Number	Date Received	Division	Commenting Organization	Commenter Location	Performance Measure	Measure Name
1	11/17/2015	MIECHV/ H	Healthy Starts Program Coordinator	NH	Not Related to Measure	
2	12/10/2015		Townhall Participants		WMH 2	Perinatal/
3	12/10/2015		Townhall Participants- MCHB Staff		Not Related to Measure	
4	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergenc	EMSC 01	NEMSIS Su
5	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergenc	EMSC 02	Pediatric E
6	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergenc	EMSC 03	Use of Ped
7	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergenc	EMSC 04	Pediatric M
8	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergenc	EMSC 05	Pediatric t
9	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergenc	EMSC 06	Inter-facili
10	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergenc	EMSC 07	Inter-facili
11	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergenc	EMSC 08	Establishe
12	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergenc	EMSC 09	Establishec

13	12/16/2015		Townhall Participants		All/ Most Domain Measures	
14	12/16/2015		Townhall Participants		All/ Most Domain Measures	
15	12/17/2015		Townhall Participants		Not Related to Measure	
16	12/28/2015	Workforce I	Excellence and the National MCH Workforce Development Center	Chapel Hill, N	CB 2	Technical A
17	12/28/2015	Workforce I	Excellence and the National MCH Workforce Development Center	Chapel Hill, N	CB 2	Technical A
18	12/28/2015	Workforce I	Excellence and the National MCH Workforce Development Center	Chapel Hill, N	CB 3	Impact Mea
19	12/28/2015	Workforce I	Excellence and the National MCH Workforce Development Center	Chapel Hill, N	CB 4	Sustainabil
20	12/28/2015	Workforce I	Excellence and the National MCH Workforce Development Center	Chapel Hill, N	CB 5	Scientific P
21	12/28/2015	Workforce I	Excellence and the National MCH Workforce Development Center	Chapel Hill, N	CB 6	Products
22	12/28/2015	Workforce I	Excellence and the National MCH Workforce Development Center	Chapel Hill, N	Core 1	Grant Impa
23	12/28/2015	Workforce I	Excellence and the National MCH Workforce Development Center	Chapel Hill, N	Core 2	Quality Imp
24	12/28/2015	Workforce I	Excellence and the National MCH Workforce Development Center	Chapel Hill, N	Core 3	Health Equ
25	12/28/2015	Workforce I	Excellence and the National MCH Workforce Development Center	Chapel Hill, N	LC 1	Adequate H

26	12/28/2015	Workforce I	National MCH Workforce Development Center	Chapel Hill, N	LC	2	Tobacco a
27	12/28/2015	Workforce I	National MCH Workforce Development Center	Chapel Hill, N	LC	3	Oral Health
28	12/28/2015	Workforce I	National MCH Workforce Development Center	Chapel Hill, N	Training	1	MCH Traini
29	12/28/2015	Workforce I	National MCH Workforce Development Center	Chapel Hill, N	Training	2	MCH Traini
30	12/28/2015	Workforce I	National MCH Workforce Development Center	Chapel Hill, N	Training	4	MCH Pipeli
31	12/28/2015	Workforce I	National MCH Workforce Development Center	Chapel Hill, N	Training	6	Demonstrat
32	12/28/2015	Workforce I	National MCH Workforce Development Center	Chapel Hill, N	Training	7	Diversity o
33	12/28/2015	Workforce I	National MCH Workforce Development Center	Chapel Hill, N	Training	8	Title V Coll
34	12/28/2015	Workforce I	National MCH Workforce Development Center	Chapel Hill, N	Training	9	Interdiscipl
35	12/28/2015	Workforce I	National MCH Workforce Development Center	Chapel Hill, N	Training	12	Work with
36	12/28/2015	Workforce I	National MCH Workforce Development Center	Chapel Hill, N	Training	13	Policy Deve
37	12/28/2015	EMSC	and the Colorado Emergency Medical Services Program	Denver, CO	EMSC	03	Use of Ped
38	12/29/2015	Workforce I	Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, A	CB	1	State capac

39	12/29/2015	Workforce I	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, A	CB 2	Technical A
40	12/29/2015	Workforce I	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, A	CB 5	Scientific P
41	12/29/2015	Workforce I	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, A	CB 6	Products
42	12/29/2015	Workforce I	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, A	LC 1	Adequate H
43	12/29/2015	Workforce I	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, A	LC 2	Tobacco a
44	12/29/2015	Workforce I	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, A	General Forms/ ADEs	
45	12/29/2015	Workforce I	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, A	General Forms/ ADEs	
46	12/29/2015	Workforce I	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, A	General Forms/ ADEs	
47	12/29/2015	Workforce I	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, A	General Forms/ ADEs	
48	1/4/2016	EMSC	Kansas Board of Emergency Medical Services	Topeka, KS	EMSC 01	NEMSIS Su
49	1/4/2016	EMSC	Kansas Board of Emergency Medical Services	Topeka, KS	EMSC 02	Pediatric E
50	1/4/2016	EMSC	Kansas Board of Emergency Medical Services	Topeka, KS	EMSC 03	Use of Ped
51	1/4/2016	EMSC	NYS Department of Health, Bureau of EMS and Trauma Systems	New York	EMSC 01	NEMSIS Su

52	1/4/2016	EMSC	NYS Department of Health, Bureau of EMS and Trauma Systems	New York	EMSC 02	Pediatric E
53	1/4/2016	EMSC	NYS Department of Health, Bureau of EMS and Trauma Systems	New York	EMSC 03	Use of Ped
54	1/4/2016	EMSC	NYS Department of Health, Bureau of EMS and Trauma Systems	New York	EMSC 04	Pediatric M
55	1/4/2016	EMSC	NYS Department of Health, Bureau of EMS and Trauma Systems	New York	EMSC 05	Pediatric t
56	1/4/2016	Workforce I	Tulane University School of Public Health and Tropical Medicine	New Orleans,	Training 6	Demonstrat
57	1/4/2016	Workforce I	Tulane University School of Public Health and Tropical Medicine	New Orleans,	Training 7	Diversity o
58	1/4/2016	Workforce I	Tulane University School of Public Health and Tropical Medicine	New Orleans,	Training 9	Interdiscipl
59	1/5/2016	CSHCN	Genetic Alliance	Washington,	Core 2	Quality Imp
60	1/5/2016	CSHCN	Genetic Alliance	Washington,	Core 3	Health Equ
61	1/5/2016	CSHCN	Genetic Alliance	Washington,	Core 2	Quality Imp
62	1/5/2016	CSHCN	Genetic Alliance	Washington,	CSHCN 1	Family Eng
63	1/5/2016	CSHCN	Genetic Alliance	Washington,	CSHCN 2	Access to
64	1/5/2016	Workforce I	Education in Neurodevelopmental and related Disabilities (LEND) Program	Cincinnati, OH	CB 2	Technical A

65	1/5/2016	Workforce I	Education in Neurodevelopmental and related Disabilities (LEND) Program	Cincinnati, OH	CB 4	Sustainabil
66	1/5/2016	Workforce I	Education in Neurodevelopmental and related Disabilities (LEND) Program	Cincinnati, OH	CB 5,CB 6,General Forms/ ADEs	Scientific P
67	1/5/2016	Workforce I	Education in Neurodevelopmental and related Disabilities (LEND) Program	Cincinnati, OH	Core 1	Grant Impa
68	1/5/2016	Workforce I	Education in Neurodevelopmental and related Disabilities (LEND) Program	Cincinnati, OH	Core 2	Quality Imp
69	1/5/2016	Workforce I	Education in Neurodevelopmental and related Disabilities (LEND) Program	Cincinnati, OH	CSHCN 2,CSHCN 3	Access to a
70	1/5/2016	Workforce I	Education in Neurodevelopmental and related Disabilities (LEND) Program	Cincinnati, OH	Training 6	Demonstrat
71	1/5/2016	Workforce I	Education in Neurodevelopmental and related Disabilities (LEND) Program	Cincinnati, OH	Training 8	Title V Coll
72	1/5/2016	Workforce I	Education in Neurodevelopmental and related Disabilities (LEND) Program	Cincinnati, OH	Training 9	Interdiscipl
73	1/5/2016	Workforce I	Education in Neurodevelopmental and related Disabilities (LEND) Program	Cincinnati, OH	Training 12	Work with
74	1/5/2016	CSHCN	Coordinating Center for the Regional Genetic Service Collaboratives	Bethesda, MD	CB 1	State capac
75	1/5/2016	CSHCN	Coordinating Center for the Regional Genetic Service Collaboratives	Bethesda, MD	CB 2	Technical A
76	1/5/2016	CSHCN	Coordinating Center for the Regional Genetic Service Collaboratives	Bethesda, MD	CB 3	Impact Mea
77	1/5/2016	CSHCN	Coordinating Center for the Regional Genetic Service Collaboratives	Bethesda, MD	CB 6	Products

78	1/5/2016	CSHCN	Coordinating Center for the Regional Genetic Service Collaboratives	Bethesda, MD	Core 2	Quality Imp
79	1/5/2016	CSHCN	Coordinating Center for the Regional Genetic Service Collaboratives	Bethesda, MD	CSHCN 1	Family Eng
80	1/5/2016	CSHCN	Coordinating Center for the Regional Genetic Service Collaboratives	Bethesda, MD	CSHCN 2	Access to
81	1/5/2016	CSHCN	Coordinating Center for the Regional Genetic Service Collaboratives	Bethesda, MD	LC 1	Adequate H
82	1/5/2016	CSHCN	Coordinating Center for the Regional Genetic Service Collaboratives	Bethesda, MD	All/ Most Domain Measures	
83	1/5/2016	EMSC	Medical Services for Children State Partnership Program - New England Region	Burlington, VT	EMSC 01	NEMSIS Su
84	1/5/2016	EMSC	Medical Services for Children State Partnership Program - New England Region	Burlington, VT	EMSC 02	Pediatric E
85	1/5/2016	EMSC	Medical Services for Children State Partnership Program - New England Region	Burlington, VT	EMSC 03	Use of Ped
86	1/5/2016	EMSC	New Hampshire EMSC Program	Lebanon, NH	EMSC 01	NEMSIS Su
87	1/5/2016	EMSC	New Hampshire EMSC Program	Lebanon, NH	EMSC 02	Pediatric E
88	1/5/2016	EMSC	New Hampshire EMSC Program	Lebanon, NH	EMSC 03	Use of Ped
89	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NC	B 1	State capac
90	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NC	B 2	Technical A

91	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NCB 3	Impact Mea
92	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NCB 4	Sustainabil
93	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NCB 5	Scientific P
94	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NCB 6	Products
95	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NCH 1	Well Child V
96	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NCH 2	Quality of V
97	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NCH 3	Developme
98	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NCH 4	Injury Preve
99	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NPIH 1	Safe Sleep
100	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NPIH 2	Breast Fee
101	1/5/2016	MIECHV/ H	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NPIH 3	Newborn S
102	1/5/2016	EMSC	Rhode Island Center for Emergency Medical Services	Providence, REMSC 01	NEMSIS Su
103	1/5/2016	EMSC	Rhode Island Center for Emergency Medical Services	Providence, REMSC 02	Pediatric E

104	1/5/2016	EMSC	Rhode Island Center for Emergency Medical Services	Providence, R	EMSC 03	Use of Ped
105	1/5/2016	DCAFH	School-Based Health Alliance	Washington,	CB 1	State capac
106	1/5/2016	DCAFH	School-Based Health Alliance	Washington,	CB 2	Technical A
107	1/5/2016	DCAFH	School-Based Health Alliance	Washington,	CB 3	Impact Mea
108	1/5/2016	DCAFH	School-Based Health Alliance	Washington,	CB 4	Sustainabil
109	1/5/2016	DCAFH	School-Based Health Alliance	Washington,	CB 5	Scientific P
110	1/5/2016	DCAFH	School-Based Health Alliance	Washington,	CB 6	Products
111	1/5/2016	EMSC	Vermont Emergency Medical Services for Children Program	Burlington, VT	EMSC 01	NEMSIS Su
112	1/5/2016	EMSC	Vermont Emergency Medical Services for Children Program	Burlington, VT	EMSC 02	Pediatric E
113	1/5/2016	EMSC	Vermont Emergency Medical Services for Children Program	Burlington, VT	EMSC 03	Use of Ped
114	1/5/2016	EMSC	Tennessee Emergency Medical Services for Children Program	Nashville, TN	EMSC 01	NEMSIS Su
115	1/5/2016	EMSC	Tennessee Emergency Medical Services for Children Program	Nashville, TN	EMSC 02	Pediatric E
116	1/5/2016	EMSC	Tennessee Emergency Medical Services for Children Program	Nashville, TN	EMSC 03	Use of Ped

