Supporting Statement A

Maternal, Infant, and Early Childhood Home Visiting Program Performance Measurement Information System

OMB Control No. 0906-0017-Revision

Terms of Clearance: None

A. Justification

1. Circumstances Making the Collection of Information Necessary

The Health Resources and Services Administration (HRSA) is requesting the Office of Management and Budget (OMB) to review and approve revisions to the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Performance Measurement Information System.

The MIECHV Program is designed to support voluntary, evidence-based home visiting services during pregnancy and to parents with young children up to kindergarten entry. States, territories, and certain non-profit entities are eligible to receive funding from the MIECHV Program and have the flexibility to tailor the program to serve the specific needs of their communities.

Section 511 of the Social Security Act (42 U.S.C. 701), as amended by the Bipartisan Budget Act of 2018 requires that MIECHV Program awardees collect data to measure improvements for eligible families in six specified benchmark areas that encompass the major goals of the program. These areas are:

1) Improved maternal and newborn health
2) Prevention of child injuries, child abuse, neglect, and maltreatment, and reduction in emergency department visits
3) Improvement in school readiness and achievement
4) Reduction in crime and domestic violence
5) Improvement in family economic self-sufficiency
6) Improvement in the coordination and referrals for other community resources and supports

Awardees were required by law to demonstrate improvement in at least four of the

six benchmark areas after the third year in which an entity conducted the program. This assessment occurred following the Fiscal Year (FY) 2014 data collection and reporting period for 53 state and territory awardees and following FY 2015 for the three non-profit awardees. The Bipartisan Budget Act of 2018 amended the original statute to require ongoing assessments of improvement to occur beginning after FY 2020 and every three years thereafter. If improvements are not demonstrated after each assessment, awardees are required to complete a Corrective Action Plan in order to improve outcomes in the benchmark areas.

In addition to providing data on these six benchmark areas, MIECHV Program awardees are required to submit annual reports that summarize the demographic, service utilization, and other administrative data related to program implementation. This package seeks to revise the current annual performance data collected by awardees beginning on October 1, 2018 with annual performance reports aligning with the federal fiscal year.

In order to continuously monitor and provide grants oversight, quality improvement guidance, and technical assistance to MIECHV Program awardees, as well comply with statutory requirements for benchmark performance reporting and administrative requirements under the Government Performance and Results Act (GPRA), HRSA is seeking to revise the current MIECHV Program Performance Measurement Information System.

2. Purpose and Use of Information Collection

HRSA will use the proposed information to demonstrate program accountability and annually monitor and provide oversight to MIECHV Program awardees. The information will also be used to provide quality improvement guidance and technical assistance to awardees and help inform the development of early childhood systems at the national, state, and local level. HRSA is seeking to collect demographic, service utilization, and select clinical indicators for participants enrolled in home visiting services. In addition, HRSA is seeking to collect a set of standardized performance indicators and systems outcome measures that correspond with the statutorily defined benchmark areas.

HRSA is seeking revisions for the two forms that are used to collect annual performance data from MIECHV Program awardees:

Form 1 – Demographic, Service Utilization, and Clinical Indicator Data (Attachment A): This section is made up of three categories of data – participant demographics, program service utilization, and insurance and clinical indicators. This form is used by MIECHV Program awardees to report data from program participants when they enroll in home visiting services. This data is used to describe the populations served by MIECHV Program awardees, nationally and at the state level, and to monitor awardee performance on key indicators, such as family engagement and retention,

alignment with statutorily defined priority populations, coordination with medical and dental services in the community, and coordination with other community resources. Data collected through Form 1 is also used to determine key program outputs, as defined in the MIECHV Program GPRA measures and reported to Congress annually in the HHS Congressional Justification.

Form 1 data are reported to HRSA in the aggregate at the state/territory level. No individual or family-level data is collected. Collecting state/territory level demographic and service utilization data ensures an appropriate data collection and reporting burden for MIECHV Program awardees.

In general, propsed revisions seek to correct technical errors in the original forms and add more specificity and instruction for the identification and reporting of missing data. These revisions will improve HRSA's ability to identify and monitor data quality issues and provide targeted technical assistance to MIECHV awardees with high levels or repeated issues with data quality. In addition, HRSA seeks to extend clearance for these revised forms through November 30, 2021 in order to ensure proper authority to collect this information through the next three annual reporting periods.

