

Number	Date Received	Division	Commenting Organization	Commenter Location	Performance Measure	Measure Name
1	11/17/2015	MIECHV/	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 Emergency	EMSC 01	NEMSIS St
5	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergency	EMSC 02	Pediatric E
6	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergency	EMSC 03	Use of Ped
7	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergency	EMSC 04	Pediatric M
8	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergency	EMSC 05	Pediatric t
9	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergency	EMSC 06	Inter-facili
10	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergency	EMSC 07	Inter-facili
11	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergency	EMSC 08	Establishe
12	12/11/2015	EMSC	PA Emergency Health Services Council- EMS for Children Project Director	PA Emergency	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 Center Development	Chapel Hill, N CB 2	Technical A
17	12/28/2015	Workforce Center Development	Chapel Hill, N CB 2	Technical A
18	12/28/2015	Workforce Center Development	Chapel Hill, N CB 3	Impact Mea
19	12/28/2015	Workforce Center Development	Chapel Hill, N CB 4	Sustainabil
20	12/28/2015	Workforce Center Development	Chapel Hill, N CB 5	Scientific P
21	12/28/2015	Workforce Center Development	Chapel Hill, N CB 6	Products
22	12/28/2015	Workforce Center Development	Chapel Hill, N Core 1	Grant Impa
23	12/28/2015	Workforce Center Development	Chapel Hill, N Core 2	Quality Imp
24	12/28/2015	Workforce Center Development	Chapel Hill, N Core 3	Health Equ
25	12/28/2015	Workforce Center	Chapel Hill, N LC 1	Adequate H

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

39	12/29/2015 Workforce	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, AL	CB 2	Technical A
40	12/29/2015 Workforce	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, AL	CB 5	Scientific P
41	12/29/2015 Workforce	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, AL	CB 6	Products
42	12/29/2015 Workforce	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, AL	LC 1	Adequate F
43	12/29/2015 Workforce	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, AL	LC 2	Tobacco a
44	12/29/2015 Workforce	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, AL	ADEs	General Forms/
45	12/29/2015 Workforce	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, AL	ADEs	General Forms/
46	12/29/2015 Workforce	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, AL	ADEs	General Forms/
47	12/29/2015 Workforce	University of Alabama at Birmingham Pediatric Pulmonary Center	Birmingham, AL	ADEs	General Forms/
48	1/4/2016 EMSC	Kansas Board of Emergency Medical Services	Topeka, KS	EMSC 01	NEMSIS St
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 St

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	Tulane University School of Public Health and Tropical IMedicine	New Orleans, Training 6		Demonstra
57	1/4/2016 Workforce	Tulane University School of Public Health and Tropical IMedicine	New Orleans, Training 7		Diversity o
58	1/4/2016 Workforce	Tulane University School of Public Health and Tropical IMedicine	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 Education in Neurodevelopmental and related Disabilities (LEND)	Washington,	CSHCN 2	Access to
64	1/5/2016 Workforce	IProgram	Cincinnati,	OF-CB 2	Technical A

		Education ... Neurodevelopmental and related Disabilities (LEND)			
65	1/5/2016	Workforce IProgram	Cincinnati, OH	CB 4	Sustainability
66	1/5/2016	Workforce IProgram	Cincinnati, OH	Forms/ ADEs CB 5, CB 6, General	Scientific P
67	1/5/2016	Workforce IProgram	Cincinnati, OH	Core 1	Grant Impa
68	1/5/2016	Workforce IProgram	Cincinnati, OH	Core 2	Quality Imp
69	1/5/2016	Workforce IProgram	Cincinnati, OH	CSHCN 2, CSHCN 3	Access to e
70	1/5/2016	Workforce IProgram	Cincinnati, OH	Training 6	Demonstra
71	1/5/2016	Workforce IProgram	Cincinnati, OH	Training 8	Title V Coll
72	1/5/2016	Workforce IProgram	Cincinnati, OH	Training 9	Interdiscipl
73	1/5/2016	Workforce IProgram	Cincinnati, OH	Training 12	Work with
74	1/5/2016	CSHCN Collaboratives	Bethesda, MD	MDCB 1	State capaci
75	1/5/2016	CSHCN Collaboratives	Bethesda, MD	MDCB 2	Technical A
76	1/5/2016	CSHCN Collaboratives	Bethesda, MD	MDCB 3	Impact Mea
77	1/5/2016	CSHCN Collaboratives	Bethesda, MD	MDCB 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 F
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	NEMESIS St
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	NEMESIS St
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/ F	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NC B 1	State capar
90	1/5/2016 MIECHV/ F	Early Childhood Comprehensive Systems Project for New York State	Rensselaer, NC B 2	Technical A