117	1/5/2016	EMSC	Tennessee Emergency Medical Services for Children Program	Nashville, TN	EMSC 04,EMSC 05	Pediatric M
118	1/5/2016	CSHCN	Got Transition/Center for Health Care Transition Improvment	Washington,	CSHCN 3	Transition t
119	1/5/2016	Workforce I	University of Arizona Pediatric Pulmonary Center	Arizona	Not Related to Measure	
120	1/5/2016	Workforce I	WI LEND Program - University of Wisconsin - Madison	Madison, WI	Not Related to Measure,Training Forms	
121	1/5/2016	Workforce I	WI LEND Program - University of Wisconsin - Madison	Madison, WI	Training 9	Interdiscipl
122	1/5/2016	Workforce I	WI LEND Program - University of Wisconsin - Madison	Madison, WI	Training 13	Policy Deve
123	1/6/2016	CSHCN	Family Voices	Albuquerque,	F2F 1	Provide Na
124	1/6/2016	CSHCN	Family Voices	Albuquerque,	CSHCN 1	Family Eng
125	1/6/2016	CSHCN	Family Voices	Albuquerque,	CSHCN 2,Suggested Addition	Access to
126	1/6/2016	CSHCN	Family Voices	Albuquerque,	F2F 1	Provide Na
127	1/6/2016	CSHCN	Family Voices	Albuquerque,	LC 3	Oral Health
128	1/6/2016	CSHCN	Family Voices	Albuquerque,	Training 1,CSHCN 1,Suggested Addition	MCH Traini
129	1/6/2016	EMSC	Illinois DPH - Division of EMS and Highway Saftey	Springfield, IL	EMSC 01	NEMSIS Su

130	1/6/2016	EMSC	Illinois DPH - Division of EMS and Highway Saftey	Springfield, IL	EMSC 02	Pediatric E
131	1/6/2016	EMSC	Illinois DPH - Division of EMS and Highway Saftey	Springfield, IL	EMSC 03	Use of Ped
132	1/6/2016	EMSC	Illinois DPH - Division of EMS and Highway Saftey	Springfield, IL	EMSC 04	Pediatric M
133	1/6/2016	CSHCN	Region 4 Midwest Genetics Collaborative - Michigan Public Health Institute	Okemos, MI	CB 1	State capac
134	1/6/2016	CSHCN	Region 4 Midwest Genetics Collaborative - Michigan Public Health Institute	Okemos, MI	CB 2	Technical A
135	1/6/2016	CSHCN	Region 4 Midwest Genetics Collaborative - Michigan Public Health Institute	Okemos, MI	CB 3	Impact Mea
136	1/6/2016	CSHCN	Region 4 Midwest Genetics Collaborative - Michigan Public Health Institute	Okemos, MI	CB 6	Products
137	1/6/2016	CSHCN	Region 4 Midwest Genetics Collaborative - Michigan Public Health Institute	Okemos, MI	Core 2	Quality Imp
138	1/6/2016	CSHCN	Region 4 Midwest Genetics Collaborative - Michigan Public Health Institute	Okemos, MI	Core 2	Quality Imp
139	1/6/2016	CSHCN	Region 4 Midwest Genetics Collaborative - Michigan Public Health Institute	Okemos, MI	CSHCN 1	Family Eng
140	1/6/2016	CSHCN	Region 4 Midwest Genetics Collaborative - Michigan Public Health Institute	Okemos, MI	CSHCN 2	Access to
141	1/6/2016	CSHCN	Region 4 Midwest Genetics Collaborative - Michigan Public Health Institute	Okemos, MI	LC 1	Adequate H
142	1/6/2016	CSHCN	Region 4 Midwest Genetics Collaborative - Michigan Public Health Institute	Okemos, MI	PIH 3	Newborn S

143	1/6/2016	EMSC	State EMS Officials (NASEMSO), Pediatric Emergency Care Council (PECC)		EMSC 01	NEMSIS Su
144	1/6/2016	EMSC	State EMS Officials (NASEMSO), Pediatric Emergency Care Council (PECC)		EMSC 02	Pediatric E
145	1/6/2016	EMSC	State EMS Officials (NASEMSO), Pediatric Emergency Care Council (PECC)		EMSC 03	Use of Ped
146	1/6/2016	EMSC	State EMS Officials (NASEMSO), Pediatric Emergency Care Council (PECC)		EMSC 04	Pediatric M
147	1/6/2016	EMSC	State EMS Officials (NASEMSO), Pediatric Emergency Care Council (PECC)		EMSC 05	Pediatric t
148	1/6/2016	CSHCN	The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders	Santa Ana, CA	Not Related to Measure	
149	1/6/2016	CSHCN	The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders	Santa Ana, CA	CB 2	Technical A
150	1/6/2016	CSHCN	The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders	Santa Ana, CA	CB 6	Products
151	1/6/2016	CSHCN	The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders	Santa Ana, CA	Core 1,Core 2,Core 3	Grant Impa
152	1/6/2016	CSHCN	The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders	Santa Ana, CA	Not Related to Measure	
153	1/6/2016	Workforce I	UAB School of Public Health	Birmingham, A	Core 2	Quality Imp
154	1/6/2016	Workforce I	UAB School of Public Health	Birmingham, A	Core 2	Quality Imp
155	1/6/2016	Workforce I	UAB School of Public Health	Birmingham, A	Training 1	MCH Traini

156	1/6/2016	Workforce I	UAB School of Public Health	Birmingham, A	Training 2	MCH Traini
157	1/6/2016	Workforce I	UAB School of Public Health	Birmingham, A	Training 6	Demonstra
158	1/6/2016	Workforce I	UAB School of Public Health	Birmingham, A	Training 9	Interdiscipl
159	1/6/2016	Workforce I	UAB School of Public Health	Birmingham, A	Training 13	Policy Deve
160	1/5/2016	CSHCN	of Medical Genetics and Genomics	Bethesda, MD	CSHCN 1	Family Eng
161	1/5/2016	CSHCN	of Medical Genetics and Genomics	Bethesda, MD	CSHCN 2	Access to
162	1/5/2016	CSHCN	of Medical Genetics and Genomics	Bethesda, MD	LC 1	Adequate H
163	1/5/2016	CSHCN	of Medical Genetics and Genomics	Bethesda, MD	CB 1	State capa
164	1/5/2016	CSHCN	of Medical Genetics and Genomics	Bethesda, MD	CB 2	Technical A
165	1/5/2016	CSHCN	of Medical Genetics and Genomics	Bethesda, MD	CB 3	Impact Mea
166	1/5/2016	CSHCN	of Medical Genetics and Genomics	Bethesda, MD	CB 6	Products
167	1/5/2016	CSHCN	of Medical Genetics and Genomics	Bethesda, MD	Core 2	Quality Imp
168	1/5/2016	CSHCN		Bethesda, MD	Core 2	Quality Imp

169	12/31/2015	EMSC	Virginia EMSC		EMSC 02	Pediatric E
170	12/31/2015	EMSC	Virginia EMSC		EMSC 03	Use of Ped
171	12/31/2015	EMSC	Virginia EMSC		EMSC 04	Pediatric M
172	12/31/2015	EMSC	Virginia EMSC		EMSC 05	Pediatric t
173	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	AH 1	Adolescent
174	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	AH 2	Injury Preve
175	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	AH 3	Screening f
176	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	CB 1	State capac
177	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	CB 2	Technical A
178	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	CB 3	Impact Mea
179	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	CB 4	Sustainabil
180	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	CB 5	Scientific P
181	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	CB 6	Products

182	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	Core 1	Grant Impa
183	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	Core 2	Quality Imp
184	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	Core 3	Health Equ
185	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	Training 1	MCH Traini
186	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	Training 2	MCH Traini
187	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	Training 6	Demonstrat
188	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	Training 7	Diversity o
189	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	Training 8	Title V Coll
190	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	Training 9	Interdiscipl
191	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	Training 10	Diverse Ad
192	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	Training 12	Work with
193	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	Training 13	Policy Deve
194	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	General Forms/ ADEs	

195	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	General Forms/ ADEs,Training Forms	
196	1/5/2016	Workforce I	Boston LEAH Program	Boston, MA	General Forms/ ADEs	
197	1/5/2016	Workforce I	The Mountain States Genetics Regional Collaborative		PIH 3	Newborn S
198	1/5/2016	CSHCN	The Mountain States Genetics Regional Collaborative		CSHCN 3,CSHCN 2,CSHCN 1	Transition
199	1/5/2016	CSHCN	The Mountain States Genetics Regional Collaborative		LC 1	Adequate H
200	1/5/2016	CSHCN	The Mountain States Genetics Regional Collaborative		CB 1	State capac
201	1/5/2016	CSHCN	The Mountain States Genetics Regional Collaborative		CB 2	Technical A
202	1/5/2016	CSHCN	The Mountain States Genetics Regional Collaborative		CB 6,CB 5,CB 4	Products, S
203	1/5/2016	CSHCN	The Mountain States Genetics Regional Collaborative		Core 3,Core 2,Core 1	Health Equ
204	1/5/2016	CSHCN	The Mountain States Genetics Regional Collaborative		Training 2,Training 1	MCH Traini
205	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	Not Related to Measure	
206	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	Not Related to Measure	
207	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	Not Related to Measure	

208	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	WMH 4	Depression
209	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	WMH 5	Severe Mat
210	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	CH 3	Developme
211	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	CSHCN 3	Transition t
212	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	AH 3	Screening f
213	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	CB 2	Technical A
214	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	Core 2	Quality Imp
215	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	Core 3	Health Equ
216	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	Training 1	MCH Traini
217	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	Training 2	MCH Traini
218	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	Training 5	MCH Pipeli
219	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	Training 10	Diverse Ad
220	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	F2F 1	Provide Na

221	1/5/2016	Healthy Sta	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	WMH 1	Prenatal Ca
222	1/5/2016	Healthy Sta	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	WMH 3	Well Woma
223	1/5/2016	Healthy Sta	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	WMH 5	Severe Mat
224	1/5/2016	Healthy Sta	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	PIH 2	Breast Fee
225	1/5/2016	Healthy Sta	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	PIH 3	Newborn S
226	1/5/2016	Healthy Sta	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	CH 3	Developme
227	1/5/2016	Healthy Sta	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	LC 1	Adequate H
228	1/5/2016	Healthy Sta	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	LC 2	Tobacco a
229	1/5/2016	Healthy Sta	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	LC 3	Oral Health
230	1/4/2016	CSHCN,Wo	Association of University Centers on Disabilities	Silver Spring,	Training 1	MCH Traini
231	1/4/2016	CSHCN,Wo	Association of University Centers on Disabilities	Silver Spring,	Training 13	Policy Deve
232	1/4/2016	CSHCN,Wo	Association of University Centers on Disabilities	Silver Spring,	General Forms/ ADEs	
233	1/4/2016	CSHCN,Wo		Silver Spring,	General Forms/ ADEs	

			Association of University Centers on Disabilities			
234	1/4/2016	CSHCN,W	Association of University Centers on Disabilities	Silver Spring,	Core 1	Grant Impa
235	1/4/2016	CSHCN,W	Association of University Centers on Disabilities	Silver Spring,	Core 2	Quality Imp
236	1/4/2016	CSHCN,W	Association of University Centers on Disabilities	Silver Spring,	CB 1	State capa
237	1/4/2016	CSHCN,W	Association of University Centers on Disabilities	Silver Spring,	CB 2	Technical A
238	1/4/2016	CSHCN,W	Association of University Centers on Disabilities	Silver Spring,	CB 3	Impact Mea
239	1/4/2016	CSHCN,W	Association of University Centers on Disabilities	Silver Spring,	CB 5,CB 6	Scientific P
240	1/4/2016	CSHCN,W	Association of University Centers on Disabilities	Silver Spring,	CSHCN 2	Access to
241	1/4/2016	CSHCN,W	Association of University Centers on Disabilities	Silver Spring,	CSHCN 3	Transition t
242	1/4/2016	CSHCN,W	American Academy of Pediatrics	Silver Spring,	CH 3	Developme
243	1/5/2016	CSHCN,W	American Academy of Pediatrics	Elk Grove Villa	Not Related to Measure	
244	1/5/2016	CSHCN,W	American Academy of Pediatrics	Elk Grove Villa	PIH 2	Breast Fee
245	1/5/2016	CSHCN,W	American Academy of Pediatrics	Elk Grove Villa	PIH 3	Newborn S
246	1/5/2016	CSHCN,W		Elk Grove Villa	CH 1	Well Child