Specific proposed revisions and corresponding rationales to Form 1 are as follows (Additional details can be found on the revised form submitted as Attachment A to this package):

1) Update Tables 4-14, 16, and 18-20 to include specific guidance to account for and report missing data. These additional instructions require awardees who report more than 10% of data in an "Unknown/Did Not Report" field on any table to provide a description in the "Notes" field addressing the reason for missing data and plans to reduce the amount of missing data in future reporting periods. This additional guidance will assist HRSA in monitoring data quality and providing targeted technical assistance to MIECHV awardees with high rates of missing data.
2) Update Table 1 title to read "Unduplicated Count of New and Continuing Program Participants Served by MIECHV." This update aligns the table name with current reporting definitions.
3) Update Table 2 title to read "Unduplicated Count of Households Served by MIECHV." This update aligns the table name with current reporting definitions.
4) Update Table 5 to reflect the following categories: "<1 year"; "1-2 years"; "3-4 years"; "5-6 years"; and "Unknown/Did Not Report." This update corrects the previous children's age categories to ensure they are mutually exclusive.
5) Update Table 8 to revise the "Never Married" category to read "Never Married (excluding not married but living together with partner)." This update ensures that the Table 8 categories are mutually exclusive.
6) Delete Table 10: Adult Participants by Educational Status. In an effort to reduce data collection and reporting burden we have proposed deleting this table.

7) Delete Table 18: Unduplicated Count of Home Visitor Full Time Equivalents. In an effort to reduce data collection and reporting burden we have proposed deleting this table.
8) Revise Table 22 to only include children greater than or equal to 12 months of age and update the title to read "Index Children (≥12 months of age) by Usual Source of Dental Care." This revision aligns data reporting for this table with the American Academy of Pediatric Dentistry best practices which indicate that children should have a dental home on or before reaching 12 months of age.[1]
9) Update Form 1 to include Table-specific "Notes." Including the ability to awardees to provide explanations of data at the table-level will improve HRSA's ability to review and ensure high-quality performance report submissions and allow awardees to address data quality issues at a more granular level. Previously there was one "Notes" section for the entire form.
10) Update "Definitions of Key Terms" for the Tables 1, 3, 5, 12, 13, 15, 20, 21, and 22. These updates align definitions with current reporting definitions.

Form 2 – Benchmark Performance Measures (Attachment B): This section collects data on a discreet set of performance indicators and systems outcome measures that correspond with statutorily defined benchmark areas and are standardized for all MIECHV Program awardees. These measures require awardees to collect information from program participants on key indicators, as outlined in the specification of each measure. These data have two purposes:

A) To describe and monitor the performance of awardees, target technical assistance resources to awardees in areas where there are opportunities for performance improvement, assist awardees in developing required continuous quality improvement (CQI) and technical assistance plans, and to demonstrate program performance accountability through statutorily required assessments of improvement. Awardee performance on these indicators may be used as one determinant in future funding formulas.

B) To describe and monitor systems-level change at the state-level (not solely attributed to home visiting interventions), target technical assistance to state-level early childhood systems building and coordination efforts of MIECHV Program awardees, and compare the outcomes of home visiting service populations with appropriate comparison populations using available state or nationally representative data sources.

Specific proposed revisions and corresponding rationales to Form 2 are as follows (Additional details can be found on the revised forms submitted as attachments to this package):

1) Update all measures (1-19) to include specific guidance to account for missing

1 http://www.aapd.org/media/Policies_Guidelines/D_DentalHome1.pdf

data and include a data collection field to report the amount of missing data. This revision will require awardees to quantify the amount of missing data excluded from each measure and will provide measure-specific instruction for defining missing data. This will assist HRSA in monitoring data quality and providing targeted technical assistance to MIECHV awardees with high rates of missing data.