91	1/5/2016 MIECHV/ F	New York State	Rensselaer, NCB 3	Impact Mea
92	1/5/2016 MIECHV/ F	New York State	Rensselaer, NCB 4	Sustainabil
93	1/5/2016 MIECHV/ F	New York State	Rensselaer, NCB 5	Scientific P
94	1/5/2016 MIECHV/ F	New York State	Rensselaer, NCB 6	Products
95	1/5/2016 MIECHV/ F	New York State	Rensselaer, NCH 1	Well Child \
96	1/5/2016 MIECHV/ F	New York State	Rensselaer, NCH 2	Quality of V
97	1/5/2016 MIECHV/ F	New York State	Rensselaer, NCH 3	Developme
98	1/5/2016 MIECHV/ F	New York State	Rensselaer, NCH 4	Injury Prev
99	1/5/2016 MIECHV/ F	New York State	Rensselaer, NPIH 1	Safe Sleep
100	1/5/2016 MIECHV/ F	New York State	Rensselaer, NPIH 2	Breast Fee
101	1/5/2016 MIECHV/ F	New York State	Rensselaer, NPIH 3	Newborn S
102	1/5/2016 EMSC	Rhode Island Center for Emergency Medical Services	Providence, REMSC 01	NEMSIS St
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, REMSC 03	Use of Ped
105	1/5/2016 DCAFH	School-Based Health Alliance	Washington, CB 1	State capaci
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	Sustainabili
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, VTEMSC 01	NEMSIS St
112	1/5/2016 EMSC	Vermont Emergency Medical Services for Children Program	Burlington, VTEMSC 02	Pediatric E
113	1/5/2016 EMSC	Tennessee Emergency Medical Services for Children Program	Burlington, VTEMSC 03	Use of Ped
114	1/5/2016 EMSC	Tennessee Emergency Medical Services for Children Program	Nashville, TN EMSC 01	NEMSIS St
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 Transition/Center for Health Care Transition	Nashville, TN	EMSC 04,EMSC 05	Pediatric M
118	1/5/2016	CSHCN	Improvement	Washington,	CSHCN 3	Transition t
119	1/5/2016	Workforce	University of Arizona Pediatric IPulmonary Center	Arizona	Not Related to Measure	
120	1/5/2016	Workforce	WI LEND Program - University of Wisconsin - IMadison	Madison, WI	Not Related to Measure, Traini ng Forms	
121	1/5/2016	Workforce	WI LEND Program - University of Wisconsin - IMadison	Madison, WI	Training 9	Interdiscipl
122	1/5/2016	Workforce	WI LEND Program - University of Wisconsin - IMadison	Madison, WI	Training 13	Policy Devt
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 St

130	1/6/2016 EMSC	Illinois DPH - Division of EMS and Highway Safety	Springfield, IL EMSC 02	Pediatric E
131	1/6/2016 EMSC	Illinois DPH - Division of EMS and Highway Safety	Springfield, IL EMSC 03	Use of Ped
132	1/6/2016 EMSC	Illinois DPH - Division of EMS and Highway Safety Region 4 Midwest Genetics	Springfield, IL EMSC 04	Pediatric M
133	1/6/2016 CSHCN	Collaborative - Michigan Public Health Institute Region 4 Midwest Genetics	Okemos, MI CB 1	State capaci
134	1/6/2016 CSHCN	Collaborative - Michigan Public Health Institute Region 4 Midwest Genetics	Okemos, MI CB 2	Technical A
135	1/6/2016 CSHCN	Collaborative - Michigan Public Health Institute Region 4 Midwest Genetics	Okemos, MI CB 3	Impact Mea
136	1/6/2016 CSHCN	Collaborative - Michigan Public Health Institute Region 4 Midwest Genetics	Okemos, MI CB 6	Products
137	1/6/2016 CSHCN	Collaborative - Michigan Public Health Institute Region 4 Midwest Genetics	Okemos, MI Core 2	Quality Imp
138	1/6/2016 CSHCN	Collaborative - Michigan Public Health Institute Region 4 Midwest Genetics	Okemos, MI Core 2	Quality Imp
139	1/6/2016 CSHCN	Collaborative - Michigan Public Health Institute Region 4 Midwest Genetics	Okemos, MI CSHCN 1	Family Eng
140	1/6/2016 CSHCN	Collaborative - Michigan Public Health Institute Region 4 Midwest Genetics	Okemos, MI CSHCN 2	Access to
141	1/6/2016 CSHCN	Collaborative - Michigan Public Health Institute Region 4 Midwest Genetics	Okemos, MI LC 1	Adequate H
142	1/6/2016 CSHCN	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 St
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	The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders	EMSC 05	Pediatric t
148	1/6/2016 CSHCN	The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders	Santa Ana, C/Measure	Not Related to
149	1/6/2016 CSHCN	The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders	Santa Ana, C/CB 2	Technical A
150	1/6/2016 CSHCN	The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders	Santa Ana, C/CB 6	Products
151	1/6/2016 CSHCN	The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders	Santa Ana, C/2,Core 3	Core 1,Core Grant Impa
152	1/6/2016 CSHCN	The Center for Comprehensive Care & Diagnosis of Inherited Blood Disorders	Santa Ana, C/Measure	Not Related to
153	1/6/2016 Workforce	UAB School of Public Health	Birmingham, /Core 2	Quality Imp
154	1/6/2016 Workforce	UAB School of Public Health	Birmingham, /Core 2	Quality Imp
155	1/6/2016 Workforce	UAB School of Public Health	Birmingham, /Training 1	MCH Traini