			American Academy of Pediatrics		
247	1/5/2016	CSHCN,W(	Elk Grove Villa	CH 2	Quality of V
			American Academy of Pediatrics		
248	1/5/2016	CSHCN,W(	Elk Grove Villa	CH 3	Developme
			American Academy of Pediatrics		
249	1/5/2016	CSHCN,W(	Elk Grove Villa	CSHCN 1	Family Eng
			American Academy of Pediatrics		
250	1/5/2016	CSHCN,W(	Elk Grove Villa	CSHCN 2	Access to
			American Academy of Pediatrics		
251	1/5/2016	CSHCN,W(	Elk Grove Villa	CSHCN 3	Transition t
			American Academy of Pediatrics		
252	1/5/2016	CSHCN,W(	Elk Grove Villa	AH 1	Adolescent
			American Academy of Pediatrics		
253	1/5/2016	CSHCN,W(	Elk Grove Villa	AH 3	Screening f
			American Academy of Pediatrics		
254	1/5/2016	CSHCN,W(	Elk Grove Villa	LC 3	Oral Health
			American Academy of Pediatrics		
255	1/5/2016	CSHCN,W(	Elk Grove Villa	CB 2	Technical A
			American Academy of Pediatrics		
256	1/5/2016	CSHCN,W(	Elk Grove Villa	CB 3	Impact Mea
			American Academy of Pediatrics		
257	1/5/2016	CSHCN,W(	Elk Grove Villa	CB 4	Sustainabil
			American Academy of Pediatrics		
258	1/5/2016	CSHCN,W(	Elk Grove Villa	CB 5	Scientific P
			American Academy of Pediatrics		
259	1/5/2016	CSHCN,W(	Elk Grove Villa	Core 1	Grant Impa

			American Academy of Pediatrics			
260	1/5/2016	CSHCN,W(		Elk Grove Villa	Core 2	Quality Imp
			American Academy of Pediatrics			
261	1/5/2016	CSHCN,W(		Elk Grove Villa	Training 1	MCH Traini
			American Academy of Pediatrics			
262	1/5/2016	CSHCN,W(		Elk Grove Villa	Training 2	MCH Traini
			American Academy of Pediatrics			
263	1/5/2016	CSHCN,W(		Elk Grove Villa	Training 3	Healthy To
			American Academy of Pediatrics			
264	1/5/2016	CSHCN,W(		Elk Grove Villa	HS 2	Medical Ho
			American Academy of Pediatrics			
265	1/5/2016	CSHCN,W(		Elk Grove Villa	General Forms/ ADEs	
			Indiana's Center of Excellence for Bleeding & Clotting			
266	1/5/2016	CSHCN	Disorders	Indianapolis,	CSHCN 1	Family Eng
			Indiana's Center of Excellence for Bleeding & Clotting			
267	1/5/2016	CSHCN	Disorders	Indianapolis,	CSHCN 2	Access to
			Indiana's Center of Excellence for Bleeding & Clotting			
268	1/5/2016	CSHCN	Disorders	Indianapolis,	CSHCN 3	Transition t
			Association of Maternal & Child			
269	1/5/2016	CSHCN,W(	Health Programs		WMH 3	Well Woma
			Association of Maternal & Child			
270	1/5/2016	CSHCN,W(	Health Programs		WMH 4	Depression
			Association of Maternal & Child			
271	1/5/2016	CSHCN,W(	Health Programs		CH 3	Developme
			Association of Maternal & Child			
272	1/5/2016	CSHCN,W(	Health Programs		CH 4	Injury Preve

273	1/5/2016	CSHCN,W(	Association of Maternal & Child Health Programs	CSHCN 1	Family Eng
274	1/5/2016	CSHCN,W(	Association of Maternal & Child Health Programs	CSHCN 2	Access to
275	1/5/2016	CSHCN,W(	Association of Maternal & Child Health Programs	CSHCN 3	Transition t
276	1/5/2016	CSHCN,W(	Association of Maternal & Child Health Programs	LC 1	Adequate H
277	1/5/2016	CSHCN,W(	Association of Maternal & Child Health Programs	LC 2	Tobacco a
278	1/5/2016	CSHCN,W(	Association of Maternal & Child Health Programs	CB 4	Sustainabil
279	1/5/2016	CSHCN,W(	Association of Maternal & Child Health Programs	CB 6	Products
280	1/5/2016	CSHCN,W(	Association of Maternal & Child Health Programs	Core 1	Grant Impa
281	1/5/2016	CSHCN,W(	Association of Maternal & Child Health Programs	Training 13	Policy Deve
282	1/5/2016	CSHCN,W(	Association of Maternal & Child Health Programs	HS 8	Father/ Par
283	1/5/2016	CSHCN,W(	Association of Maternal & Child Health Programs	F2F 1	Provide Na
284	1/5/2016	CSHCN,W(	Association of Maternal & Child Health Programs	General Forms/ ADEs	
285	1/5/2016	CSHCN	Heartland Genetics Services Collaborative	Not Related to Measure	

286	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI		LC 2	Tobacco a
287	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI		HS 3	Interconcep
288	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI		Suggested Addition,CH 1	Well Child \
289	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI		HS 4	Early Electi
290	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI		HS 5	Perinatal D
291	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI		HS 6	Perinatal D
292	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI		HS 7	Intimate Pa
293	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI		LC 1	Adequate H
294	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI		HS 1	Reproducti
295	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI	Bow, NH	WMH 2	Perinatal/
296	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI		HS 2	Medical Ho
297	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI	Bow, NH	WMH 3	Well Woma
298	1/6/2016	Healthy Stɛ	Healthy Start EPIC Center/ JSI		PIH 1	Safe Sleep

299	1/6/2016	Healthy Sta	Healthy Start EPIC Center/ JSI Association of University Centers on Disabilities		PIH 2	Breast Fee
303	1/4/2016	CSHCN,Wo	Association of University Centers on Disabilities	Silver Spring,	Suggested Addition	
304	1/4/2016	CSHCN,Wo		Silver Spring,	Suggested Addition	
305	1/5/2016	CSHCN	Family-Led Organization	Newark, NJ	Suggested Addition	

Comment Summary

#10 - need to look at cultural sensitivity and other factors to rework measure.

There is a lot of mention of data compared/needed in ETO report.

Due to the increase of data collection and required interventions/screenings, funds will be required (see list).

Question: For the program specific measures is there an expectation about how many would be assigned?
Answer: Havenâ€™t mapped it out that far, want to make sure there is some flexibility and to figure out how itâ€™s most effect. The biggest effort is on making the utility work better. They havenâ€™t set a firm number.

Question: Can grantees make recommendations now through the town halls and formal comment to add additional options in the tier 2 and 3 lists?
Answer: Yes, now is the time to make recommendations!

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We suggest amending this PM to reference specifically to EMS agencies that respond to emergency calls and are transport-capable. We believe these EMS agencies are the ones who a) will benefit the most from an EMS agency PECC and b) will be the most willing to comply with the creation of such a position. In addition, we believe this PM will require significant support from both HRSA and the soon-to-be awarded EIIC to help make this proposed PM become a reality.

We fully support the verification that EMS providers are able to use pediatric-specific equipment on pediatric pat

We thank HRSA for extending the deadlines related to each of these PMs. We have no further comments on these PMs.

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Need for direct service as an option for tier 2 and 3 of the measures.
Debbie Mays de- Is it possible to provide some additional definition (ex. Table 1) Columns that differentiate local partners from national partnersâ€¦
Answer: Submit that for comments, then they will take that into consideration for the official OMB package.

reporting provided via TVIS?
Answer: TVIS is dedicated to the state block grant. If you as a state have a discretionary grant, youâ€™ll be using DGIS to report on that grant.

CB2 - This measure captures reasonable domains. The metric, i.e., # of participants, exhibits the same challenge as described for T8.

- Note that Injury Prevention is duplicated in the list on page 41.

CB3 - This is a useful and valuable measure.

CB4 - Sustainability is relevant in certain projects and not in others. This should be made clear. For example,

CB5 - Articles and in press seems much too narrow. The universe of scholarly work is much broader. Scholarly p

CB6 - This measure is closely related to CB5. It would be more illuminating to create a single measure that clearl

Core 2 - QI is clear and appropriate.

Core 3 - Health equity is an important measure. The Tier 2 items do not capture the breadth of this domain. For e

LC1 - Tier 3 activities are relevant to training grants. It is not clear, however, how to measure the # receiving TA training or the # receiving professional/organizational development training.

- The Data Collection form should be illuminating overall.

LC2 - While important, individual training programs may or may not have any individuals directly engaged in tobacco cessation. We assume this activity is not an expectation for all programs.

- The Data Collection form should be illuminating overall.

While important, individual training programs may or may not have any individuals directly engaged in oral health. We assume this activity is not an expectation for all programs.

T2 - Useful PM. Each of the 6 items are valuable for programs to think about, but itâ€™s not clear that there will b
women, children and youth from communities with limited access to comprehensive care. One goal of pipeline programs is to increasing the pool of students who seek to provide services to the MCH population._x000D_
Data Form - The data collection form seems restrictive. We would consider it a success if pipeline graduates bring insights about the MCH population to whatever professional setting they are in, even if not strictly defined as an MCH program.

T6 - The relevance of the Benchmarks is not clear._x000D_
Data Form - Data Collection Section A: The categories are reasonable. If this PM is meant to get a snapshot it is useful. If, however, programs will be measured, either explicitly or implicitly, 2 years is a very short window for demonstrating meaningful leadership.

T7 - The Significance would be appropriate for T4 as previously noted._x000D_
- A broader definition of diversity would be illuminating: first in family in graduate school, gender identity, first generation in U.S. are some examples.
could be reported similarly if it was a training directed at the State Health Department (1 activity) or at an interdisciplinary group of MCH stakeholders (1 activity). The metrics does not capture the magnitude of potential or actual impact on the practice of MCH or the potential to actually affect population outcomes in MCH. We appreciate that the Bureau is challenged to â€˜quantifyâ€™ these measures, but we lose much in the translation.
question would be time limited. For example, â€œduring the past 3 months, how often have trainees sought information from other professions or disciplines.â€ As the question stands, all the responses are likely to be very high._x000D_
- While we appreciate the value of 10 year follow-up, the costs of ascertaining this information are quite high, especially when considering the 5 year duration of the training grants.

T12 - Straightforward and valuable measure

T13 - Straightforward and valuable measure

Kathleen M. Adelgais, MD, MPH

CB2 - The proposed Capacity-Building Measure 2 (TA) is duplicative of information collected in the Administrative

CB5/6 - The proposed Capacity-Building Measure 5 (scientific publications) and proposed Capacity-Building Meas

CB5/6 - The proposed Capacity-Building Measure 5 (scientific publications) and proposed Capacity-Building Meas allocated for training activities for graduate students pursuing careers as leaders in MCH, to provide continuing education, and technical assistance for MCH professionals. Adding a reporting requirement on patient care/client activities (for example, number of clients referred for insurance coverage as part of Performance Measure LC1; number of clients assessed/screened for tobacco cessation as part of Performance Measure LC2, etc.) would require significant time of project faculty to develop a system to track this information.

'-Having training grantees report on measures that involve patient/client information does not align with the purpo

The â€œrevised form 6â€□ (abstract), Section V, section 2, is titled â€œAims and Key Activities.â€□ Our 2015 F(

We have been notified by MCHB that they intent to replace the Continuing Education reporting administrative for

7. Quality Improvement Activities	(no instructions for reporting of QI activities)
V. (V is repeated) Key Words	V. Key Words
VI. Annotation	VI. Annotation

The proposed administrative form for TA is a significant change from prior reporting requirements. Having very dif licensure/certification of their personnel is within that jurisdiction. We also believe that if the desire is to have an all-encompassing view of prehospital care, then those air and water-only EMS services should also be included._x000D_
We are very appreciative of HRSA wishing to find ways of automated collection techniques to minimize the information collection burden. We feel that this will prove to be a more efficient method of timely analysis.
licensure/certification of their personnel is within that jurisdiction. We also believe that if the desire is to have an all-encompassing view of prehospital care, then those air and water-only EMS services should also be included._x000D_
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We are very appreciative of HRSA wishing to find ways of automated collection techniques to minimize the information collection burden. We feel that this will prove to be a more efficient method of timely analysis.

By requiring NEMSIS submission, HRSA is imposing an unfunded mandate and thereby a burden to EMS services. This is an issue for NHTSA to work out with states, not for HRSA/MCHB to require of its grantees.

under Recommended Roles). "Protocols are developed at the state or regional level." Asking EMS agencies when surveyed if â€œthe [PEC Coordinator] ensures the pediatric perspective is included in the development of EMS protocolsâ€□ makes the states and HRSA/MCHB look ignorant to the EMS protocol development process.

(EMS trainings are paid for by the state). "If the Measure were changed to require â€œapproveâ€□ instructors (or a state like NY were to require certified instructors be evaluators) this Measure would then create a financial burden and thereby another unfunded mandate.

higher level pediatric capable hospitals." Therefore NY would not meet the 25% threshold, as it would need 48 out of 190 hospitals to meet this Measure, and realistically the system could not support this excessive number of pediatric hospitals.

hospitals is not a coordinated, regionalized sustainable system that can be supported (nor is necessary)." As with the previous performance measure, the number or percentage of hospitals should not be the evaluative measure.

