

**Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Advancing Health Equity in  
Response to the COVID-19 Public Health Emergency**

**Supporting Statement**

Table of Contents

Contents

A. Justification..... 3

    A.1 Circumstances Making the Collection of Information Necessary..... 3

    A.2 Purposes and Use of the Information Collection..... 3

    A.3 Use of Information Technology and Burden Reduction..... 7

    A.4 Efforts to Identify Duplication and Use of Similar Information..... 7

    A.5 Impact on Small Businesses or Other Small Entities..... 7

    A.6 Consequences of Collecting the Information Less Frequently..... 8

    A.7 Special Circumstances Relating to the Guidelines of 5 CFR1320.5..... 8

    A.8 Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency. 8

    A.9 Explanation of Any Payment or Gift to Respondents..... 9

    A.10 Assurance of Confidentiality Provided to Respondents..... 11

    A.11 Justification for Sensitive Questions..... 11

    A.12 Estimates of Annualized Burden Hours and Costs to Respondents..... 12

        A.12.1 Estimated Annualized Burden Hours..... 12

        A.12.2 Estimated Annualized Cost to Respondents..... 13

    A.13 Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers..... 15

    A.14 Annualized Cost to the Federal Government..... 15

    A.15 Explanation for Program Changes or Adjustments..... 15

    A.16 Plans for Tabulation and Publication and Project Time Schedule..... 15

    A.17 Reason(s) Display of OMB Expiration Date Is Inappropriate..... 16

    A.18 Exceptions to Certification for Paperwork Reduction Act Submissions..... 16

B. Collections of Information Employing Statistical Methods..... 16

    B.1 Sampling..... 16

    B.2 Procedures for Collection of Information..... 17

    B3. Methods to Maximize Response Rates..... 18

    B4. Pre-testing of Procedures and Methods..... 18

    B5. Consultants on Statistical Aspects of the Design..... 20

Appendices

- Appendix A. 60-Day Notice for Public Comments
- Appendix B. Public Comments
- Appendix C. IRB Approval Letter

## A. Justification

### A.1 Circumstances Making the Collection of Information Necessary

This is a new Information Collection Request (ICR). The Health Resources and Services Administration (HRSA) requests Office of Management and Budget (OMB) approval to initiate data collection for the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Advancing Health Equity in Response to the COVID-19 Public Health Emergency project.

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program: Advancing Health Equity in Response to the COVID-19 Public Health Emergency project aims to understand how health equity has been advanced during the COVID-19 public health emergency in communities with MIECHV-funded home visiting programs. The MIECHV Program makes grants to states, jurisdictions, and tribal communities, which then have flexibility to develop, implement, and tailor their home visiting programs based on community needs, capacity, and resources within the parameters of statutory and programmatic requirements. In fiscal year 2021, MIECHV awarded about \$342 million in funding to programs that served 140,000 parents and children and provided over 920,000 home visits across all 50 states, the District of Columbia, and five U.S. territories.<sup>1,2</sup> In addition, in calendar year 2021, HRSA issued approximately \$122 million in emergency COVID-19 relief funding appropriated through the American Rescue Plan to MIECHV awardees to address the immediate and ongoing needs of low-resourced families participating in home visiting services.

HRSA provide grants to state awardees, who are generally state departments of health, public health, or early childhood. State awardees, in turn, contract with local implementing agencies (LIAs) to provide home visiting services in the community. This LIA and community level will be the unit of analysis for each of the case studies to be conducted for this project. Five communities from across the United States will be selected based on a county level assessment from the County Response Index to Support Equity in Home Visiting (County RISE-HV), the variation in COVID-19 patterns including data indicating disproportionality in experiences of COVID-19, and the existence of MIECHV-funded local implementing agencies. The County RISE-HV is an index created for this project using data from national data sources such as the American Community Survey, the Current Population Survey, the County Health Rankings, the CDC Wide-ranging Online Data for Epidemiologic Research, and the Civil Rights Data Collection. The index includes social determinants of health indicators that were present in counties before the COVID-19 pandemic, with particular attention to those most relevant to home visiting-related outcomes. The five communities will represent a mix of urban and rural counties, will include a Tribal community, and will include communities with existing health disparities by race and ethnicity.