156	1/6/2016 Workforce	UAB School of Public Health	Birmingham, AL	Training 2	MCH Traini
157	1/6/2016 Workforce	UAB School of Public Health	Birmingham, AL	Training 6	Demonstra
158	1/6/2016 Workforce	UAB School of Public Health	Birmingham, AL	Training 9	Interdiscipl
159	1/6/2016 Workforce	UAB School of Public Health of Medical Genetics and Genomics	Birmingham, AL	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	MDLC 1	Adequate H
163	1/5/2016 CSHCN	of Medical Genetics and Genomics	Bethesda, MD	MDCB 1	State capac
164	1/5/2016 CSHCN	of Medical Genetics and Genomics	Bethesda, MD	MDCB 2	Technical A
165	1/5/2016 CSHCN	of Medical Genetics and Genomics	Bethesda, MD	MDCB 3	Impact Mec
166	1/5/2016 CSHCN	of Medical Genetics and Genomics	Bethesda, MD	MDCB 6	Products
167	1/5/2016 CSHCN	of Medical Genetics and Genomics	Bethesda, MD	MDCore 2	Quality Imp
168	1/5/2016 CSHCN		Bethesda, MD	MDCore 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	Boston LEAH IProgram	Boston, MA	AH 1	Adolescent
174	1/5/2016 Workforce	Boston LEAH IProgram	Boston, MA	AH 2	Injury Prev
175	1/5/2016 Workforce	Boston LEAH IProgram	Boston, MA	AH 3	Screening I
176	1/5/2016 Workforce	Boston LEAH IProgram	Boston, MA	CB 1	State capaci
177	1/5/2016 Workforce	Boston LEAH IProgram	Boston, MA	CB 2	Technical A
178	1/5/2016 Workforce	Boston LEAH IProgram	Boston, MA	CB 3	Impact Mea
179	1/5/2016 Workforce	Boston LEAH IProgram	Boston, MA	CB 4	Sustainabili
180	1/5/2016 Workforce	Boston LEAH IProgram	Boston, MA	CB 5	Scientific P
181	1/5/2016 Workforce	Boston LEAH IProgram	Boston, MA	CB 6	Products