'-Current phrasing in the data collection forms A and B is still a bit confusing, as numerator suggests current/crosssectional, while the four domains suggest current or past.
-Suggest inserting phrase â€œSince completing training program,â€□ if that captures intent of measure (or â€œin past 3 years,â€□ if that is intent of Form B).

'- Based on the ultimate intent behind this measure, it may be useful to also capture if a person has immigrated fr

'- Suggest removing part C, as this is the only measure that requires a 10 year followup.
- Again, suggest using phrase â€œsince completing training program,â€□ (consistent with Training 6) as that is understood intent of measure (rather than crosssectional).

We commend the wording of the Tier 4 measure regarding related outcomes as it allows for demonstration of succ
deciding to participate in health services, such as genetic testing, is driven in part by values and cultural considerations. Therefore, measuring uptake of testing would not be a good indicator for success towards health equityÍ¾ instead, establishing objectives around education and activities to reduce barriers (cost, not knowing how/where to get tested) for testing would be more indicative of success
towards this goal.

Consider including easily accessible definitions for each of these types of activities in the form to improve consistency across grantees. Overall, Table 1 is a good way to get a national snapshot of what is being done but it will not tell the full story of impact or benefit of programs, especially for programs that do not provide direct services.
It's important to point out that the target of many of our programs is individuals with genetic conditions (and their families), who make up only a portion of the estimated population of children with special health care needs (CSHCN). It is difficult to estimate and inaccurate for us to report our success towards any of the CSHCN measures because our programs focus on genetic services and individuals with genetic conditions, not the overall population of CSHCN.

Many of our programs focus on population health and determining individual level related outcomes as in Tier 4 m

CB 2: There are 2 rows for Depression Screening/Screening for Major_x000D_ Depressive Disorder. There are nc

CB 4: Tier 3 is confusing. How would this be measured?

CB 5/6: This seems to overlap with data that is captured in other areas regarding_x000D_ products/activities.

CORE 1: Yes/No format will make it challenging for programs to demonstrate when_x000D_ they have only met p

Tier 2 â€“ Can multiple aims be checked? It would be helpful to also have more detail regarding each of these options (such as examples)
Tier 3 â€“ Will programs be sharing what type of training they
received/ who provided the training so information can be shared with other programs interested in QI?

CSHCN 2/3: Tier 3: What is the difference between # trained and # educated/receiving information? Also, there is

Training 6: The omission of the 10 year followup is a concern. While it has historically been difficult to track in

Training 8: Thank you for adding the examples of other MCHfunded and related programs â€“ that is very helpful!

Training 9: We like the list of interdisciplinary skills. Is there a reason why 10year followup is included in this PM

Training 12: Again, is there a reason why 10 year followup_x000D_ is not included here?

In Tier 3, the list of State agencies should separate Newborn Screening (NBS) from Genetics as each is an import
separate from State or National Partners. We recommend that HRSA distinguish between governmental and non-governmental partnerships.

The definition of Technical Assistance is well done. We applaud HRSA for recognizing that this is a collaborative activity that can be done on a regional basis.

This is an opportunity to ask grantees about the State and national data sources that they are using to assess the

Tier 3 should also include some measure of use of these products. The NCC/RC system uses number of unique v

We applaud HRSA for recognizing cross-sectorial collaborative across multiple organizations in Tier 2. We sugges
more efficiently achieved on a regional basis._x000D_

While desirable to have racial and ethnic data on family CSHCN leaders, how feasible is it to obtain this information? Perhaps collecting data to show that affected individuals and families are engaged as CSHCN leaders would be easier to report.
National. We recommend that HRSA distinguish between governmental and non-governmental partnerships._x000D_

Tier 4 could be enhanced by including other performance measures, e.g., promoting a framework for medical home, increasing the number of medical homes, or improving care coordination with specialists.

Add Tracking and Monitoring to Tier 2 to emphasize the importance of data collection around health insurance coverage. Similarly, add Tracking and Monitoring to the LC1 Data Collection form._x000D_

In Tier 4, it would be helpful to provide a definition for adequate health insurance coverage.

As indicated in our comments on CSHCN 1, we recommend that HRSA distinguish between governmental and non-governmental partnerships in the column headings.
>>>>> The differentiation between these are not meaningful
>>>>> Need to be cautious about not adding burden for information that will not be used meaningfully.
benchmarks. A more accurate reflection might be gained by measuring the percentage of 9-1-1 response data (numerator) in relationship to the total estimated 9-1-1 statewide volume (denominator).
â€¢ The EMS COMPASS Project includes proposed performance measures for agencies, including data collection and use. We recommend that COMPASS, funded by NHTSA, will provide more appropriate opportunity to measure this information.
development of EMS protocols. In many states this would never be the role of an agency level coordinator, as it is handled at a higher level. The â€˜pediatric representativeâ€™ that is embedded within the stateâ€™s EMS medical advisory board, (reference existing EMSC performance measure 79) and/or the EMSC advisory committee, holds the responsibility for input on pediatric protocol development. We recommend that the referenced language be removed.
pediatric patients in a given year. This removes the service option to respond to the referenced item in the rubric. If they are presently assessing skill review annually and can also include the 2- year reviews that come with the standardized courses previously mentioned, they can achieve a score of â€˜6â€™ and the state data will reflect that these agencies are indeed working to maintain pediatric skill levels. We therefore recommend that the rubric goal of â€œ8â€ be changed to â€œ6â€ to prevent bias against the rural/volunteer agencies.
pediatric specific performance measure and is being address by other groups. EMS Compass is working on developing overarching EMS performance measures that will be based on the latest version of the National EMS Information System (NEMSIS) and will allow local and state EMS systems to use their own data meaningfully.

more accurate data.
--- Add additional, explanatory information to the statement â€œOversee pediatric process improvementâ€ so that the survey respondent understands what this means and how it differs from â€œEnsure that fellow providers follow pediatric clinical practice guidelines/protocolsâ€.

EMS services have already integrated various methods of pediatric skill verification. Do not penalize the services by eliminating standardized courses and the CCP recertification process.

This is somewhat of a confusing section.

Some of this could be covered by the Office of Children and Family Services and CACFP training requirements, but a challenge to collect.

ace Headstart

This would be difficult to collect because there are different systems across the state.

New training developed for Child Care Health (expected date: February 2016). Training modules and updating of website, supported by ECCS funds, will be available and ongoing.

Not much here. This really isnâ€™t a focus of HV and the ECCS grant.

Health Consultants. Many state agencies/entities, such as Docs for Tots, the Early Childhood Advisory Council, Early Care & Learning Council, NYS Zero-To-Three all do publications. This would not be difficult to track, but time-consuming.

appointments if necessary. Tiers 2 and 3 are not currently collected. Both Tier 4 measures can be reported using MIECHV data, but will be based on parental self-report. MIECHV benchmark is different, measuring the children receiving the recommended number of well-child visits based on age.

This would be difficult to collect, although important.

Additionally, the Child Care Resource & Referral agencies are now surveying providers who do developmental screening. The Early Intervention group might also have this information and other individual child care programs. The CCDBG will make this more prominent and programs will have to do this.

Lastly, a new training is being developed for Child Care Health Consultants that will address the injury prevention (expected date: February 2016). Outreach data could be analyzed.

data collection system, but it is limited. The first measure in Tier 4 is part of a composite measure that ac- s been proposed for the new MIECHV benchmarks so New York State would have that information for MIECHV-funded sites. The second measure in Tier 4 could be collected by reviewing past violations of a program.

Lastly, a new training is being developed for Child Care Health Consultants that will address the importance of breastfeeding (expected date: February 2016) and therefore outreach data will be collected.

Newborn screening program is not explicitly part of the HV curricula, so our MIECHV partners would not have this data, nor would our other available sources. This would be difficult to collect, although important for New York State.

survey techniques, and help NRC collect pediatric specific data collection as well a submitting data to HRSA.
2. In addition, EMS Compass is working on developing overarching EMS performance measures that will be based on the latest version of the National EMS Information System (NEMSIS) and will allow local and state EMS systems to use their own data meaningfully.

utilize State protocols and this might either confuse the role into creating their own pediatric protocol and overriding state mandate or simply changing the yes answer of number one back to no.
6. Add additional, explanatory information to the statement â€œOversee pediatric process improvementâ€ so that the survey respondent understands what this means and how it differs from â€œEnsure that fellow providers follow pediatric clinical practice guidelines/protocolsâ€.

that may be considered when answering the proposed survey questions. The creation of this list will assist in defining the â€œprocessâ€□.
--- 4. Recommend clarifying and justifying the limitation of the use of standardized courses (PEPP, PALS, APLS, and ENPC) and the use of the National Registry of EMTâ€™s Continued Competency Program (CCP) in the services â€œprocessâ€□.
The Center for School Mental Health is currently leading a National School Mental Health Census to identify the states
and districts providing comprehensive school mental health services (CSMHS); it could be adapted to include some of
these measures in a future version once all CSMHSs are counted in the initial Census.

In order to complete the data form for CB2, it would require drastic changes in both the School-Based Health Allianceâ€™s
and Center for School Mental Healthâ€™s data collection methodologies. It would be extremely difficult to track the number of individuals receiving TA by type of audience reached.

This category does not really apply to our organizations. We use participant surveys related to the trainings and TA

Also, both the School-Based Health Alliance and the CSMH are leading a Collaborative Improvement and Innovation Network as a result of their MCHB-funded cooperative agreement, and are focusing efforts with half of the engaged sites specifically on sustainability at local and state levels. Therefore, both
organizations could be actively involved in supporting the mechanisms listed in Tier 2.

Both organizations currently report on this measure, which is very applicable to capturing the performance of our

Both organizations currently report on this measure, which is very applicable to capturing the performance of our work with MCHB, and we are enthusiastic about continuing to report this measure.

The proposed performance measure related to NEMSIS is not a pediatric specific performance measure. EMS data is essential in understanding trends/opportunities for improvement in the prehospital setting; however addressing statewide EMS data systems is the responsibility of the State EMS offices. As future performance measures are developed, please take into consideration the need to ensure clear applicability to pediatric specific efforts.
adding the word will preclude confusion and ensure more accurate data.

Add additional information to the statement â€œOversee pediatric process improvementâ€□ so that the survey respondent understands what this entails and how it differs from â€œEnsure that fellow providers follow pediatric clinical practice guidelines/protocolsâ€□.
Since many services include standardized classes/courses in their â€œprocessâ€□ to ensure that providers physically demonstrate the correct use of pediatric-specific equipment, it is important that the survey include information regarding PALS, PEEP, APLS, ENPC, and NRP. All these courses require physical demonstration of some pediatric specific equipment skills. It is strongly recommended that use of these courses be acknowledged and allowed when answering the survey questions for PM 3.
Technical Assistance Center (TAC).
-TN EMSC applauds the proposed performance measure related to NEMSIS and believes it will improve the overall care of all the citizens in our country but is not a pediatric specific performance measure.
-As future performance measures are developed, please take into consideration the need to ensure clear applicability to pediatric specific efforts.
that the survey respondent understands what this means and how it differs from â€œEnsure that fellow providers follow pediatric clinical practice guidelines/protocolsâ€□.
-The proposed survey includes a question regarding the development of EMS protocols. In Tennessee, this role is done by the EMS medical director and not the providers. Most TN EMS agencies adopt the state EMS Medical Directors protocols but the individual medical director can adopt the stateâ€™s, modify them or create their own.
-How would an all EMS providers at a service that answers calls in small communities meet this matrix when it is most likely statistically impossible to every provider to have a pediatric encounter in the timeframe outlined?
-An additional concern from Tennesseeâ€™s perspective is the competency or credentialing of the person evaluating the EMS providers. As this performance measure is written it would allow a non-certified â€œinstructorâ€□ to make competency judgements.

"As an example, EMS transports are reviewed at the Comprehensive Regional Pediatric Centers. A report is sent to the EMS service and hospitals if this was an inter-facility transfer on the quality of care. This process would address both quality improvement and field encounter skill demonstration. Prior to the recognition system in Tennessee, there was some trauma outreach. Now every hospital and EMS service is connected with a CRPC for QI, education, and some research.

% of grantees linking transition efforts with adolescent preventive care efforts
Numerator: Number of grantees promoting transition as part of routine adolescent preventive care
Denominator: Total number of grantees reporting transition performance measure

Thank you for giving us this opportunity to review and provide feedback on the proposed performance measures. category/option.

Also, I'm not sure why Title V is added as a separate primary target audience for technical assistance this appears redundant with listing Title V as the recipient of TA/Collaborator, and would be very confusing to complete data entry.

Training 09 Interdisciplinary Practice

While the aggregate data on per cent of longterm trainees that work in an interdisciplinary manner would be relevant based on responses for the listed activities, I'm not sure why the individual % for each item is helpful.

Training 13 Policy_x000D_ Development
Under Category #1 Training, Elements 13_x000D_ is this referring to participants in the LONGTERM training program? Please specify whether the intended measurement is for longterm trainees, both activities and the % of trainees with increased policy knowledge and skills.