There are no legal or administrative requirements that necessitate this data collection.

### A.2 Purposes and Use of the Information Collection

HRSA is seeking additional information about the strategies and partners home visiting programs have used to advance health equity in communities disproportionately impacted by the COVID-19 public health emergency. HRSA intends to use this information to provide technical assistance and disseminate best practices to MIECHV awardees, publish findings for lay and research audiences to advance the field's knowledge of home visiting's role in COVID-19 response, and to prepare state and local home visiting programs for future public health emergencies.

The case studies will lead to a deeper understanding of the ways in which COVID-19 has shaped families' experiences, and the role home visiting plays (and could play) in addressing the inequities that continue to accrue from the pandemic within a community. See Table 1 for more detail on the types of information to be collected. Information gained from these case studies can inform the development of more responsive home visiting systems and more equitable health and family support systems, in general. Data collection activities include key informant interviews, focus groups, and online surveys.

**Table 1. Constructs, sub-constructs, and data sources**

Construct	Sub-Constructs	Data Source		
		Interview	Focus Group	Survey
Policy and health systems context in the community	COVID-19 policy responses and impacts on families	X		
	Awareness of historical disparities	X		
Families experience of COVID-19	Risk and fear of infection; Experiences with infection, hospitalization, and vaccination; Effects of social distancing, stay-at-home orders, quarantines; COVID impacts on familial structure/relationships, including grandparent and fatherhood engagement; Mental health; Housing instability; Economic, school/child care, and business shut downs		X	X
	Changes in the needs of families across time (e.g., material support, housing)		X	X
	Barriers and inequities experienced by families based on community or geography (e.g., regional food shortages), identities (e.g., race/ethnicity, age, sex, sexual orientation, country of origin, etc.) and various lived experiences (e.g., immigration)		X	
Home visiting response to COVID-19	Context and changes to the MIECHV program in the state or Tribal entity, and in the selected community	X		
	COVID-19 impacts on outreach and recruitment	X		
	Changes in service delivery methods throughout the course of the pandemic (e.g., use of video, text communication)	X		X
	Changes in screening, assessment, and referral processes			X
	COVID-19 impacts on home visiting staff including home visitor well-being, deployments, turnover, and shortages and impact on service delivery	X		X
Home visiting's role in health equity	Role of home visiting in addressing community historical context with families		X	X
	Ways home visiting considers equity during COVID-19		X	
	Perceived role of home visiting to address health equity			X
Home visiting's role in the community system	Home visiting's role in community service response to COVID-19 via cross-sector collaboration	X		
	Role of home visiting in the network of supports for families		X	
	Role of home visiting in addressing service gaps and limits in addressing gaps		X	

Construct	Sub-Constructs	Data Source		
		Interview	Focus Group	Survey
Community strengths and challenges	Factors that promote resilience (e.g., power of culture and tradition)		X	
	Community service needs and gaps including those beyond the scope of home visiting such as mental health, physical health, material needs (e.g., food), social support	X	X	
	Community response to COVID-19-related service needs	X		
Families experience of services including home visiting	Ways in which, and reasons why, families access services, resources, and information		X	
	Resources used during the pandemic to support families		X	
	Distrust of home visiting, social services, health services		X	
	Successes and challenges for enrolling in services		X	
Perceptions of community organizations <sup>a</sup>	Beliefs about home visiting programs'/other organizations' relative importance in the system of care for families			X
	How well home visiting programs/other community organizations are equipped to meet families' needs			X
	Changes in home visiting programs'/other community organizations' ability to meet families' needs across the course of the pandemic			X
Organizational collaboration <sup>a, b</sup>	Awareness of specific programs in the community			X
	Extent to which home visiting program collaborates with other community organizations			X
	Changes in collaboration, including strengthening of existing partnerships and development of new partnerships, across the course of the pandemic			X

<sup>a</sup> Questions will be asked of home visitors about other community service providers and questions will be asked of other community service providers about home visiting programs and other community service providers.

