V (By class of Individuals and Percent of Health Coverage) (former Form 7) would be helpful. The former Form 7 was challenging to complete as programs had difficulty accurately accounting for numbers served. Challenges included duplicated counts or undercounting due to difficulty interpreting how to account for individuals served by population. An example of guidance that leads to confusion is the instruction to provide numbers of individuals served (and their insurance type) by all Title V programs at ALL LEVELS of the pyramid, which includes population based programs. It is challenging to accurately enumerate the number of individuals our population based programs serve. Estimates of these numbers may be the best a state can deliver. More specific instructions as to exactly what should be included would be helpful. It is possible that the definitions, once

available, will provide this clarity. This concern should be considered as definitions are drafted, revised and finalized. Additional guidance about how to avoid duplicated counts would also be appreciated as many of our programs serve the same clients and states generally lack completely linked data sets.

- Regarding Form 4, Number & Percentage of Newborn and Others Screened, Cases Confirmed and Treated:
  - Column D – the percentage of those "getting treatment" is auto-calculated as the number of cases needing treatment/number of confirmed cases. Since not all confirmed cases need treatment, this throws off the percentage in Column D. The columns should be:
    - (C) Number confirmed cases
    - (D) Number needing treatment
    - (E) Number receiving treatment
    - (F) Percent needing treatment that received treatment = # needing Tx/# receiving Tx

- The organization of the newly developed MCH BG Application, Annual Report and Needs Assessment will increase accountability by states. The reporting will be more cohesive and improved comparability across states is also anticipated.

On behalf of Ohio's Title V Maternal Child Health and Children and Youth with Special Health Care Needs programs housed in the Division of Family and Community Health Services at the Ohio Department of Health, we would like to again thank you for the opportunity to comment on the Guidance and Forms for the Title V Application/Annual Report OMB No. 0915-0172-Revision. We look forward to the next round of review and are excitedly anticipating the final release of the new guidance.

Sincerely,

William McHugh, D.M.
Assistant Director
Title V Maternal and Child Health Director, Acting
Ohio Department of Health

Jessica Foster, MD, MPH, FAAP
Ohio Title V Children and Youth with Special Health Needs, Medical Director
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Ohio Department of Health

Guardino, Taylor (HRSA)

From: Rachel Sisson <RSisson@kdheks.gov>
Sent: Tuesday, August 26, 2014 3:33 PM
To: HRSA Paperwork
Cc: 'bewig@amchp.org'; Heather Smith
Subject: Public Comment: FRN Vol. 79, No. 124; HRSA HHS Title V MCH Services Block Grant
Attachments: FINAL KS Comments Proposed Title V BG Guidance 8-26-14.pdf

Good afternoon:

Please find attached comments related to the Title V Maternal and Child Health Services Block Grant (Federal Register Notice – Vol. 79, No. 124 – 6.27.2014). Thank you for the opportunity.

Rachel (Berroth) Sisson, MS, Director
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Federal Register Notice Vol. 79, No. 124 – June 27, 2014
Title V Maternal & Child Health Services Block Grant to States Program
Public Input/Comments
August 26, 2014

Section	Topic	Comments/Questions
General Comments	Guidance/Aims of Transformation	The proposed guidance appears to achieve the overall aims of the transformation. Pre-populating data and streamlining the forms/reporting reduces burden, allowing states to choose 8 of 15 NPMs offers states flexibility, and developing the S&PMs improves accountability. The new guidance is in line with the state's vision and direction. Many of the new state priorities identified for SHCN fit nicely into the new MCH Pyramid and show the integration of the proposed NHS/OMs and proposed NPMs. However, the first year (application under new structure/reporting under the current) will be more time-consuming and potentially even more complicated, fragmented, and confusing during the transition period. The increase in the number of measures across the board will be more burdensome for the writers even though data is prepopulated for the MCH Epidemiologists. The number of report elements is greater than before; compared to past years, this is more burdensome in ways. There appears to be much cross-over with the intent to integrate CYSHCN, this could be increased under the new guidance.
	Family Engagement	The state is glad to see the focus on family engagement; however, it appears to be very detailed as to approaches/methods states are expected to utilize to engage families versus allowing states the flexibility to determine the specific activities and strategies. Even though some states may already be doing some or all, it could present barriers for those that have other successful methods/approaches.
	Title V as "safety-net provider"	Could it say that "Title V will support safety-net systems of care" – regardless of us providing direct reimbursable services, we will be supporting that system of care with our efforts and initiatives. Perhaps this could be the catalyst for assuring all states have fully engaged the FQHCs and not only local health departments?
	Legislative Requirements	Section C: Application for Block Grant Funds (Section 505) On page 10, when discussing the 30% of funds to be spent on Children and CSHCN, the 30% of funds to be spent on Pregnant Women and (Mothers?), per this application's language, seems to be missing in this particular area. This seems inconsistent with the overall message of improving the health of mothers and pregnant women.
Funding/Resources/ Capacity	Formula/Allocations	For the states that did not expand Medicaid and therefore not receiving additional assistance related to health care/reform, will this be considered in the Title V formula funding? The MCH/Title V programs are likely filling remaining gaps in the health care services/system and will continue to do so. This is additional burden for some states vs. others related to program and fiscal responsibility. What additional support would be available from MCHB to assist in addressing services and system barriers in