Family Voices recommends that MCHB provide resources for training for grantees, and consider the resources needed by grantees for data collection based on the specific program requirements in future grant awards. _x000D_

Family Voices recommends that MCHB provide guidance which includes definitions and specific suggestions for tools and processes to collect the data that is intended to inform the measures. Family Voices also recommends that groups of grantees and Project Officers meet periodically to discuss protocols, processes and strategies for reporting these performance measures. _x000D_

programs serving the full range of MCH populations._x000D_

Family Voices recommends that a performance measure be added to the Women, Child and Adolescent domains to address promoting and /or facilitating medical home access._x000D_

"From an F2F comment submitted with their 2014-2015 data report to the NCHPH: "Even with the customized Salesforce data system, data collection and reporting remains extremely time consuming. There are several steps required to enter all of the information for each encounter with a family. New cases can take up to five minutes to enter all information and details._x000D_

Family Voices recommends that the life course performance measure on oral health be revised to have a specific domain for children and youth with special health care needs. This will align this performance measure with the other life course performance measures

grantees be required to gather feedback from their engaged families/consumers as part of their measurement protocol and that this feedback represent and be gathered from the full diversity of populations served, including particularly those from underserved groups, and family-led organizations

initiative which is working to develop overarching EMS performance measures based on the latest version of the National EMS Information System (NEMSIS) and will allow local and state EMS systems to use their own data meaningfully. In addition, itâ€™s very important to understand that the funding provided to state partnership grantees is limited, and therefore should be used to primarily target performance measures with clear applicability to the pediatric community.

Change â€œpediatric clinical practice guidelinesâ€□ to â€œEMS pediatric clinical practice guidelines/protocolsâ€□, since most EMS agencies utilize the term â€œEMS protocolsâ€□. In addition, â€œprotocolsâ€□ is used in the first question on page 108 so this change will ensure consistency in language.
--- Clarify â€œpediatric process improvementâ€□ by changing to â€œpediatric quality improvementâ€□ (or similar language) to avoid misinterpretation.
higher is needed to meet achievement). This change takes into account that field encounters are less realistic or achievable for many providers, particularly small volume agencies.
ï‚§ Allow the skills demonstrations within standardized courses (such as PALS, PEPP, APLS and ENPC) and the use of the National Registry of EMTâ€™s Continued Competency Program (CCP) to meet the skill station component in the scoring rubric.
tiered recognition system is the resultant collaborative efforts and cross institutional work. For example, small community hospitals lacking the resources to truly invest in pediatric quality improvement initiatives can benefit from the collaboration with pediatric tertiary care centers, through a pediatric facility recognition process. Recommend a steadfast exploration of strategies and commitment of resources to assist more states in attaining this performance measure.

In Tier 3, the list of State agencies should separate Newborn Screening (NBS) from Genetics as each is an import

Genetics is missing from the list of MCH priorities. Genetics should be added to Tier 3 and to the Data Collection
their activities and impact. It could give data HRSA data on the use of the National Survey of Children's
Health, birth defects registries, etc. This data would help support the importance taxpayersâ€™ investment in these State and national data resources.

Impact should be defined in Tier 1, 2, and 4
another metric to consider.

Web based products should be categorized for data collection. Web based products vary greatly in their reach and it would be helpful to collect this at a national level. Particularly as we move towards the future and most products/outreach is taking place through the internet.

We applaud HRSA for recognizing crosssectorial_x000D_ collaborative across multiple organizations in Tier 2. W

As indicated in our comments on CSHCN 1, we recommend that HRSA distinguish between governmental and nongovernmental
partnerships in the column headings.
Add Tracking and Monitoring to Tier 2 to emphasize the importance of data collection around family engagement. Meaningful participation should be defined.

Add regional to the geographic units included in Tier 4. This addition would recognize that some activities can be more efficiently achieved on a regional basis.
Table 1 is to be used to report activities. It would be helpful to clarify where local public health activities should be counted. We recommend that HRSA distinguish between governmental and nongovernmental partnerships.

Tier 4 could be enhanced by including other performance measures, e.g. improving care coordination with specialists.

-- Add Tracking and Monitoring to Tier 2 to emphasize the importance of data collection around health insurance coverage. ------- Similarly, add Tracking and Monitoring to the LC1 Data Collection form.
-- In Tier 4, it would be helpful to provide a defini

We applaud the Stateâ€™s newborn screening programs and the identification and followup testing saving thous

improvement, however it is not within the scope of the EMS for Children programs to oversee the data collection or police data submissions for their state. The process of becoming NEMSIS version 3 compliant is a job for State EMS offices who may have more funding and/or more staff to devote to this goal. In short, while this is a worthy goal for national EMS in general, it is not pediatric specific and thus should not be the sole responsibility of EMS for Children programs.

as being in an "ivory academic tower," especially to smaller numerous rural providers and we cannot realistically mandate in regulation that these agencies name someone to assume this role with the current wording. They would immediately enlist legislators to come to their assistance to block us, even if their medical directors did not. Please consider replacing "coordinator" with "advocate".

It should be further noted that the measurement of these additional areas to a high degree of specificity will likely require no more than 10-20 survey questions, significantly less than the amount of information solicited from EMS organizations under previous performance measures.

Comment: Recommend that "statewide or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies" be better defined. Is compliance with the minimum standards set forth by the AAENA/ACEP consensus document (most current version) by emergency departments considered to meed that definition, or is it more appropriate to construct a multi-level recognition/categorization/designation system?

pediatric components), and the hospital must transfer or redirect patients meeting those criteria to a designated trauma center. So, the hospitals DO participate in such a system as the performance measure implies - they are not formally designated or recognized like the designated trauma centers (other than by licensure). Unfortunately, we would never be able to achieve the 50% goal stipulation with the way Performance Measure EMSC 05 is currently worded.

address: 1) the necessity and utility of the proposed information collection for the proper performance of the agencyâ€™s functions, 2) the accuracy of the estimated burden, 3) ways to enhance the quality, utility and clarity of the information to be collected, and 4) the use of automated collection techniques or other forms of information technology

to minimize the information collection burden.

adding definitions for each form and measureâ€™s key terms. As definitions may vary, we recommend HRSA seek guidance from nationally recognized agencies such as the Institute of Medicine, or Agency for Healthcare Quality and Research to determine the definitions Good starts are at CB 2 â€“ technical assistance, which is defined under the Tier 2 measure. But health equity and QI, for example, are core measures that would benefit from definitions of those key terms.

Automated collection techniques: The proposed measure CB 6 (Page 47, Attachment B): percent programs suppo

specifically the three core measures required of all grantees [meeting stated aims, quality improvement (QI), and health equity]. QI and health equity data, uniformly collected as proposed, will provide new and valuable information that documents trends in the breadth and depth of these efforts. These data will be useful not only to HRSA, but also to the individual grantees, who could use these data to identify potential partners for future collaborations to advance QI and health equity efforts.

Within a small program, the estimated 41 burden hours per response can be roughly accurate. However, within a larger program, the amount of time needed to review the instructions; to validate and verify information; to train personnel and to be able to respond to a collection of information; and to transmit or otherwise disclose the information can be time consuming. We recommend adding additional requirements such as type of program, size of the population and number of collaborators, in order to accurately determine the burden.

Core 2 PM â€“ Goal 2: Quality Improvement â€¨ Because some projects are primarily academic institutions, their

aceProviders/Professionalsâ€¨ and aceCommunity Partnersâ€¨, for instance. Frequently, the â€œConsumersâ€¨ of our TA efforts are both Providers/Professionals AND Community Partners, which would make them eligible for all 3 categories. In addition, for academic programs that provide TA to many groups through

individual faculty, collecting this information will be cumbersome.

On the detail sheet for â€œFamily/Youth/Community Engagement in MCH Training Programsâ€¨, the word_x00

On the detail sheets for â€œCultural Competence in MCH Training Programsâ€□, I LOVE that boxes 4 and 5_x0(

On the data collection forms for â€œField Leadershipâ€□, both 2 and 5 years after training completion, different
On a separate note, if we're contacting former trainees 10 years after training completion, it's just not
that big of a deal to ascertain their field leadership along with their interdisciplinary practice. Why wouldn't we collect both at 10 years rather than only collecting interdisciplinary practice at 10 years? Additionally, the required information for interdisciplinary practice is vague. We can glean this information from our graduates, but a clearer explanation for these data points might be helpful in asking the questions.

On the sheet for â€œCategory #2: Participation in Policy Change and Translation of Research into Policyâ€□, the
more efficiently achieved on a regional basis.

While desirable to have racial and ethnic data on family CSHCN leaders, how feasible is it to obtain this information? Perhaps collecting data to show that affected individuals and families are engaged as CSHCN leaders would be easier to report.
counted. As currently constructed this table has the columns of Community Partners separate from State and
National. We recommend that HRSA distinguish between governmental and nongovernmental partnerships.

Tier 4 could be enhanced by including other performance measures, e.g., promoting a framework for medical home, increasing the number of medical homes, or improving care coordination with specialists.
Add Tracking and Monitoring to Tier 2 to emphasize the importance of data collection around health insurance coverage.
Similarly, add Tracking and Monitoring to the LC1 Data Collection form.

In Tier 4, it would be helpful to provide a definition for adequate health insurance coverage.

In Tier 3, the list of State agencies should separate Newborn Screening (NBS) from Genetics as each is an import
separate from State or National Partners. We recommend that HRSA distinguish between governmental and
nongovernmental partnerships.

The definition of Technical Assistance is well done. We applaud HRSA for recognizing that this is a collaborative activity that can be done on a regional basis.

This is an opportunity to ask grantees about the State and national data sources that they are using to assess the

Tier 3 should also include some measure of use of these products. The NCC/RC system uses number of unique v

We applaud HRSA for recognizing crosssectorial collaborative across multiple organizations in Tier 2. We suggest

Add Tracking and Monitoring as a new row. Data collection and analysis is sufficiently distinct from quality

agencies whom we are nurturing relationships in order to achieve these performance measures. We would be coming off as being in an â€œivory academic towerâ€□, especially to our smaller numerous rural providers and we cannot realistically mandate in regulation that these agencies name someone to assume this role with the current wording. They would immediately enlist legislators to come to their assistance to block us, even if their medical directors did not. Please consider replacing â€œcoordinatorâ€□ with â€œadvocateâ€□.

The scoring method is not realistic for small EMS agencies who see very few pediatric patients, and who do not ha
better defined.

Is compliance with the minimum standards set forth by the AAENA/ACEP consensus document (most current version) by emergency departments considered to meet that definition, or is it more appropriate to construct a multi-level recognition/ categorization/ designation system?

now contain specific pediatric components), and the hospital must transfer or redirect patients meeting those criteria to a designated trauma center. So, the hospitals DO participate in such a system as the performance measure impliesâ€"they are just not formally designated or recognized like the designated trauma centers (other than by licensure). Unfortunately, we would never be able to achieve the 50% goal stipulation with the way Performance Measure EMSC 05 is currently worded.

might seems simple to know how â€œmany are reached,â€□ these data are not available and would require significant funding and new methodology to begin to estimate. Currently, programs do not know how many individuals actually receive information through education or outreach. Similarly for Tier 4, the enrollment should include all teens; all insurers could be encouraged to report this information directly to state MCH programs. Further discussion might be helpful.

the second section of Tier 2, I would add to Motor Vehicle traffic □ a word such as accidents □ or Policy □ or DUI □. Traumatic Brain Injury □ should include Concussion □ and a category to include Opioids □ added. Youth violence □ should include Intimate partner violence □ or Dating violence □. The age ranges are different for well visits and injuries but likely related to current Data collection systems. If completed by LEAHs, the form on page 30 would need to use Yes/No □ checkboxes but not numbers of those reached (see above).

As in two PMs above, I am not sure if LEAH will be reporting this PM. If helpful to MCHB, the reporting should be

The comments for this section are similar to those for the adolescent health domain above. If LEAH is included in

TA is currently reported and would be easier if in both Tiers 2 and 3 the â€œcheck all that applyâ€□ were avai

The overall statement is good and helpful for LEAHs using Tier 1 and 2, although the categories in Tier 2 would n

Not/Applicable to training programs. MCH is the only funding source for Adolescent Medicine training and for inte

I believe that the wording of the PM would benefit from including scholarly contributions â€“ i.e. â€œthe percen

For Tier 2, the wording â€œwith grant supportâ€□ needs to be clarified, or preferably deleted. Most products fr

Since the PM relates to meeting aims at the â€œend of the current grant cycle,â€□ I interpret this to imply the qu

Currently QI initiatives are required by hospital accreditation organizations, residency and fellowship Boards, A set of definitions. For training programs (with perhaps exception of LEND program that receive more funding), these boxes should be a checkboxes for â€œYes/Noâ€□ (see page 2). Given the limited resources for LEAH training, I am hopeful that LEAHs would not be asked to record the number of services, referrals or other new data. A full time data coordinator would be needed to accurately record and catalog activities of fellows, faculty and staff and would not add to the fundamental goal to train leaders and augment the MCH workforce!