182	1/5/2016 Workforce IProgram	Boston LEAH	Boston, MA	Core 1	Grant Impa
183	1/5/2016 Workforce IProgram	Boston LEAH	Boston, MA	Core 2	Quality Imp
184	1/5/2016 Workforce IProgram	Boston LEAH	Boston, MA	Core 3	Health Equ
185	1/5/2016 Workforce IProgram	Boston LEAH	Boston, MA	Training 1	MCH Traini
186	1/5/2016 Workforce IProgram	Boston LEAH	Boston, MA	Training 2	MCH Traini
187	1/5/2016 Workforce IProgram	Boston LEAH	Boston, MA	Training 6	Demonstra
188	1/5/2016 Workforce IProgram	Boston LEAH	Boston, MA	Training 7	Diversity o
189	1/5/2016 Workforce IProgram	Boston LEAH	Boston, MA	Training 8	Title V Coll
190	1/5/2016 Workforce IProgram	Boston LEAH	Boston, MA	Training 9	Interdiscipl
191	1/5/2016 Workforce IProgram	Boston LEAH	Boston, MA	Training 10	Diverse Ad
192	1/5/2016 Workforce IProgram	Boston LEAH	Boston, MA	Training 12	Work with
193	1/5/2016 Workforce IProgram	Boston LEAH	Boston, MA	Training 13	Policy Deve
194	1/5/2016 Workforce IProgram	Boston LEAH	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 F
200	1/5/2016	CSHCN	The Mountain States Genetics Regional Collaborative		CB 1	State capaci
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 Start - Dallas - Parkland Health and Hospital System	Dallas, TX	WMH 1	Prenatal Ca
222	1/5/2016	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	WMH 3	Well Woma
223	1/5/2016	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	WMH 5	Severe Mat
224	1/5/2016	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	PIH 2	Breast Fee
225	1/5/2016	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	PIH 3	Newborn S
226	1/5/2016	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	CH 3	Developme
227	1/5/2016	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	LC 1	Adequate F
228	1/5/2016	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	LC 2	Tobacco a
229	1/5/2016	Healthy Start - Dallas - Parkland Health and Hospital System	Dallas, TX	LC 3	Oral Health
230	1/4/2016	CSHCN, Work Association of University Centers on Disabilities	Silver Spring,	Training 1	MCH Traini
231	1/4/2016	CSHCN, Work Association of University Centers on Disabilities	Silver Spring,	Training 13	Policy Deve
232	1/4/2016	CSHCN, Work Association of University Centers on Disabilities	Silver Spring,	General Forms/ ADEs	
233	1/4/2016	CSHCN, Work	Silver Spring,	General Forms/ ADEs	

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

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

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

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

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

Comment Summary

7/10 - 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: Haven't mapped it out that far, want to make sure there is some flexibility and to figure out how it's most effect. The biggest effort is on making the utility work better. They haven'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 patients.

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.

Public may be able to provide some additional definition (ex. Table 1) columns that differentiate local partners from national partners.

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, you will 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 it's not clear that there will be 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. 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. 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. - 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 "quantify" these measures, but we lose much in the translation. question would be time limited. For example, according the past 6 months, how often have trainees sought information from other professions or disciplines. As the question stands, all the responses are likely to be very high. - 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 "revised form 6" (abstract), Section V, section 2, is titled "Aims and Key Activities." 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
icensure/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.
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all-encompassing view of prehospital care, then those air and water-only EMS services should also be
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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.

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 "the [PEC Coordinator] ensures the pediatric perspective is included in the development of EMS protocols" 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 "approved" 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 45 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 "Since completing training program," if that captures intent of measure (or "in past 3 years," 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 "since completing training program," (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 success. Uptake of genetic testing, 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 equity. 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 is 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 no

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 products/activities.

CORE 1: Yes/No format will make it challenging for programs to demonstrate when they have only met p
Tier 2 “ Can multiple aims be checked? It would be helpful to also have more detail regarding each of these
options (such as examples)

Tier 3 “ 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 “ 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 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 suggest 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 "pediatric representative" that is embedded within the state'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 "6" 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 "8" be changed to "6" 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 "Oversee pediatric process improvement" so that the survey respondent understands what this means and how it differs from "Ensure that fellow providers follow pediatric clinical practice guidelines/protocols".

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.

and Medicaid.

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 isn'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 has 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 HIV 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 HVs collect pediatric specific data collection as well as submitting data to HIVSA.
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 "Oversee pediatric process improvement" so that the survey respondent understands what this means and how it differs from "Ensure that fellow providers follow pediatric clinical practice guidelines/protocols".

that may be considered when answering the proposed survey questions. The creation of this list will assist in defining the "process".

--- 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 EMT's Continued Competency Program (CCP) in the services "process".

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 Alliance's

and Center for School Mental Health'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 T. 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 "Oversee pediatric process improvement" so that the survey respondent understands what this entails and how it differs from "Ensure that fellow providers follow pediatric clinical practice guidelines/protocols".

Since many services include standardized classes/courses in their "process" 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 "Ensure that fellow providers follow pediatric clinical practice guidelines/protocols".

-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 state's, modify them or create their own. How would all TN EMS providers at a service that answers calls in small communities meet this metric when it is most likely statistically impossible to every provider to have a pediatric encounter in the timeframe outlined?