		implementing ACA for states that did not expand Medicaid? Especially since this is intended to build upon and support a stronger system of care in conjunction with ACA. Special consideration should be given to these new expectations for budgeting and reporting expenditures for state/federal within domains and additional categories. State data systems as well as fiscal systems will need to be modified, enhanced, or substantially overhauled to meet the new requirements. The cost of systems development/enhancement is high and it's not likely that states will have the resources to meet the needs without additional funding. This could result in more manual collection and injury of data, duplication of effort, and waste.
Framework	Pyramid	The MCH Pyramid on page 3 is a revision of the previous Public Health pyramid. - Previously activities had to be reported on a summary sheet indicating which level of the pyramid was being addressed. Does the 5 year action plan table (Appendix page 8) replace that? - Will funding of services need to be reported by pyramid level or by MCH Essential Services/Public Health Standards? - Clarification that Infrastructure (which was the base of the pyramid) has been integrated into "Public Health Services and Systems" - What are the expectations for integrating the life course indicators?
	Health Status/Outcome Measures	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. What is the proposed timeline for MCHB to make available to states the data to be pre-populated? HS/OMs will be prepopulated with national data, but this data source is two years behind, one year older than data the state has access to; this reduces burden but results in state reports that do not reflect the most current data; as a state, we have the option to access provisional yet very current data. Opportunity: State can include most current data in the narrative. For many of the NPMs, the data source is the National Survey of Children's Health. It is our understanding that new data for these measures will not be available until 2017 or later. The current data is 2011/12, which is already outdated. Can MCHB/HRSA provide clarification as to how they will assure more timely data with regard to this survey? Additionally, it would be great if there were ways to drill down to the county level for certain data sets, so initiatives could be targeted for those specific populations. Is that a possibility with the revamped survey? 16 – Rate of deaths to children aged 15-19 years caused by MV crashes: Believe this is beyond our general MCH purview and is actually under injury prevention. How can we show/document work and impact on this?

		17 – Rate of suicide deaths among youths 15-19 years: Same as above and begs broader mental health responsibility/supports. 19.2 & 19.3 – Percent of children diagnosed with autism spectrum disorder and ADD/ADHD: The description provided indicates states simply track these. Is it just so states know the status of these percentages? Otherwise, are states expected to drive improvement in the rates and if so, how can we document? Is improvement increased or decreased percentage? 24 – Percent of children meeting criteria for school readiness: The description provided states the definition and criteria are still under development, so it is hard to make comment. Again, how broad or narrow they make this will be critical for our role and how we can impact independently vs. collectively with the broader Early Childhood system.
	NPMs	NPM 4: Percent of infants placed to sleep on their backs: The description states PRAMS is the data source but does not note how to collect/report if a non-PRAMS state. It's disappointing to be unable to select it when it's state's priority issue, especially related to Infant Mortality efforts. Are there plans to look at funding the non-PRAMS states in the future? NPM 5: Percent of children ages 9-71 mo. receiving developmental screening: The description states that this must be provided by a health care provider; what about other providers in the early childhood realm and states working on ECCS strategies to expand screening? This is somewhat in opposition to and in conflict with ECCS which requires improving systems across these sectors. NPM 8: Percent of adolescents bullied: As with MV crashes and suicide rates, Title V is concerned about the capacity to impact without the broader educational, mental health, and related systems. States of course have the option to select another measure. NPM 9: Children age 0 - 17 years with adequate insurance: Consider adding "Adolescents". Currently, it only states "children" even though the age range addressed extends to age 17. This will draw attention to the adolescent specific needs regarding insurance coverage. NPM 11: Could this be revised more like NPM 12 and break down into A and B to distinctly separate the age categories? NPM 12: Percent of dental visits for women during pregnancy and children ages 1-6. What about kids ages 7-18? Are we mainly concerned with early years and habits, dental care, etc? This is not clear. NPM 13 and 14: Contains wording, "with and without"—Is this really necessary? This applies to all children anyway so this is not necessary and is redundant.