Item #5 might be changed to include trainees and faculty â€“ â€œTrain MCH/CSHCN staff, providers, faculty and traineesâ€□ unless the PM is meant only for training state Title V staff.

For #6 Measure Progress, a standard assessment might be helpful in the future; I would also include other issues related to diversity including LGBTQ, disabilities, health literacy, etc. The title of this item could also change to â€œMeasurement of Progressâ€□ to have parallel titles.

On page 71, should the text in item 5, last bullet say â€œinfluenced legislation for the benefit of MCH populationsâ€□ rather than â€œMCH related legislationâ€□? The biggest issue for this PM is the overlapping definitions which either could be changed or perhaps it would be easier is to leave the same and in the Introduction to the section, let the respondents know that they may be checking off the same text under more than one category.

This measure is fairly straightforward to fill out with one exception: the element â€œ2 or more racesâ€□ prevents

To keep the time spent in data collection and entry for projects sustainable, I would favor â€œYes/Noâ€□ responses and examples in the narrative, not adding the number of activities in this next grant cycle.

I agree that adding follow-up at 2 years makes sense given the 5 year cycles. For the trainees, I assume the l

I am worried that this measure by adding â€œactivitiesâ€□ will significantly increase time spent by grantees in

The trainee grads answering this survey often do not understand the meaning of â€œMCH populationsâ€□ so the

For #6 I would add, â€œcommunicating research findings, program development, QI, qualitative studies and focus groups, etcâ€¦â€□ and delete â€œ(both original and non-original)â€□.

of people reachedâ€□ in CB 2 is not possible with current resources and would benefit from further study and discussion. Some activities have 1 person reached, some have 200. For the Target audience, it is important to be able to â€œcheck all that apply.â€□

emerging issue._x000D_

I actually liked the 5-10 most noteworthy CE and the ability to highlight emerging issues and other activities but this section could be in narrative. _x000D_

Distance Learning Modules: How to differentiate between these and web-based products/electronic products? Sub-categories are over-lapping and some entries could be reported in both categories.

Newborn Screening Work group, have previously played a role on specific issues such as emergency preparedness. Outcome measures as suggested in
Tier 4 will only be obtainable with state and other partnerships. Tier 4 will only be obtainable with state and other partnerships.

Tier 4 points on â€œtrainingâ€□ and measurable links to be medical home should be incorporated into work plans and are attainable measures for both the MSGRC and NCC.

Add facilitation of collaboration to Tier 2. Regional collaboratives that have partnered with each other and other organizations to review existing gaps and needs around health insurance coverage. The outcome measures in Tier 4 will be difficult for RCs to measure without such collaboration.

Tier 2 measures (delivery of training program, support of state strategic planning activities, provide expertise on priority topics and facilitate state level partnerships) could be developed further for RCs.

Technical!assistance!has!been!a!focal!discussion!point!for!NCC!and!the!RCs!and!is!an!_x000D_
activity!that!can!be!achieved!by!MSGRC.!â€œGenetics!technical!assistanceâ€□!should!be!_x000D_
added!as!an!additional!topic!to!Tier!3.!

CB 4 (program sustainability) and 5 (production of scientific publications) are feasible measures. Peer reviewed Necessitates more QA and QI to be integrated into program.

Core 3 (equity) is also appropriate as a goal of ensuring all individuals have improved access to genetic services, information, and expertise. MSGRS has focused on underserved populations in region in past.

Achievable and currently being sustained through MSGRCâ€™s engagement of consumer advocates and our inv can tend to be limiting, and we generally support the structure of the proposed DGIS performance measures in providing a more thorough assessment of impact. We believe that this revision will enhance reporting and convey a more accurate picture of the diverse services that DGIS grantees provide.

However, we note that the data collection required of PPPs for a grant that is much smaller than the usual MCHB discretionary grant is comparatively much larger and burdensome than that required of larger grants and grantees that usually have more sophisticated data systems
.

MCHB, but will also provide discretionary grantees with a better project framework for meeting MCHB objectives. However, we do believe that improvements can be made in order to enhance the quality, utility, and clarity of these performance measures to ensure the collection of accurate and useful data.

Specific comments for improvement are attached to specific measures.

We also note that, although depression screening tools may be validated for certain populations, they may not be validated for other racial/ethnic/linguistic groups. We would encourage the Department to include â€œculturally and linguistically appropriate evidence-based tool.â€□

access to quality MCH care and reduce disparities in access for underserved communities.

systems. Further, MCH programs must be encouraged to use data from family organizations such as data from F2Fs, FV SAOs, FFCMH chapters, EI/education- focused parent centers, and parent to parent programs, as well as to work with family organizations to develop, disseminate, and analyze results of surveys, focus groups, and other mechanisms that are most likely to garner diverse family feedback._x000D_

outcome to measure in ensuring that CSHCN are not only ready to transition to adult health systems themselves, but that networks of informed and trained general physicians are ready to serve them to maintain the presence of a medical home through adulthood.

adequacy must be addressed, including the use of innovative models such as the No Child Left Behind Primary Care Psychiatry Collaborative which, along with programs in over 30 other states, addresses specialist shortages by utilizing child psychiatrists in a consultative model with primary care.

Under â€œTier 2: To whom are you providing TA?â€□ missing from the list are â€œprogram participants/the publ

Under â€œTier 2: QI Initiative,â€□ we encourage the inclusion of a question that asks whether grantees are enga include the aforementioned missing domains, as well as provide an open-ended list for grantees to identify domains not explicitly stated that they may be targeting in their programs based on their own data and population characteristics as well as family/consumer input. Here again network inadequacies must be addressed as these lead to health disparities and poor outcomes._x000D_

health outcomes for MCH populations and gives grantees and MCH a more complete understanding of the population they serveâ€”increasing efficiency and effectiveness of MCH programs. This measure should specify that relevant professional development opportunities should be provided to diverse family leaders and family organizations who are a key component of the MCH workforce._x000D_

communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious, social or political group; includes gender, sexual orientation, etc.â€□

populations such as â€œcancer survivors, immigrants and refugees, incarcerated men & women, persons who use drugs, pregnant women, veterans, etc.â€□ (Centers for Disease and Control Prevention, Minority Health, Other At Risk Populations, February 2014). We feel it is important to have an inclusive definition of â€œvulnerable populationsâ€□ in order to ensure gaps in equity are truly met._x000D_

that consumers of health care services â€“ children and families â€“ should play a critical role in informing policy and driving program activities that are relevant to the services they consume. Involvement of diverse families and adolescents in the training of future leaders in adolescent health is paramount to ensuring a culturally competent workforce able to serve MCH populations._x000D_

Other comments_x000D_
Please note that the data collection form for F2F 1 does not include the race/ethnicity category of Native American/American Indian or Alaskan Native, and it should. These groups should not be lumped under â€œOther.â€□_x000D_

Because Healthy Start programs serve the highest risk women, they often recruit women who have denied their p

Well women visits are different from prenatal care. Should there be something identifying that either prenatal vi

This would require a good definition of what constitutes 'a woman needing services to address maternal mortality

Bother denominators should clarify that it includes only infants who were born into the program - not infants who

Newborn screening is outside of the range of activities performed by Healthy Start who are generally not health ca

For Healthy Start consider the older age being reduced to 24 months since that's as long as they are served in thi

The health insurance measure is problematic for programs in states where they did not accept the Medicaid expar

While we appreciate the importance of a smoke-free environment, we will not have control over someone in the

Would HRSA provide an oral health risk assessment instrument? Can you please clarify what that would consist o

Training 1 (Family member/youth/community member participation): The use of "other family members/youth/community membersâ€□ in this performance measure is confusing. It is not clear whether a program needs to have all of these categories of participants for an element to indicate a YES response for each element, or whether a program just needs one of these groups. We recommend including some clarifying language for this.

Training 13 (Policy): Most of the elements for this measure (2-6) include additional data collection in addition to

Technical Assistance/Collaboration Form: This form includes a new â€œList Bâ€□ for grantees to select the topic

Continuing Education Form: The same comments and recommendations made for the Technical Assistance/Colla

Core Measure 1 (Grant Impact): LEND training grants and the autism training resource center grant are all current programs potentially reported quality improvement aims (Tier 2), therefore, important information could be missing related to positive outcomes of quality improvement efforts.

We recommend that for Tier 4, the related outcomes be expanded to match the aims reported in Tier 2, and that programs only be required to complete Tier 4 outcomes for the aims selected in Tier 2.

Capacity Building 1 (State capacity): It is our understanding that this performance measure is intended for progra performance measure NOT be assigned to LEND training programs.

If this measure must be assigned in some fashion, we recommend that Tier 3 NOT be assigned and that there be an auto-population of data between this performance measure and the Technical Assistance/Collaboration form so grantees are not entering the same data twice.

Capacity Building 3 (Impact Measurement): LEND training programs report impact data on trainees as part of thei

Capacity Building 5 & 6 (Scientific Publications and Products): The data required in these two measures overlap

CSHCN 2 (Medical Home): Tiers 1 and 2 of this measure could be considered for LEND training programs. The additional data required in Tiers 3 and 4 is not reasonable for these programs as medical home is not a core area of focus.

CSHCN 3 (Transition): Tiers 1 and 2 of this measure could be considered for LEND training programs. The additic

Child Health 3 (Developmental Screening): Tiers 1 and 2 of this measure could be considered for LEND training p the information to be collected.

- It is difficult to assess from the available information whether or not the use of automated collection techniques or other forms of information technology to minimize the information collection burden will truly decrease the burden related to same for discretionary grantees.

Consider including an additional measure under Tier 4â€"Percent of premature infants (less than 37 weeks) who e for children by including a critical provision to ensure that children enrolled in all individual and group non-grandfathered health care plans receive the preventive care as recommended in the Bright Futures Guidelines (and on the Bright Futures/AAP Periodicity Schedule). Newborn Screening is on the Bright Futures/AAP Periodicity Schedule. Newborn screening is promoted through the BFNC. However, individual screening and follow-up could not be reported through BFNC as it measured at the community and/or health care provider level.
- There are 31 recommended child well visits on the Bright Futures/AAP Periodicity Schedule. Child well visits are promoted through the BFNC. However, the % of children enrolled could not be reported through BFNC as it measured at the community and/or health care provider level._x000D_
- Suggest considering ways to incorporate language from Bright Futures into these measures (eg, when â€œannual screeningsâ€□ are referenced).

As noted above, there are 31 recommended child well visits on the Bright Futures/AAP Periodicity Schedule. Chil

- Developmental screening is on the Bright Futures/AAP Periodicity Schedule (9 month, 18 month, and 30 month well child visits). Developmental screening and surveillance is promoted through Bright Futures for all well child visits. However, individual screening and follow-up could not be reported through BFNC as it measured at the community and/or health care provider level.
guidance on where the number and denominator information for this tier can be found so that grantees are able to report consistently and in line with how/what other grantees are reporting; catchment area implies that this information may be applicable only to local/community/state grantees, not national grantees and, as such, needs clarification; and guidance is needed to help grantees determine what constitutes racial and ethnic family and CSHCN leaders □.
â€œ receiving tracking and monitoringâ€□.

- Tier 4â€”Suggest clarifying what â€œdirect linkageâ€□ means and how to define and measure it.

- Significanceâ€”How can a â€œcultivated partnershipâ€□ be measured in a quantifiable and meaningful way?
readinessâ€□)._x000D_
- Consider encouraging grantees to utilize the MCHB-funded Got Transition materials; specifically those focused on the 6 core elements of healthcare transition and related measures, tools, materials and resources._x000D_
- Significanceâ€”Suggest language that is more appropriate for this age group. Perhaps language that emphasizes youth/young adult involvement in and responsibility for their own health care.

-- Consider including the importance of preparing for the transition to adult health care.
-- There are 11 recommended adolescent well visits on the Bright Futures/AAP Periodicity Schedule. Adolescent well visits are promoted through Bright Futures. Howev

- Adolescent depression screening is on the Bright Futures/AAP Periodicity Schedule for 11-21 year olds. Depress
-- Percent of program participants aged 6 months to 5 years who received topical fluoride varnish application during the last year. ------- numerator: infants and children involved with the program who received topical fluoride varnish application in the reporting year.
--denominator: infants and children involved with the program during the reporting year.
-- Consider incorporation of oral health needs and challenges specific to the CYSHCN population

- Tier 2â€”Suggest adding â€œFamiliesâ€□.