-An additional concern from Tennessee'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 "instructor" 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 making 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 youth 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 FY 21 comment submitted with their 2014-2015 data report to the NCFF: 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, it'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 all pediatric clinical practice guidelines to all EMS pediatric clinical practice guidelines/protocols, since most EMS agencies utilize the term "EMS protocols". In addition, "protocols" is used in the first question on page 108 so this change will ensure consistency in language. --- Clarify "pediatric process improvement" by changing to "pediatric quality improvement" (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. i,§ Allow the skills demonstrations within standardized courses (such as PALS, PEPP, APLS and ENPC) and the use of the National Registry of EMT's Continued Competency Program (CCP) to meet the skill station component in the scoring rubric. facility 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 activities and impact. It could give data on the use of the National Survey of Children's Health, birth defects registries, etc. This data would help support the importance taxpayers' 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. We

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 State's newborn screening programs and the identification and followup testing saving thousa

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 overly academic tower, especially to smaller, numerous rural providers and we cannot reasonably 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 meet 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 agency'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 measure. 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 " 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 support specifically the three core measures required of all grantees [previously 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 " Goal 2: Quality Improvement " Because some projects are primarily academic institutions, their core partners, professionals, and community partners, for instance, frequently, the "Consumers" 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 "Family/Youth/Community Engagement in MCH Training Programs", the word_x00C

On the detail sheets for "Cultural Competence in MCH Training Programs", I LOVE that boxes 4 and 5_x00

On the data collection forms for "Field Leadership", both 2 and 5 years after training completion, different
On a separate note, it would be contacting former trainees 10 years after training completion, that'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 "Category #2: Participation in Policy Change and Translation of Research into Policy", 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.

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 sugges

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 "ivory academic tower", 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 "coordinator" with "advocate".

The scoring method is not realistic for small EMS agencies who see very few pediatric patients, and who do not have a pediatric unit.

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? (some hospitals 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 implies "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.

It might seem simple to know how many are reached, but 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.

In the second section of Tier 2, I would add to motor vehicle traffic a word such as accidents or injury 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 "check all that apply" were available

The overall statement is good and helpful for LEAHs using Tier 1 and 2, although the categories in Tier 2 would not

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

I believe that the wording of the PM would benefit from including scholarly contributions "i.e. the percentage

For Tier 2, the wording "with grant support" needs to be clarified, or preferably deleted. Most products for

Since the PM relates to meeting aims at the "end of the current grant cycle," 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 LEAH program that receive more funding), these boxes should be a checkboxes for "Yes/No" (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 "Train MCH/CSHCN staff, providers, faculty and trainees" 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 "Measurement of Progress" to have parallel titles.

On page 71, should the text in item 3, last bullet say "accommodated legislation for the benefit of MCH populations" rather than "MCH related legislation"? 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 "2 or more races" prevents To keep the time spent in data collection and entry for projects sustainable, I would favor "Yes/No" 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 I

I am worried that this measure by adding "activities" will significantly increase time spent by grantees in

The trainee grads answering this survey often do not understand the meaning of "MCH populations" so the For #6 I would add, "communicating research findings, program development, QI, qualitative studies and focus groups, etc." and delete "(both original and non-original)".

or people reached" in CD 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 "check all that apply."

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 "training" 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 or 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 activity that can be achieved by MSGRC. "Genetics technical assistance" should be 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 MSGRC's engagement of consumer advocates and our involvement 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 Tier 3 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 "culturally and linguistically appropriate evidence-based tool."

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.

outcome to measure in ensuring that children 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 New Hampshire's 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 "Tier 2: To whom are you providing TA?" missing from the list are "program participants/the publ

Under "Tier 2: QI Initiative," we encourage the inclusion of a question that asks whether grantees are engaged in 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.

health outcomes for MCH populations and gives grantees and MCH a more complete understanding of the population they serve" 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.

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.

populations such as adolescent survivors, immigrants and refugees, incarcerated men & women, persons who use drugs, pregnant women, veterans, etc." (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 "vulnerable populations" in order to ensure gaps in equity are truly met.

that consumers of health care services do "children and families do" 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.

Other comments

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 "Other."

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 & family member/youth/community member participation). The use of adult 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 "List B" 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. If 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 program 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 their

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 additional

Child Health 3 (Developmental Screening): Tiers 1 and 2 of this measure could be considered for LEND training programs. The additional 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 4 "Percent of premature infants (less than 37 weeks) who are not children by including a critical provision to ensure that children enrolled in an 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 "annual screenings" 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 numerator 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 □.

receiv receiving tracking and monitoring□.