2) Update Measure 3: Depression Screening to include additional inclusion criteria in the denominator. This update aligns the specification of the denominator with the broader measure and ensure that all eligible primary caregivers are included, as appropriate.
3) Update Measure 7: Safe Sleep to include additional detail in the numerator. This update aligns the specification of the numerator with the broader measure.
4) Update Measure 8: Emergency Department Visits to clarify that nonfatal injury-related visits to the Emergency Department must have occurred within the reporting period in order to be included in the numerator. This update will ensure that data are time specified and will allow for discreet measurement within each annual reporting period.
5) Update Measure 9: Child Maltreatment to clarify that investigated cases of child maltreatment must have occurred within the reporting period in order to be included in the numerator. This update will ensure that data are time specified and will allow for discreet measurement within each annual reporting period.
6) Update Measure 13: Behavioral Concerns to include additional inclusion criteria to the numerator and denominator indicating that only postnatal home visits should be included. This update aligns the specification with the conceptual purposes of this measure, which is to report only on home visits among primary caregivers with children (as opposed to prenatal home visits).
7) Update Measure 14: Intimate Partner Violence (IPV) Screening to add a screening timeframe to the specification of the performance measure. This addition aligns the measure with the specification of the numerator and further clarifies that IPV screenings must be conducted within 6 months of enrollment in order to be included in the numerator.
8) Update Measure 15: Primary Caregiver Education to add primary caregivers enrolled in middle school to the specification of the numerator. This update aligns the measure with all possible ages of primary caregivers enrolled in home visiting programs.
9) Update Measure 17: Completed Depression Referrals to include additional inclusion criteria in the denominator. This update aligns the specification with Measure 3 to ensure all primary caregivers are included, as appropriate.
10) Update Measure 19: IPV Referrals to add the screening timeframe to the specification of the denominator. This update aligns the specification with Measure 14 to further clarify that IPV screenings must be conducted within 6 months in order to be included in the denominator.

Additional revisions were proposed in the 60-day Federal Register Notice (Attachment E) and were ultimately dropped in response to public comment. A

summary of all original proposed changes and HRSA's responses can be found in Attachments C and D.

Forms 1 and 2 are not linked for the purposes of description or analysis. While HRSA acknowledges the analytic benefits to linking participant demographic, service utilization, and benchmark outcomes, we feel that the associated burden for awardees is not appropriate for the purposes of performance measurement. HRSA is engaged in a broad range of descriptive and outcomes research beyond the performance data described here, including the Mother and Infant Home Visiting Program Evaluation (MIHOPE) study, which will link participant information with program outcomes. In the future, HRSA plans to continue to engaging in evaluation and research which will expand our knowledge of the interaction between participant characteristics and program outcomes.

The objective for this data collection activity is to provide HRSA with annual updates on demographic, service utilization, and benchmark data. HRSA uses this information to describe and report the performance of the program at a national and state level, assist in grants monitoring and oversight activities, to target technical assistance resources to underperforming awardees, and to reward high performance through future funding opportunities. Performance data is also used to summarize demographic, service utilization, and performance indicators in public and academic settings, such as conference presentations or peer-reviewed publications.

3. Use of Improved Information Technology and Burden Reduction

Improved information technology is utilized where appropriate. Awardees collect information from home visiting participants using their own established methods. Awardees aggregate and report this information to HRSA using the Home Visiting Information System (HVIS), a Bureau Reporting System within HRSA's Electronic Handbooks grants management application. The system is an electronic reporting tool used by MIECHV Program awardees for annual and quarterly performance reporting, and allows for the appropriate storage, extraction, and records management of performance data by federal staff.

4. Efforts to Identify Duplication and Use of Similar Information

The information collected through this request is not available from another source. Only MIECHV Program awardees can supply the requested information. This information collection request seeks to revise and extend the current MIECHV Program Performance Measurement Information System.

5. Impact on Small Businesses or Other Small Entities

Information will be collected from individuals participating in home visiting programs by staff at Local Implementing Agencies. Local Implementing Agencies are contracted by the state, territorial, or non-profit awardee to provide home visiting

services and may be small businesses. Because information collection may involve small businesses, the information being requested has been held to the absolute minimum necessary for the intended use of the data and to demonstrate programmatically important outputs and outcomes.

6. Consequences of Collecting the Information Less Frequently

The information collected through this request is reported on an annual basis. The intended use of this information is to assist HRSA in describing and reporting program performance, monitoring and grants oversight activities, and to target technical assistance resources more efficiently. This information is required to demonstrate awardee performance related to the statutorily defined benchmark areas and to comply with GPRA reporting requirements.

There are no legal obstacles to reduce the burden.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

The request fully complies with the regulation.