- Tier 2â€”Although a definition/description of technical assistance is provided, the definition is so broad and all encompassing that it has the potential for grantees to include far too much related to their wo

- Tier 1â€”Suggest clarifying/defining what â€œimpact measurementâ€□ means.
- Tier 2â€”Suggest specifying what a â€œcase reportâ€□ means and clarifying how this relates to all discretionary grantees.
- Tier 4â€”Suggest rethinking and reframing this tier a

Tier 3â€”Need clarification on what â€œHow many are reached through those activities?â€□ and what N/A mean

Tier 4â€”Is tracking of dissemination vehicles a way to assess outcomes? Also, there are numerous challenges re

- Will there be an opportunity for grantees to indicate if they have changed an objective during the course of the project or if they have partially met an objective?_x000D_
- This appears to be a somewhat streamlined approach to what was used in the past; the

their quality improvement project aims/measures in the categories listed. Those listed are too specific and also too variable for any type of reliable and consistent grant reporting._x000D_
- Tier 4â€”Why is the focus only on population health and how is that measured/quantified in a meaningful manner given the broad definition of same? Why is the focus on â€œorganizationalâ€ improvement as opposed to (or in addition to) individual improvement? Not all quality improvement is organizationally focused.

The AAP recommends that measures related to family engagement and cultural competence (Training 1 and Trai

The AAP recommends that measures related to family engagement and cultural competence (Training 1 and Trai
o CB 04 Products_x000D_
o CH1 Well Child Visit_x000D_
We understand that these additional measures may not be applicable to some HT grantees, but many of our grantees address a wide range of topics and could potentially provide meaningful data with regard to these elements.

Suggest defining medical home and/or breaking it down into a few measurable characteristics. The numerator, as

The AAP agrees with the removal of the â€œInfrastructure Buildingâ€ category on Form 4. Many projects that d
"quality improvement" initiatives._x000D_
3. ner 4-define "CSHCN leaders" and explain the types of community/state/nationallevelteams that are being referenced. What would constitute a family or CSHCN being "trained" and how will "increased knowledge,skill, ability and self-efficacy" be measured by these leaders to serve the population?_x000D_

1. Tier 1- define "medical home."_x000D_
2. Tiers 2 and 3- define fields referenced on the "Activity Data Collection Form."
Regarding the reporting burden,the FederalRegister/Vol. 80,No.213/Friday,November 6,2015 references an estimated 41hours per response.This is likely a reasonable estimate for the IHTC to gather information to complete the report but will be highly dependent on the ease of interpreting and therefore compiling information requested. Clear definitions for terms used will ease the burden of reporting._x000D_

On page 7, regarding the well woman visit, we note that under well child visit there is a measure for quality, yet

On page 8, regarding depression screening, could you consider broadening to screen for mental health issues in general? For example, by identifying women with anxiety disorders more women might also be identified and receive treatment for substance use disorders. Also, the number of women referred to treatment is important, but we suggest consider measuring how many are lost in the system.

On page 18, regarding Developmental Screening - under "Grantee Data Sources" it lists NOM#12, which is newbo

On page 20, regarding Injury Prevention â€“ please consider if NPM#7 should also be listed under "Grantee Dat

On page 21 regarding Family Engagement: Tier 4: numerator: What does â€œmeaningfulâ€□ mean? How will thi

On page 23 regarding Medical Home; Tier 4 numerator will be potentially difficult to determine what % of target po

On Page 26, regarding Transition - similar to above, NPM#6 is listed under "Grantee Data Sources.â€□ We sugge

On page 33, for the percent of programs promoting and/or facilitating adequate health insurance coverage, consic

On page 36, where data collection tables are first introduced, pregnant women and adolescents are included, but

On Page 44, regarding the measure of percent of programs providing technical assistance on MCH priority topics,

On page 47, regarding the percent of programs supporting the development of informational products and through

On page 48, regarding introduction of the core measures, it is presumed but not clear from the narrative that all g

On page 94, regarding Training for Policy Development, consider adding â€œWriting an Op-Ed or Letter to the Ec

On page 134, regarding father / partner involvement, we are pleased to see this proposal and are strongly suppor

On page 143, under Models of Family Engagement, please consider adding â€œChildrenâ€™s Hospitalsâ€□ as a

On page 150, where the terms â€œDirect Health Care, Enabling Services and Population Based Servicesâ€□ are

national database funded by HRSA. Second,the regional genetics collaboratives have had the flexibility to select HRSA priority areas that are important to the constituents in each region. Therefore,for the 2016-2017 grant year,we request flexibility in selecting measures that reflect the work conducted for the past five years on specific HRSA priority areas provided in the grant application guidance.

-- Impact Measure
Numerator: Number of HS participants who stop smoking cigarettes (including all tobacco products and e-cigarettes) during their pregnancy.
Denominator: Number of HS prenatal participants who smoked at the beginning of their pregnancy.

Rationale: The interval between the most recent pregnancy and previous birth is derived from the delivery date of the birth and the date of conception for the most recent pregnancy. Optimal spacing of 18 months applies to both live births and stillbirths.

Consistent with Healthy Start Benchmark #10

Healthy Start Benchmark requires reporting on infant well-child visit. So, recommend that this be extended to a

NOTE: EPIC has requested guidance on how to identify a medically necessary vs. elective delivery from our MCH OB/GYN expect as followup.

Consistent with Healthy Start Benchmark #12

NOTE: EPIC is checking to see if questions included in screening tool constitute a â€œvalidatedâ€□ tool.

Consistent with one part of Healthy Start Benchmark #13
A participant is considered to have been referred for follow-up services and included in the numerator if she is referred to a qualified practitioner for further assessment for depression. Referral can be to either an internal or external provider depending on availability and staffing model.

Consistent with the second part of Healthy Start Benchmark #13
_x000D_
A list of validated IPV screening tools is included in the Data Dictionary as a reference._x000D_

Consistent with Healthy Start Benchmark #15

-- Comments
: Include instruction in manual that undocumented participants and participants who do not quality for subsidy under ACA are included in denominator.

Consistent with Healthy Start Benchmark #1
having or not having childrenâ€□ suggests that it would not be applicable for a woman who enrolled pregnant. However, in the event of an early pregnancy, wouldnâ€™t you still want to evaluate the participantâ€™s choice to have and/or keep the baby?

Consistent with Healthy Start Benchmark #3

--- Comments: From the most recent ACOG guidelines dated 2012 7th Edition â€œPostpartum visit is approximately 4-6 weeks after delivery.â€□ I have attached the source document.

Consistent with Healthy Start Benchmark #3
participant receiving regular prenatal care from a prenatal provider is considered to have a medical home.

Consistent with Healthy Start Benchmark #4

Note: BF- Ed and MCH measure require annual well woman/preventive visit.

Consistent with Healthy Start Benchmark #5

met.
_x000D_
Although safe sleep behaviors are self-reported, programs are encouraged to observe safe sleep practices during home visits, as possible. _x000D_

Denominator: Total number of HS infants aged 7 mo to 2 years whose mother was enrolled prenatally or at the time of birth

Consistent with Healthy Start Benchmark #7 and #8

strengthen MCH systems of care (Goal 3, p. 10). Facilitating medical home access for all children ensures we still reach non-CSHCN populations that would greatly benefit from coordinated, family-centered care. We recommend that this performance measure include a component that continues to allow us to gauge the extent to which CSHCN have access to a medical home within the overall population of children.

systems. Further, MCH programs must be encouraged to use data from family organizations such as data from F2Fs, FV SAOs, FFCMH chapters, EI/education- focused parent centers, and parent to parent programs, as well as to work with family organizations to develop, disseminate, and analyze results of surveys, focus groups, and other mechanisms that are most likely to garner diverse family feedback._x000D_

and Child Health Equity Blueprint Draft, p. 8) and we believe it is a crucial measure for ensuring equity and access to quality healthcare for all women. It is particularly important to ensure access to a medical home for those women who, by reason of immigrant or socio-economic status, do not have access to sufficient health insurance coverage.

Resolution Decision	Final Resolution
Not related to this OMB Package	No changes neccessary
specific measures will have more.	No changes neccessary
Resolution provided in comment summary.	No changes neccessary
variables; pediatric patients are included	Change/ addition to wording,Definition added
throughout as well as in program-specific information.	No changes neccessary
of recertification/re-licensure.	Change/ addition to wording,Definition added
No resolution needed	No changes neccessary
No resolution needed	No changes neccessary
No resolution needed	No changes neccessary
No resolution needed	No changes neccessary
No resolution needed	No changes neccessary
No resolution needed	No changes neccessary

Direct service added to Tiers 2 and 3 connected to Form 7	Change/ addition to wording
Resolved in individual comments.	
	Addressed in other similar or identical comment.
No resolution needed	No changes neccessary
No resolution needed.	No changes neccessary
Fix: Injury Prevention is duplicated in the list on page 41	"Grammar/ spelling/ error issue, now fixed"
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
needs to be added after in press.	
	Change/ addition to wording
adding to the scholarly body of work from the catchall of products.	No changes neccessary
No resolution needed	No changes neccessary
No resolution needed	No changes neccessary
Leave as is, but add 'other'.	Change/ addition to wording
Addressed elsewhere.	Addressed in other similar or identical comment.

consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
LC2 is unlikely to be required of training programs	No changes neccessary
No resolution needed	No changes neccessary
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
the program outlined in the FOA.	No changes neccessary
Benchmarks revised.	Change/ addition to wording
ethnicity categories will not be revised for this measure.	No changes neccessary
information on more intensive technical assistance activities.	No changes neccessary
Significance language has been modified slightly.	Change/ addition to wording,Definition added
No resolution needed	No changes neccessary
No resolution needed	No changes neccessary
of recertification/re-licensure.	Change/ addition to wording,Definition added
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu

because data system will autopopulate wherever possible.	No changes neccessary
that it is not burdensome to use that information in two ways.	No changes neccessary
that it is not burdensome to use that information in two ways.	No changes neccessary
be assigned to those programs they are not applicable to.	No changes neccessary
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
measures vary across programs.	
	"Grammar/ spelling/ error issue, now fixed"
No resolution needed	No changes neccessary
PROJECT ABSTRACT"	
	"Grammar/ spelling/ error issue, now fixed"
addition to TA form for topics related to Autism CARES legislation	Change/ addition to wording
variables; pediatric patients are included	Change/ addition to wording,Definition added
Growing Painsâ€□ (2006).	
_x000D_	Change/ addition to wording,Definition added
of recertification/re-licensure.	
	Change/ addition to wording,Definition added
variables; pediatric patients are included	
	Change/ addition to wording,Definition added

Growing Painsâ€ (2006). _x000D_	
of recertification/re-licensure.	Change/ addition to wording,Definition added
EMSC	Change/ addition to wording,Definition added
stakeholders informed throughout the development.	Change/ addition to wording,"Relates to ability to report, and should be taken into consideration
EMSC stakeholders informed throughout the development.	Change/ addition to wording,"Relates to ability to report, and should be taken into consideration
consistent to indicate that leadership could be current or past.	Change/ addition to wording
ethnicity categories will not be revised for this measure.	No changes neccessary
time, MCHB does not plan to expand 10-year follow-up data collection.	No changes neccessary
No resolution needed	No changes neccessary
Grantee-specific for now.	No changes neccessary
Definition will be added.	Definition added
-	
The intention of these measures	Change/ addition to wording
not required to quantify outcomes on an individual level.	No changes neccessary
depressive is AH; Depression screening is WMH	Definition added

note that there is no Tier 3 measure (as apparently NA isn't clear.)	Change/ addition to wording
measures and forms will auto-populate wherever possible.	No changes neccessary
No change needed.	No changes neccessary
will not be done through this system.	
	No changes neccessary
Defer to MCHB project officer guidances for #trained and #educated	No changes neccessary
time, MCHB does not plan to expand 10-year follow-up data collection.	No changes neccessary
No resolution needed	No changes neccessary
time, MCHB does not plan to expand 10-year follow-up data collection.	No changes neccessary
time, MCHB does not plan to expand 10-year follow-up data collection.	No changes neccessary
separate categories.	
	Change/ addition to wording
Yes.	
	Change/ addition to wording
will not be added here, as it would add additional burden,	No changes neccessary
not how many people are reached by it.	
	No changes neccessary

This should be captured in the third bullet--orgs should be all orgs.	No changes neccessary
data on family CSHCN leaders_x000D_	Change/ addition to wording,Definition added
medical home can be captured in Tier 1 of this measure	Definition added
coverage purchased through the Health Care Marketplace."	Definition added
Add Tracking and Monitoring as it's own row in Tier 2.	Change/ addition to wording
variables, pediatric patients are included	Change/ addition to wording,Definition added
Growing Painsâ€ (2006). _x000D_	Change/ addition to wording,Definition added
of recertification/re-licensure.	Change/ addition to wording,Definition added
variables, pediatric patients are included	Change/ addition to wording,Definition added
Growing Painsâ€ (2006). _x000D_	Change/ addition to wording,Definition added
of recertification/re-licensure.	Change/ addition to wording,Definition added
that this is confusing, no specific resolution needed.	No changes neccessary
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu

consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
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consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
variables, pediatric patients are included	Change/ addition to wording,Definition added
Growing Painsâ€ (2006). _x000D_	Change/ addition to wording,Definition added