- 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?

- 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. Depres
-- Percent of program participants aged 9 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 4- 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 "organizational" 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 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 "Infrastructure Building" category on Form 4. Many projects that d
quality improvement initiatives. _x000D_
3. Tier 4- define "CSHCN leaders" and explain the types of community/state/national level teams 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, and I believe registration for 00,100,2107 today, November 9, 2019 references an estimated 41 hours 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 newbr

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

On page 21 regarding Family Engagement: Tier 4: numerator: What does "meaningful" 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." We sugg

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

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 "Writing 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 "Children's Hospitals" as ;

On page 150, where the terms "Direct Health Care, Enabling Services and Population Based Services" 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 expert as followup.

Consistent with Healthy Start Benchmark #12

NOTE: EPIC is checking to see if questions included in screening tool constitute a "validated" 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

A list of validated IPV screening tools is included in the Data Dictionary as a reference.

Consistent with Healthy Start Benchmark #15

--- Comments

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

Consistent with Healthy Start Benchmark #1

having or not having a miscarriage suggests that it would not be applicable for a woman who enrolled pregnant. However, in the event of an early pregnancy, wouldn't you still want to evaluate the participant'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 "Postpartum visit is approximately 4-6 weeks after delivery." 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: DT, ED and MCH measure require annual well woman/preventive visit.

Consistent with Healthy Start Benchmark #5

incl.

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

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

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. 16). 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. 6) 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.

Direct service
added to Tiers
2 and 3
connected to
Form 7
received in
individual
comments.

Change/ addition to wording

Addressed in other similar or identical comment.

No resolution
needed

No changes necessary

No resolution
needed.

No changes necessary

Prevention is
duplicated in
the list on page

41

"Grammar/ spelling/ error issue, now fixed"

when we
assign
measures later
this year.

"Relates to ability to report, and should be taken into consideration when assigning measures fu

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.

adding to the
scholarly body
of work from
the catchall of
products.

Change/ addition to wording

No changes necessary

No resolution
needed

No changes necessary

No resolution
needed

No changes necessary

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 necessary

No resolution
needed No changes necessary

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 necessary

Benchmarks
revised. Change/ addition to wording

category
categories will
not be revised
for this
measure. No changes necessary

information on
more intensive
technical
assistance
activities. No changes necessary

Significance
language has
been modified
slightly. Change/ addition to wording, Definition added

No resolution
needed No changes necessary

No resolution
needed No changes necessary
recertification/r
e-licensure.

consideration
when we
assign
measures later
this year. Change/ addition to wording, Definition added

"Relates to ability to report, and should be taken into consideration when assigning measures fu

because data system will autopopulate wherever possible. No changes necessary

that it is not burdensome to use that information in two ways. No changes necessary

that it is not burdensome to use that information in two ways. No changes necessary

be assigned to those programs they are not applicable to. No changes necessary

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. "PROJECT ABSTRACT" No changes necessary

"Grammar/ spelling/ error issue, now fixed"

addition to the form for topics related to Autism CARES legislation variables, pediatric patients are included Change/ addition to wording

Growing Pains (2006). Change/ addition to wording, Definition added

recertification/ e-licensure. Change/ addition to wording, Definition added

variables, pediatric patients are included Change/ addition to wording, Definition added

Change/ addition to wording, Definition added

Showing
Painsâ€œ²
(2006).
x000D

Change/ addition to wording, Definition added

recertification/r
e-licensure.

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

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

Change/ addition to wording

current or past.
categories will
not be revised
for this
measure.

No changes necessary

does not plan
to expand 10-
year follow-up
data collection.

No changes necessary

No resolution
needed

No changes necessary

Grantee-
specific for
now.

No changes necessary

Definition will
be added.

Definition added

The intention
of these
measures
not required to
quantify
outcomes on
an individual
level.

Change/ addition to wording

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 necessary

No change needed. No changes necessary
will not be done through this system.

No changes necessary

Refer to MCHIE project officer guidances for #trained and #educated. No changes necessary
MCHIE does not plan to expand 10-year follow-up data collection. No changes necessary

No resolution needed. No changes necessary
MCHIE does not plan to expand 10-year follow-up data collection. No changes necessary

MCHIE does not plan to expand 10-year follow-up data collection. No changes necessary
separate categories.