<sup>b</sup> Questions will be included as part of social network analyses

### A.3 Use of Information Technology and Burden Reduction

The planned information collection does include the use of technological data collection techniques. Specifically, the project includes:

- Online community and home visitor survey
- Online program data tool

Online data collection allows for efficiencies and reductions in respondent burden. Web-based surveys provide efficient ways of using skip logic to quickly move to the next relevant question depending upon a respondent's answer selection. Web-based surveys also provide ways to limit invalid responses so that they cannot be entered and can prompt the respondent to enter a valid response. Web-based surveys reduce burden related to completing and mailing (or otherwise submitting) paper forms.

For the online program data tool, the information collection has made efforts to ensure home visiting programs can use existing information when possible. The online data collection tool allows for programs to enter data for enrollment, services, and referrals for the categories they already collect as part of regular program operations.

The planned information collection includes interviews and focus groups conducted in-person. However, if an individual respondent would prefer to not to participate in-person, the interviews and focus groups can be completed online using a web-based video platform (e.g., Microsoft Teams). If travel is not advisable due to the pandemic or if individual communities are under COVID related restrictions that impact in-person activities, the interviews and focus groups will be completed online.

All data collection tools have been tested in consultation with a representative sample (fewer than 10) of potential respondents.

### A.4 Efforts to Identify Duplication and Use of Similar Information

This project seeks to understand the strategies home visiting programs have used to advance health equity in communities disproportionately impacted by the COVID-19 public health emergency. To date, this information has not been systematically collected. The team is aware of small studies and anecdotal information to support this understanding which has informed the design of the data collection instruments.

Prior to collecting any data within each community, the project team will complete an environmental and policy scan to address the broader policy and health systems contexts that contributed to the disproportionate impact of COVID-19 on some groups. These scans will enable the study team to understand how those contexts have been shaped by historical disparities and inequities. This information will also allow the project team to identify any potential duplication of available information from secondary sources.

### A.5 Impact on Small Businesses or Other Small Entities

This information collection will not have a significant economic impact on a substantial number of small businesses or other small entities.

Information will be collected from individuals employed by Local Implementing Agencies. Local Implementing Agencies are contracted by the state or territorial 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.

## A.6 Consequences of Collecting the Information Less Frequently

The information collection will occur only one time for each respondent.

## A.7 Special Circumstances Relating to the Guidelines of 5 CFR1320.5

This request fully complies with all guidelines of 5 CFR 1320.5. There are no special circumstances required.

## A.8 Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A 60-day notice for public comments on the proposed data collection activities required by Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 was published in the Federal Register on March 17, 2022 (87 FR 15254,) (Appendix A). Public comments were requested by May 16, 2022. HRSA received 3 comments. An abbreviated version of the comments and responses are summarized here. Copies of the public comments are included as Appendix B.

1. Comment: Respondents expressed concern for the estimated burden to complete data collection instruments.
  - a. Response: The number of items on each of the data collection instruments has been reduced. To reduce items, the team identified item content where there was unnecessary overlap across instruments and identified items that were extraneous to addressing research questions.
2. Comment: Respondents asked for clarification on surveys used in the local implementing agency (LIA) selection process, the role of the awardee, the division of labor between the LIA and the awardee, and the timing of inviting families to participate in focus groups.
  - a. Response: No surveys will be used to invite LIAs to participate in the project. All potential communities and LIAs will be identified through analysis of existing data. The project team will reach out to the MIECHV awardee or Tribal grantee before beginning any recruitment of specific communities or programs to participate in the project. The team will meet with the MIECHV state Project Director to explain more about the case study process. Additionally, if the community agrees to participate in the case study, the Project Director would be asked to complete the community interview and to help identify other potential key informants to complete the community interview. Staff at the LIA would be asked to participate in data collection activities (e.g., complete web-based survey) and to support recruitment of families for data collection activities. The project team would recruit families to participate in focus groups who had been enrolled in home visiting for at least 6 months and therefore had an established relationship with their home visitor and familiarity with the program and services provided. Project Directors, staff, and families would be included in the development of the community profiles as interested.
3. Comment: Respondents suggested an analytical strategy that should include a comparison of responses to questions about staff well-being in the community interview with responses from the community and home visitor survey of frontline staff.