8. Comments in Response to the Federal Register Notice/Outside Consultation

Section 8A:

A 60-day Federal Register Notice was published in the *Federal Register* on February 9, 2018, vol. 83, No. 28; pp. 5791-5793 (see Attachment E). HRSA received comments from 20 individuals/organizations providing feedback on the proposed revisions. The feedback was reviewed and synthesized. HRSA has provided summaries of comments and actions taken to address public comments in Attachment C (Form 1 comments) and Attachment D (Form 2 comments).

In general, public commenters were supportive of HRSA's efforts to make technical corrections to forms and provide more detailed instructions on identifying and reporting missing data. Several commenters requested more specificity and rationale related to measure definitions, including definitions of key terms.

Additional revisions were initially proposed in the 60-day Federal Register Notice and were ultimately dropped in response to public comment. Commenters generally urged against proposed revisions to substantively change reporting definitions for several measures (Measure 4: Well Child Visits; Measure 10: Parent-Child Interaction, and; Measure 16: Continuity of Insurance Coverage). HRSA initially proposed these revisions as ways to improve either the conceptual clarity of the measure or improve overall operationalization of the measure. However, the field's strong preference is to not substantively change measures at this time and ensure consistency.

HRSA agrees with these comments for several reasons. First, new authority included in the Bipartisan Budget Act of 2018 amends the MIECHV statute to require

ongoing assessments of improvement in relation to the six benchmark areas, which HRSA as operationalized as the 19 measures on Form 2. This amendment was enacted after HRSA first proposed these revisions. Future assessments of improvement will require consistency of performance data over time beginning in FY 2018. This consideration was not as immediate a concern prior to the new requirement for ongoing assessment of improvement. At this time, HRSA believes data consistency to ensure appropriate and meaningful baseline and comparison data for this purpose outweighs the benefits gained from improvements to conceptual clarity or operationalization.

Second, HRSA is sensitive to the burden on MIECHV awardees, other stakeholders, and the public that repeated changes to required reporting requirements can cause. HRSA introduced the new MIECHV annual performance reporting system in FY 2017 and many awardees and other stakeholders who support MIECHV data collection and reporting did not complete their transitions to the new measures until fairly recently. At this time, the feedback HRSA has received is to limit changes to this requirement to regular cycles and can be anticipated and planned for by pertinent stakeholders. As such, HRSA is only seeking relatively minor technical corrections and additions at this time and will pursue more substantive changes, in consultation with our broader stakeholder community for future reporting periods.

Section 8B:

HRSA held multiple discussions with stakeholders to develop and review the proposed revisions included in this request. Examples of stakeholder discussions include with the Association of State and Tribal Home Visiting Initiatives (ASTHVI) Data Committee, which represents MIECHV Program awardees, and with the Home Visiting Model Alliance, which represents developers of evidence-based home visiting models approved for use under the MIECHV Program.

HRSA also worked collaboratively with federal partners to define the requirements for this revision to our information collection request. A number of federal staff from multiple agencies with HHS were consulted during the development. The following public stakeholders were consulted to provide feedback on the clarity and estimated overall annual burden of the data collection instrument.

Specific representatives of these groups who were consulted are listed below:

Angela Miller, PhD, MSPH
Co-Chair, ASTHVI Data Committee
Epidemiologist 2
Division of Family Health and Wellness
Tennessee Department of Health
Angela.m.miller@tn.gov

615-253-2655

Leslie Schwartz
Co-Chair, ASTHVI Data Committee
Program Director/Manager of Program Evaluation
Illinois Governor's Office of Early Childhood Development
Lesley.schwartz@illinois.gov
312-814-6379

Kerry Caverly
Vice President, Program Implementation and Support
Parents as Teachers
Kerry.Caverly@parentsasteachers.org
301-432-4330

9. Explanation of any Payment/Gift to Respondents

Respondents will not receive any payments or gifts.

10. Assurance of Confidentiality Provided to Respondents

No personally identifiable information (PII) is being collected through this information collection request. All data will be reported in aggregate by the awardee. This project does not require IRB approval.

11. Justification for Sensitive Questions

Several demographic questions related to race/ethnicity, household income, educational attainment, or housing status may be considered sensitive to some home visiting participants.

Performance indicators and systems outcomes measures related to the presence of interpersonal violence, child injury or maltreatment, and tobacco use may be considered sensitive to some home visiting participants.