Change/ addition to wording

Yes.

Change/ addition to wording
will not be added here, as it would add additional burden, not how many people are reached by it. No changes necessary

No changes necessary

This should be captured in the third bullet-- orgs should be all orgs.
data on primary CSHCN leaders_x000D

No changes necessary

— medical home can be captured in Tier 1 of this measure coverage purchased through the Health Care Marketplace." Definition added

Definition added

Definition added

Add Tracking and Monitoring as it's own row in Tier 2. variables, pediatric patients are included

Change/ addition to wording

Change/ addition to wording, Definition added

Growing Painsâ€ (2006). _x000D_ or recertification/r e-licensure.

Change/ addition to wording, Definition added

variables, pediatric patients are included

Change/ addition to wording, Definition added

Growing Painsâ€ (2006). _x000D_ or recertification/r e-licensure.

Change/ addition to wording, Definition added

Change/ addition to wording, Definition added

that this is confusing, no specific resolution needed.

Change/ addition to wording, Definition added

No changes necessary

when we assign measures later this year. "Relates to ability to report, and should be taken into consideration when assigning measures f

LMSC
 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 Change/ addition to wording, Relates to ability to report, and
 be assigned to should be taken into consideration when assigning
 all grantees. measures further down the road.
 made by
 University of
 Alabama at
 Birmingham
 PPC. No changes necessary
 have been
 made. An
 Other category
 has been
 added. Change/ addition to wording
 present a more
 detailed picture
 of former
 trainee
 outcomes. No changes necessary
 variables. This
 has been
 clarified in the
 Training 13
 measure. Change/ addition to wording
 what the
 anticipated
 burden on
 each specific
 grantee. "Relates to ability to report, and should be taken into consideration when assigning measures fu
 and you will
 special health
 care needs?
 x000D
 Change/ addition to wording, Definition added

 No CSHCN-
 specific
 resolution is
 needed. No changes necessary
 associated with
 community-
 based
 organizations.â
 €
 included in EC
 measure
 tables. Change/ addition to wording, Definition added

 no training or
 CSHCN-
 specific
 resolution is
 needed. No changes necessary
 variables,
 pediatric
 patients are
 included

 Change/ addition to wording, Definition added

growing
Painsâ€œ
(2006).
x000D

Change/ addition to wording, Definition added

recertification/
e-licensure.

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

Same as
above.

No changes necessary

Yes.

Change/ addition to wording

for impact
measurement--
tie to logic
model--

Jamelle Banks Definition added

Same as
comment 166

Addressed in other similar or identical comment.

recommendati
on will not be
implemented
at this time.

No changes necessary

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'.
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 f

variables, pediatric patients are included	Change/ addition to wording,Definition added
growing Painsâ€œ (2006). _x000D_	Change/ addition to wording,Definition added
recertification/r e-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 necessary
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	
comment is about Table 1, not Core 2. Addressed elsewhere	Change/ addition to wording
students/trainee es to Box 5 as suggested_x00	Definition added
OD_	Change/ addition to wording,"Grammar/ spelling/ error issue, now fixed"

No resolution needed that it is consistent across the measure with the DMCHWD performance measure workgroup. Recommendation on adopted, change made on Training 13 detail sheet. Not an action of measures will be assigned to all grantees.

No changes necessary

Change/ addition to wording

No changes necessary

Change/ addition to wording, "Grammar/ spelling/ error issue, now fixed"

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

Showing
Painsâ€œ[□]
(2006).
x000D

Change/ addition to wording,Definition added

recertification/r
e-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

Violence" as
this includes
dating
violence.

Change/ addition to wording

Fix Heading
Under Tier 2.

Definition added,"Grammar/ spelling/ error issue, now fixed"

Comment
relates to
ability to
report.

No changes necessary

ES, 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.
MCHD funded,
then yes.

Change/ addition to wording

Use this for CB
5 as well.

Change/ addition to wording,Definition added

achievement of
aims across
programs.

No changes necessary

Check all that
apply has been
added.
is based on
grantee-
specific goals.

Change/ addition to wording

No changes necessary

consideration
when we
assign
measures later
this year.

"Relates to ability to report, and should be taken into consideration when assigning measures fu

the measure is
around race
and ethnicity.

No revisions
will be made.

No changes necessary

revised
language

around

educating

policymakers.

Change/ addition to wording, Definition added

Community

categories will

not be revised

for this

measure.