		Acknowledge that proposed NPMs # 5-9, 11, 12b, and 15b could technically also be CYSHCN, therefore we'd like the opportunity to select our NPM for the CYSHCN domain from one of those as well, rather than limiting our choices to 13 and 14 only.
	S&PMs	Understand these must be developed for each NPM selected by the states—one S&PM for each NPM. There will be more to come on these such as examples, training, technical assistance, correct?
Narrative Reporting	Six Population Health Domains	This approach is understood but it's not clear how counts should be reported for each domain when a service may touch the same individual in different domains—how do states know where to count and what assurances are there to prevent duplication OR are duplicate counts expected within the domains if an individual accesses services in more than one? Example: Maternal/women's health and Perinatal/infant health periods – a woman could be served in MCH for counseling and then become pregnant. Within which domain should this be counted? This is not clear. Leaving it up to the states to determine where certain activities and expenditures should fall would be burdensome. Reporting CYSHCN as a separate domain can present challenges for states looking to fully integrate. There is potential for duplicate reporting in multiple categories in order to show the impact the state is having on the CYSHCN population since the CYSHCN is called out as a separate domain. Considerations: - CYSHCN should always cross the Child and Adolescent domains, and will cross from time to time the maternal and women's health and perinatal health, for our young women in transition and our adult CYSHCN population. - For the Application/Annual Report, states are expected to organize the narrative by the three legislatively defined populations – again, there is tremendous cross-over for the CYSHCN population and we will need to be careful to highlight that we are integrating CYSHCN into those other populations while still reporting separately. As we move forward, if SHCN begins to integrate family planning in our transition efforts, prenatal education referrals through care coordination, coordination with home visiting and WIC, effective referrals for early intervention and developmental screenings, school health, family engagement across all MCH, and countless other integration opportunities…we are going to have to report all of that in multiple places the way these domains are set up. It will be challenging to separate the data out and show that CYSHCN crosses many domains without being duplicative.
Forms	Form 3a Form 3a Form 5	CSHCN Population – How are we defining this? Are we defining as MCHB definition of CYSHCN or KS definition for eligible for SHCN program? The sections on the forms do not line up with the domains—Maternal/Women's Health is not listed and this is concerning considering the discussion related to the need for MCH to focus on healthy women/maternal health to support improved birth outcomes. What if states are supporting preconception

		health activities? How would this be reported?
	Form 3b	Request a clear description of what falls in the "Direct Reimbursable MCH Health Care Services" section. Define "Non-Reimbursable Primary and Preventive Health Care Services for MCH Populations." A clearer definition could be helpful. The former list of "enabling" could be used.
	Form 4 pp. 47-48	This appears to be more expansive than just NBS; screening for older children and women. If so, does it still only apply to additional screening for those with a condition identified through the NBS program? Also noticed here states will report on resident births only vs. resident and out of state, correct? What's in the new dropdown box? States are unable to determine if we can report and access data (implications) without knowing the list of variables.
	Form 5	States need a clear definition of what is meant by CSHCN in this breakdown: broader special health services population, national data, specialty clinic clients with eligible conditions? Also, there isn't a clear place to account for women's and/or men's health if addressed by State.
	Form 6 p. 51	No Hispanic ethnicity breakdown like before, why?
	Form 7b	Concerned about Title V's ability/capacity to report on 211—no access to data. Is this just an example and no other hotline is expected to be reported on if there aren't additional to the 800 line? The Title V Program Website Address: Specifically, what website are we to be tracking…if states have multiple websites? Social Media: What if a state doesn't have a Title V Social Media page?
	Form 11	State Demographic Data (SDD): Why Rate of juvenile crime arrests is listed as a category? What is the rationale? The same could be said for Percent of HS dropouts. These data points don't appear to be directly related to any of the OMs or NPMs—could these be deleted to reduce burden?
	Form 13	This form is no longer included. Why? The guidance calls for states to report on "level of commitment to consistently engaging family / consumer partnership." How will states determine "level"? The KS Family Advisory Council recommended the definition as follows. This was also discussed and agreed upon by AMCHP FYLC members and will be submitted to the AMCHP Board this fall: "Family/Consumer and Professional Partnership is the intentional practice of working together for the ultimate goal of positive outcomes in all areas throughout the life course. It is a collaborative and respectful partnership, where all members are given the opportunity to share their information, preferences and values and share responsibility in planning for and achieving optimal outcomes. Family partnership reflects a core value and commitment to family leadership at the individual, community and policy level."
Needs Assessment		The expectations are clear. The 20 page limit seems acceptable. The way it's presented on page 16

		reads like HRSA MCHB isn't concerned with states working to improve the health of women. The focus begins with pregnant women; prenatal care isn't enough and MCH can play a role in improving the health of women before pregnancy.