Same as comment 88.	
	Addressed in other similar or identical comment.
services on this list"-- This would be captured under 'education'.	Relates to ability to report, and should be taken into consideration when assigning measures further down the road."
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
variables, pediatric patients are included	"Relates to ability to report, and should be taken into consideration when assigning measures fu
	Change/ addition to wording,Definition added
Growing Painsâ€□ (2006). _x000D_	Change/ addition to wording,Definition added
of recertification/re-licensure.	
	Change/ addition to wording,Definition added
variables, pediatric patients are included	
	Change/ addition to wording,Definition added
Growing Painsâ€□ (2006). _x000D_	Change/ addition to wording,Definition added
of recertification/re-licensure.	
	Change/ addition to wording,Definition added

EMSC stakeholders informed throughout the development.	Change/ addition to wording,"Relates to ability to report, and should be taken into consideration
Measure has been revised, not all Tiers will be assigned to all grantees.	Change/ addition to wording, Relates to ability to report, and should be taken into consideration when assigning measures further down the road.
made by University of Alabama at Birmingham PPC.	No changes neccessary
have been made. An Other category has been added.	Change/ addition to wording
present a more detailed picture of former trainee outcomes.	No changes neccessary
trainees. This has veen clarified in the Training 13 measure.	Change/ addition to wording
than the anticipated burden on each specific grantee.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
and youth with special health care needs? _x000D_	Change/ addition to wording,Definition added
No CSHCN-specific resolution is needed.	No changes neccessary
accNumber of community-based organizations.â€	Change/ addition to wording,Definition added
included in EC measure tables.	Change/ addition to wording
No Training of CSHCN-specific resolution is needed.	No changes neccessary
variables; pediatric patients are included	Change/ addition to wording,Definition added

Growing Painsâ€□ (2006). _x000D_	Change/ addition to wording,Definition added
of recertification/re-licensure.	
EMSC stakeholders informed throughout the development.	Change/ addition to wording,Definition added
	Change/ addition to wording,"Relates to ability to report, and should be taken into consideration
Same as above.	No changes neccessary
Yes.	
for impact measurement--tie to logic model--Jamelle Banks	Change/ addition to wording Definition added
Same as comment 166	
this recommendation will not be implemented at this time.	Addressed in other similar or identical comment. No changes neccessary
Addressed elsewhere.	Change/ addition to wording
Changed to meaningful roles. Definition is attached	Definition added
Refer to comment 80	Addressed in other similar or identical comment.
Same as above-- adopt 'tracking and surveillance'.	Change/ addition to wording
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu

variables; pediatric patients are included	
	Change/ addition to wording,Definition added
Growing Painsâ€□ (2006). _x000D_	
	Change/ addition to wording,Definition added
of recertification/re-licensure.	
	Change/ addition to wording,Definition added
EMSC stakeholders informed throughout the development.	
	Change/ addition to wording,"Relates to ability to report, and should be taken into consideration
EMSC stakeholders informed throughout the development.	
	Change/ addition to wording,"Relates to ability to report, and should be taken into consideration
consideration when we assign measures later this year.	
	"Relates to ability to report, and should be taken into consideration when assigning measures fu
injustices, and the elimination of health and health care disparities.	
	Definition added
so no changes made to this measure.	
	No changes neccessary
consideration when we assign measures later this year.	
	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	
	"Relates to ability to report, and should be taken into consideration when assigning measures fu
Yes	
	Change/ addition to wording
Comment is about Table 1, not Core 2. Addressed elsewhere	
	Definition added
Added students/trainees to Box 5 as suggested_x000D_	
	Change/ addition to wording,"Grammar/ spelling/ error issue, now fixed"

No resolution needed	No changes neccessary
leadership so that it is consistent across the measure	Change/ addition to wording
with the DMCHWD performance measure workgroup.	No changes neccessary
Recommendation adopted, change made on Training 13 detail sheet.	Change/ addition to wording,"Grammar/ spelling/ error issue, now fixed"
Not all sections of measures will be assigned to all grantees.	Change/ addition to wording,"Relates to ability to report, and should be taken into consideration
Refer to comment 80	Addressed in other similar or identical comment.
Comment is the same as 141.	Addressed in other similar or identical comment.
Same as above.	Addressed in other similar or identical comment.
Yes.	Change/ addition to wording
Same as 135	Addressed in other similar or identical comment.
not how many people are reached by it.	Addressed in other similar or identical comment.
Same comment as 78.	Addressed in other similar or identical comment.
Yes to tracking and monitoring, but not in Core 2.	Change/ addition to wording

Growing Painsâ€ (2006). _x000D_	Change/ addition to wording,Definition added
of recertification/re-licensure.	
EMSC stakeholders informed throughout the development.	Change/ addition to wording,Definition added
EMSC stakeholders informed throughout the development.	Change/ addition to wording,"Relates to ability to report, and should be taken into consideration
consideration when we assign measures later this year.	Change/ addition to wording,"Relates to ability to report, and should be taken into consideration
"Youth Violence" as this includes dating violence.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
Fix Heading Under Tier 2.	Change/ addition to wording
	Definition added,"Grammar/ spelling/ error issue, now fixed"
Comment relates to ability to report.	No changes neccessary
Yes, Tier 2 is Check All that Apply	
	Change/ addition to wording
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
Changes were made based on comment provided.	Change/ addition to wording
MCHB funded, then yes.	
Use this for CB 5 as well.	Change/ addition to wording,Definition added

achievement of aims across programs.	
	No changes neccessary
Check all that apply has been added.	Change/ addition to wording
is based on grantee-specific goals.	
consideration	No changes neccessary
when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
this measure is around race and ethnicity. No revisions will be made.	No changes neccessary
Revised language around educating policymakers.	Change/ addition to wording,Definition added
ethnicity categories will not be revised for this measure.	No changes neccessary
definitions/guid elines will be provided by Project Officers.	Definition added
measure workgroup and will not be revised at this time.	No changes neccessary
Activities column has been deleted.	Change/ addition to wording
nature of coding qualitative, open-ended questions.	No changes neccessary
measures workgroup, so no changes are recommended.	Change/ addition to wording,Definition added
consistent with other measures and MCHB investments.	Definition added

No definition will be added	No changes neccessary
while maintaining relevance for different types of programs.	Change/ addition to wording
provide meaningful responses in this structure.	No changes neccessary
Facilitation of collaboration was added to Tier 2 measures	Change/ addition to wording
Not being added at this time.	
consideration when we assign measures later this year.	No changes neccessary
	"Relates to ability to report, and should be taken into consideration when assigning measures fu
Yes.	
consideration when we assign measures later this year.	Change/ addition to wording
	"Relates to ability to report, and should be taken into consideration when assigning measures fu
No resolution needed.	
consideration when we assign measures later this year.	No changes neccessary
	"Relates to ability to report, and should be taken into consideration when assigning measures fu
No resolution needed.	No changes neccessary
consideration when we assign measures later this year.	
	"Relates to ability to report, and should be taken into consideration when assigning measures fu
No resolution needed.	No changes neccessary

Validated would include this.	No changes neccessary
across the board, it is not reasonable to apply to just this.	No changes neccessary
programs funded for this type of work to justify this suggesstion.	No changes neccessary
noted but will not include the suggested outcome at this time.	No changes neccessary
K Data Sourcesâ€ section of this performance measure	Change/ addition to wording
participants/the public.â€ -- it is referenced elsewhere in the measure.	Change/ addition to wording
this recommendation will not be implemented at this time.	No changes neccessary
Look at using this for health disparities--cross check with list.	Change/ addition to wording
measure, and therefore not to be assigned by other types of programs.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
around race and ethnicity. No revisions will be made at this time.	No changes neccessary
around race and ethnicity. No revisions will be made at this time.	No changes neccessary
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
category" will be added to the race category within item A1b.	Change/ addition to wording,Definition added

far lower rates than the national average for this measure.	No changes neccessary
visit during the twelve month period would meet the standard.	Change/ addition to wording
Measure was removed.	Measure or portion referenced was removed.
Addressed in comment 299.	Addressed in other similar or identical comment.
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
Definition has been added.	Definition added
measure, as recommended by the Healthy Start workgroup.	No changes neccessary
Guidance by project officers upon assigning measures, as necessary.	No changes neccessary
Added and/or changed language to clarify instructions.	Change/ addition to wording
clarified to indicate that it only applies to long-term trainees	No changes neccessary
addition to TA form for topics related to Autism CARES legislation	Change/ addition to wording
enforceds for DMCHWD programs.	No changes neccessary

individual project objectives.	
	No changes neccessary
Systems improvement -- Call it Cross Sectorial Collaboration	Change/ addition to wording
No resolution needed.	No changes neccessary
Duplication will not be an issue because data system will autofill.	No changes neccessary
This comment relates to ability to report.	No changes neccessary
Will autopopulate, therefore mot creating duplication	No changes neccessary
consideration when we assign measures later this year.	No changes neccessary
consideration when we assign measures later this year.	No changes neccessary
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
Someone responds no, then the PO needs to follow up on that.	No changes neccessary
While the idea is good, this is not reasonable for anyone to report.	No changes neccessary
matter what the specific condition is.	
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
	"Relates to ability to report, and should be taken into consideration when assigning measures fu

Definition from Bright Futures should be referenced.	Definition added
provided when measures are assigned.	
	Change/ addition to wording,Definition added
Officers will provide technical assistance to gran	Change/ addition to wording,Definition added,"Relates to ability to report, and should be taken into consideration when assigning measures further down the road."
"Tracking and monitoring refers to tracking and monitoring t	Change/ addition to wording,Definition added
assistance to grantees regarding the performance measures	No changes neccessary
families. The two resource centers have a cooperative relationship.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
on any adolescents served, with a place to report age range.	Change/ addition to wording
likely to be valuable in the bigger picture, so not added at this time.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
categories to clarify where 'families' would be included, etc.	Definition added
Need definition for Case Report.	Definition added
no Herd Measure for this.	
	Change/ addition to wording
not how many people are reached by it.	
	No changes neccessary
ensure that this measure reflects their up-to-date objectives.	"Relates to ability to report, and should be taken into consideration when assigning measures fu

guidance and examples when assigning measures.	Change/ addition to wording,"Relates to ability to report, and should be taken into consideration
modified to include Healthy Tomorrows grantees	Change/ addition to wording
modified to include Healthy Tomorrows grantees	Change/ addition to wording
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
to Usual Source of care, and definition has been added.	Definition added,Change/ addition to wording
consideration when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
when measures are assigned.	
	Change/ addition to wording
common definitions for the fields in Table 1._x000D_	No changes neccessary
be defined as:_x000D_	
Assessing youthâ€™s trans	Definition added
challenge defining the quality of well child visit measure.	No changes neccessary
made in order to keep consistent with HS benchmarks.	No changes neccessary
add NPM 6 as Grantee data source	Definition added
UI: NPM#7 should also be listed under "Grantee Data Sources.â€□	Definition added

as measures are being assigned.	Addressed in other similar or identical comment.
	"Relates to ability to report, and should be taken into consideration when assigning measures fu
Yes	Change/ addition to wording
Yes. these are current definition that the bureau is using.	Change/ addition to wording
TA, which would be very challenging to accurately quantify.	Change/ addition to wording
No metrics are necessary, just dissemination methods,	Definition added
Yes. Move Capacity Measures to the front as well.	No changes neccessary
performance measure workgroup. No changes are planned	Change/ addition to wording
No Resolution necessary.	No changes neccessary
be added as an optional organization type for item B1b.	No changes neccessary
added to the definitions in MCH Block Grant guidance.	Change/ addition to wording
consideration when we assign measures later this year.	Definition added
	"Relates to ability to report, and should be taken into consideration when assigning measures fu

Yes. Healthy Start data collection efforts.	Definition added
child visit will be reported as HS measure.	Change/ addition to wording,Definition added
Healthy Start data collection efforts.	Change/ addition to wording
Healthy Start data collection efforts.	Change/ addition to wording,Definition added
Healthy Start data collection efforts.	Change/ addition to wording,Definition added
Healthy Start data collection efforts.	Change/ addition to wording,Definition added
	Change/ addition to wording,Definition added
Yes. Healthy Start data collection efforts.	Definition added
	Change/ addition to wording,Definition added
Cross check with current Tier 4.	Change/ addition to wording
Changed to "usual source of care" with definition provided.	Change/ addition to wording,Definition added
Cross check with current Tier 4.	Change/ addition to wording,Definition added
group-- can this replace what is currently T4, or be in addition.	Change/ addition to wording

definitions and 3Ps reconciliation.		
	Change/ addition to wording,Definition added	
through CSHCN, and this is included in block grant reporting.	No changes neccessary	
through CSHCN, and this is included in block grant reporting.	No changes neccessary	
through CSHCN, and this is included in block grant reporting.	No changes neccessary	

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