- a. Response: The team appreciates the suggestion to compare reports of staff well-being across different types of respondents. However, in an effort to reduce duplicative content across data collection instruments, the team has eliminated items where program administrators are answering questions about their staff's well-being and instead focused on responses from the frontline staff themselves.
- 4. Comment: Respondents provided specific recommendations for revisions to item wording and instructions for participants.
  - a. Response: All recommendations have been incorporated into the revised data collection instruments. More details on changes made are provided in Section B.4.

Other comments did not merit changes to the information request, but instead provided support for the project and highlighted the importance of addressing how COVID-19 has shaped the experiences of families and the meaningful role MIECHV plays and could further play in addressing inequities. Other comments emphasized the important role that virtual service delivery has played in reaching families in areas where vulnerable populations may lack an entrance to health care services, including rural and frontier areas. Lastly, other comments expressed interest in whether this project would be tied to or lead to additional initiatives in this area.

## A.9 Explanation of Any Payment or Gift to Respondents

Providing incentives to respondents is an important strategy for ensuring high response rates in data collection activities.<sup>3</sup> By participating in data collection activities, respondents may encounter financial (e.g., through missed work or lost wages) and emotional costs (e.g., through recalling and discussing potentially stressful or sensitive events). Providing incentives to respondents is a way of acknowledging the value of the time and knowledge being shared with the study team. Incentives also reinforce the notion that the local community knowledge being shared by respondents is valued, respected, and honored. This is particularly important given the community-level case study methods to be used in this project.

Table 2 provides an overview of the respondent type and number, the estimated burden, the planned incentive and rationale for the incentive (e.g., respondent incurs financial costs) for each of the data collection activities. Although the incentive rationale for the Community Interview Protocol and the Family and Community Focus Group Guide is similar, the planned incentive amount has been adjusted to reflect the difference in anticipated burden for the two activities (1.5 hours and 2 hours, respectively). For the Community and Home Visitor Survey, the project team will provide each respondent with a one-time, \$20 gift card as a token of appreciation. The value of this gift card was selected to approximate a .75 hourly rate, given the estimate of hourly wages from potential respondents (see section A12).

**Table 2. Planned Incentives**

Form Name	Example Respondents	Estimated number of respondents <sup>1</sup>	Average Burden per response (hours)	Incentive	Incentive Rationale
<b>Community Interview Protocol</b>	Leaders of states, territories, and, where applicable, nonprofit organizations receiving MIECHV funding to provide home visiting services within states; state and local representatives from home visiting, public health, health care, and other human service agencies in the early childhood system; community organizers, Tribal elders, religious leaders	60	1.50	\$50	<ul style="list-style-type: none"> <li>- Financial costs of participation (high)</li> <li>- Emotional costs of participation (low)</li> <li>- Sharing of local community knowledge</li> </ul>
<b>Family and Community Focus Group Guide</b>	Families (including families participating in MIECHV-funded home visiting services and those with shared experiences)  Community providers, including home visitors	240	2.00	\$75	<ul style="list-style-type: none"> <li>- Financial costs of participation (high)</li> <li>- Emotional costs of participation (high)</li> <li>- Sharing of local community knowledge</li> </ul>
<b>Community and Home Visitor Survey Instrument</b>	Staff from organizations in the communities providing services relevant/complementary to home visiting;  Home visitors	500	0.75	\$20	<ul style="list-style-type: none"> <li>- Financial costs of participation (low)</li> <li>- Emotional costs of participation (low)</li> <li>- Sharing of local community knowledge</li> </ul>

Form Name	Example Respondents	Estimated number of respondents <sup>1</sup>	Average Burden per response (hours)	Incentive	Incentive Rationale
Program Data	Data entry or data intake staff at home visiting programs	15	10.00	N/A	N/A

<sup>1</sup> There may be variation in the number of study participants and home visiting programs in each community (e.g., some selected communities may have fewer home visitors). The total burden hours presented here provide information assuming the maximum number of respondents in each community.