No changes necessary

guidelines will be

provided by

Project

Officers.

Definition added

workgroup and

will not be

revised at this

time.

No changes necessary

Activities

column has

been deleted.

Change/ addition to wording

nature of

coding

qualitative,

open-ended

questions.

No changes necessary

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

Validated
would include
this. No changes necessary

across the
board, it is not
reasonable to
apply to just
this. No changes necessary

programs
funded for this
type of work to
justify this
suggestion. No changes necessary

noted but will
not include the
suggested
outcome at this
time. No changes necessary

Sourcesâ€”
section of this
performance
measure Change/ addition to wording

participants are
public.â€” -- it
is referenced
elsewhere in
the measure. Change/ addition to wording

recommendati
on will not be
implemented
at this time. No changes necessary

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 necessary

around race
and ethnicity.
No revisions
will be made at
this time. No changes necessary

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 necessary
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 necessary

conducted by project officers upon assigning measures, as necessary. No changes necessary

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 necessary

added to the form for topics related to Autism CARES legislation Change/ addition to wording

erroneous for DMCHWD programs.

No changes necessary

individual
project
objectives.

systems
improvement --
Call it Cross
Sectorial
Collaboration No changes necessary
Change/ addition to wording

No resolution
needed. No changes necessary
Duplication will
not be an issue
because data
system will
autofill. No changes necessary

This comment
relates to
ability to
report. No changes necessary

autopopulate,
therefore not
creating
duplication No changes necessary
consideration
when we
assign

measures later
this year. No changes necessary
consideration
when we
assign
measures later
this year. No changes necessary
consideration

when we
assign
measures later
this year. "Relates to ability to report, and should be taken into consideration when assigning measures fu

responds no,
then the PO
needs to follow
up on that. No changes necessary

while the idea
is good, this is
not reasonable
for anyone to
report. No changes necessary
report 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. provided when measures are assigned.

Definition added

Directors will provide technical assistance to grant tracking and monitoring refers to tracking and monitoring technical assistance to grantees regarding the performance measures

Change/ addition to wording, Definition added

Change/ addition to wording, Definition added, "Relates to ability to report, and should be taken into consideration when assigning measures further down the road."

two resource centers have a cooperative relationship. primary adolescents served, with a place to report age range.

Change/ addition to wording, Definition added

No changes necessary

valuable in the bigger picture, so not added at this time. categories to clarify where 'families' would be included, etc.

"Relates to ability to report, and should be taken into consideration when assigning measures fu

Change/ addition to wording

"Relates to ability to report, and should be taken into consideration when assigning measures fu

Definition added

Need definition for Case Report. Measure for this.

Definition added

not how many people are reached by it.

Change/ addition to wording

ensure that this measure reflects their up-to-date objectives.

No changes necessary

"Relates to ability to report, and should be taken into consideration when assigning measures fu

guidance and examples when assigning measures. include Healthy Tomorrows grantees	Change/ addition to wording,"Relates to ability to report, and should be taken into consideration
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
Source of care, and definition has been added.	Definition added,Change/ addition to wording
when we assign measures later this year.	"Relates to ability to report, and should be taken into consideration when assigning measures fu
measures are assigned.	
common definitions for the fields in Table 1.	Change/ addition to wording
as: Assessing youth's trans	No changes necessary
challenge defining the quality of well child visit measure.	Definition added
made in order to keep consistent with HS benchmarks.	No changes necessary
add NPM 6 as Grantee data source	Definition added
should also be listed under "Grantee Data Sources."	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. Change/ addition to wording
these are current definition that the bureau is using.

Change/ addition to wording
I'm, which would be very challenging to accurately quantify.

Definition added
No metrics are necessary, just dissemination methods, res. move

Capacity Measures to the front as well. Change/ addition to wording

performance measure workgroup. No changes are planned No changes necessary

No Resolution necessary. No changes necessary

be added as an optional organization type for item B1b. Change/ addition to wording

added to the definitions in MCH Block Grant guidance. 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

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

definitions and
3Ps
reconciliation.

through
CSHCN, and
this is included
in block grant
reporting. Change/ addition to wording, Definition added

through
CSHCN, and
this is included
in block grant
reporting. No changes necessary

through
CSHCN, and
this is included
in block grant
reporting. No changes necessary

through
CSHCN, and
this is included
in block grant
reporting. No changes necessary

urther down the road."

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when assigning measures further down the road."

when assigning measures further down the road."

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when assigning measures further down the road."

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