However, these questions are vitally important to understanding the needs of the at-risk and statutorily defined priority populations served by the MIECHV Program. Home visiting programs are uniquely qualified to serve these populations and assist families with overcoming challenges related to these sensitive questions. Home visitors are trained to assess family readiness to open up about sensitive topics and programs and supervisors are required to engage in reflective supervision with home visitors to assist in the processing of challenging information. HRSA has the utmost confidence that home visitors funded through this program will approach these topics with sensitivity and care, in fidelity to the evidence-based home visiting model they are implementing.

12. Estimates of Annualized Hour and Cost Burden

12A. Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. of Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
MIECHV Program Awardees	Form 1: Demographic, Service Utilization, and Select Clinical Indicators	56	1	560	31,360
MIECHV Program Awardees	Form 2: Performance Indicators and Systems Outcome Measures	56	1	200	11,200
Total		56		760	**42,560**

12B.

Estimated Annualized Burden Costs

Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Home Visiting Program	42,560	$30.82[2]	$1,311,699

2 Wages for MIECHV data collection and entry staff are based on the 2017 Bureau of Labor Statistics data for the median hourly wage for Social and Community Service Managers.

Grantees			

13. Estimates of other Total Annual Cost Burden to Respondents or Recordkeepers/Capital Costs

Other than their time, there is no cost to home visiting program participants. MIECHV Program awardees devote time and resources to the development and/or update of management information systems used to collect, aggregate, and report performance data in order to align with the information requested under this request. HRSA will provide technical assistance to awardees in order to promote efficiencies in this development work. Additionally, HRSA has exempted awardee costs related to these updates from the programmatic ceiling for infrastructure costs. Awardees may use grant funds to pay for these developments/updates.

14. Annualized Cost to Federal Government

Costs to the federal government fall into the following categories:

- Cost of developing and maintaining the reporting system
- Cost of federal staff time for project oversight and development
- Cost of federal staff time for technical assistance and review and approval of annual performance reports
- Cost of contractual support for data cleaning and analysis

Type of Cost	Description of Services	Annual Cost
HVIS Development – Contracted	Development and maintenance of the electronic reporting system for annual data collection	$300,000
Government Social Science Analyst (100%)	Project management and oversight, consultation, and development	$103,435
Government Project Officers (10%)	10 regional project officers provide TA to awardees and review and approve annual reports	$104,416
Total Estimated Annual Cost		$507,851

HRSA estimates the average annual cost for the federal government will include personnel costs for project and contract oversight, instrument design, and analysis.

This will include federal program analyst at Grade 13 Step 3 ($49.73 hourly rate) for 2080 hours.

Government costs will also include personnel costs for providing technical assistance to awardees and time for federal project officers to review and approval annual reports. These tasks will be completed by 10 federal project officers at Grade 13 Step 5 ($50.20 hourly rate) for 208 hours each, or a total annual level of effort of 2080 hours.

The total annual cost to the Federal Government for this requirement is estimated at $507,851.

15. Explanation for Program Changes or Adjustments

The current burden inventory for this information collection request is 47,600 hours with this revision requesting 42,560 hours. The proposed decrease is due to the proposed revisions.

16. Plans for Tabulation, Publication, and Project Time Schedule

Aggregation and descriptive statistics on annual demographic and service utilization data are conducted in order to summarize the performance of awardees, as well as the MIECHV Program as a whole. This summary information may be made public through data briefs, fact sheets, professional presentations, and/or published manuscripts.

Time series comparisons of performance indicators and systems outcome benchmark performance data will be conducted for awardees. Performance values will be compared to baseline values in order to determine whether each awardee has made improvement in each benchmark construct. Where appropriate and applicable, performance data will be compared to state or national representative data sources. Summary benchmark performance data may be made public through data briefs, fact sheets, professional presentations, and/or published manuscripts.

HRSA is requesting a two and a half year clearance extension beyond the original expiration date of 3/31/2019 for this data collection activity.

Project Timeline

Activity	**Time Schedule**
Distribute revised data collection forms and instructions to MIECHV Program awardees	Immediately following OMB approval
Annual Reporting Period begins	October 1, 2018
Annual Reporting Period ends	September 30, 2019
Annual Performance Report due	October 30, 2019
Data collection and reporting will continue on an annual schedule throughout the	

OMB approved clearance timeframe.

17. Reason(s) Display of OMB Expiration Date is Inappropriate

The OMB number and expiration date will be displayed on every page of every form/instrument.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.