## A.10 Assurance of Confidentiality Provided to Respondents

Participation in all data collection activities is voluntary. All respondents will be informed that their responses are confidential. For interviews, confidentiality means that their responses will not be shared with anyone outside of the study team. For focus groups, confidentiality means that the study team will not share any of their individual responses with any home visiting program or local or state agencies or in any report. However, given the nature of a focus group (i.e., multiple respondents sharing information together), all respondents will hear responses from the group and confidentiality cannot be fully guaranteed. The focus group facilitators will ask that respondents do not share any information or personal experiences that they hear from others during the group. Focus groups and interviews will be recorded. The recordings, notes, and transcriptions will be saved to a secure drive and only the study team will have access. For surveys, confidentiality means that only the study team will have access to their responses and that their individual responses will not be shared with any home visiting program or local or state agencies or identified in any report.

This study was reviewed and approved by the Child Trends Institutional Review Board (IRB). See Appendix C for documentation of initial IRB approval. The Child Trends IRB operates under Federal-wide Assurance Number 00005835, and thereby adheres to the requirements in the HHS Protection of Human Subjects regulations at 45 CFR Part 46. Final IRB approval will be obtained prior to the beginning of any data collection activities when OMB and any local approvals are in place.

## A.11 Justification for Sensitive Questions

Questions in some components of the focus group and survey protocols are potentially sensitive for respondents. For example, in the focus groups, respondents are asked about sensitive topics related to the impacts of COVID-19 on their health, mental health, employment, need for services, barriers to meeting their needs related to their lived experiences, including their race, ethnicity, sexual orientation, disability status, or nationality, and their families' health. Respondents are also asked about issues related to social determinants of health including structural racism. For respondents who experienced trauma and loss during the pandemic, or who have experienced discrimination based on some aspect of their identity, these questions may cause psychological discomfort and upset. To minimize this risk, every effort will be made to establish a supportive and respectful relationship with respondents, and respondents will be reminded that they are free to refrain from answering questions or excuse themselves from participating at any time. These questions are being asked to better understand how

these issues have impacted families in the community and how home visiting and other community services have responded to address families' needs.

In the surveys, respondents are asked about their well-being and mental health. These questions are being asked because previous work has shown that home visitors and community services providers have experienced high rates of stress and depressive symptoms during COVID-19.<sup>4,5</sup> Previous research has also found that provider psychological well-being influences family engagement and turnover.<sup>6,7</sup> The well-being and mental health questions used in the surveys are from standardized measures or have been used in other studies of home visiting with no evidence of harm.

As part of the consent process for all activities, respondents will be informed that sensitive questions will be asked and that they may be asked to share about their experiences during the COVID-19 pandemic. Respondents will be told that it is their choice to share what they are comfortable sharing and that they are able to skip questions they are not comfortable answering. They will also be told that their responses are confidential, only the study team will have access to their responses (with the exception of focus group participants), and that their individual responses will not be shared with any home visiting program or local or state agencies or identified in any report.

## A.12 Estimates of Annualized Burden Hours and Costs to Respondents

### A.12.1 Estimated Annualized Burden Hours

For each data collection protocol, the data collection process will be conducted only once. The estimated burden per respondent varies (as shown in Table 3). The total burden for this information collection is 1095 hours. There may be variation in the number of respondents in each community (e.g., some selected communities may have fewer home visitors). The total burden hours presented here assumes the maximum number of respondents in each community. This burden estimate includes the time expended by persons to generate, maintain, retain, disclose, or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install, and utilize technology and systems for the purpose of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. The burden estimates for the program data collection have been revised to reflect consultation with a sample of potential respondents and comments received in response to the 60-day Federal Register Notice public comment period. Other burden estimates have remained the same but the number of items for the data collection instruments has been significantly reduced (as described in Section B.4).

**Table 3. Estimated Annualized Burden Hours<sup>1</sup>**

<b>Form Name</b>	<b>Number of Respondents</b>	<b>Number of Responses per Respondent</b>	<b>Total Responses</b>	<b>Average Burden per Response (in hours)</b>	<b>Total Burden Hours</b>
<b>Community Interview Protocol</b>	60	1	60	1.50	90
<b>Family and Community Focus Group Guide</b>	240	1	240	2.00	480
<b>Community and Home Visitor Survey Instrument</b>	500	1	500	0.75	375
<b>Program Data</b>	15	1	15	10.00	150
<b>Total</b>	815		815		1095

<sup>1</sup>There may be variation in the number of study participants and home visiting programs in each community (e.g., some selected communities may have fewer home visitors). The total burden hours presented here provide information assuming the maximum number of respondents in each community.

### **A.12.2 Estimated Annualized Cost to Respondents**

The estimated total cost to respondents is approximately \$50,046.40 (as shown in Table 4). There may be variation in the number of respondents in each community (e.g., some selected communities may have fewer home visitors). The total respondent cost presented here assumes the maximum number of respondents in each community.

For the Community Interview Protocol, the cost to respondents is based on the average wage of social and community service managers from the 2021 U.S. Bureau of Labor Statistics Occupational Employment and Wage Statistics.<sup>8</sup> This wage category was used because it includes those who “plan, direct, or coordinate the activities of a social service program or community outreach organization.” This category includes individual who are managers in individual and family services, local governments, state governments, and other relevant organizations. This category broadly reflects the types of respondents who will complete this interview.

For the Family and Community Focus Group guide, the cost to respondents is based on two types of respondents: families and community service providers (including home visitors). Based on the planned data collection, a maximum of 160 respondents will be families and 80 will be community service providers. For families, the cost to respondents is based on the median hourly wage of women ages 16 and over from the 2019 U.S. Bureau of Labor Current Population Survey.<sup>9</sup> This wage category was used because it is anticipated that the majority of family participants will be women over age 16 and there is no pre-determination of occupation. For community providers (including home visitors), the cost to respondents is based on the average wage of community and social service occupations from the

2021 U.S. Bureau of Labor Statistics Occupational Employment and Wage Statistics.<sup>10</sup> This wage category was used because it includes a range of providers (e.g., health education specialists, counselors, social workers) and broadly reflects the types of respondents who will participate in this focus group.

For the Community and Home Visitor Survey Instrument, anticipated respondents include home visitors and community service providers. The cost to respondents is based on the average wage of community and social service occupations from the 2021 U.S. Bureau of Labor Statistics Occupational Employment and Wage Statistics.<sup>11</sup> This wage category was used because it includes a range of providers (e.g., health education specialists, counselors, social workers) and broadly reflects the types of respondents who will participate in this focus group.

For the Program Data collection, the cost to respondents is based on the average wage of office and administrative support workers, other from the 2021 U.S. Bureau of Labor Statistics Occupational Employment and Wage Statistics.<sup>12</sup> This wage category was used because it includes administrative workers such as data entry or data intake staff which reflects the anticipated respondents who will enter the program data.

For all forms, the average hourly wage was multiplied by 2 to account for the costs of fringe benefits and overhead.

**Table 4. Estimated Annualized Cost to Respondents<sup>1</sup>**

<b>Form Name</b>	<b>Type of Respondent Category</b>	<b>Number of Respondents</b>	<b>Total Burden</b>	<b>Average Hourly Wage (Multiplied by 2 for total respondent cost)</b>	<b>Total Respondent Cost (\$)</b>
<b>Community Interview Protocol</b>	Social and Community Service Managers	60	90	\$36.92	\$6645.60
<b>Family and Community Focus Group Guide</b>					
Family	Employed Women Age 16 and over	160	320	\$14.85	\$9504.00
Community Provider	Community and Social Service Occupations	80	160	\$25.94	\$8300.80
<b>Community and Home Visitor Survey Instrument</b>	Community and Social Service Occupations	500	375	\$25.94	\$19455.00
<b>Program Data</b>	Office and Administrative Support Workers, other	15	150	\$20.47	\$6141.00
<b>Total</b>			1095		\$50046.40

<sup>1</sup>There may be variation in the number of study participants and home visiting programs in each community (e.g., some selected communities may have fewer home visitors). The total burden hours presented here provide information assuming the maximum number of respondents in each community.

### A.13 Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

The project team will provide an honorarium to LIAs participating in the project in recognition of the administrative burden associated with their participation in the project. The honoraria will be \$800 per LIA and is less than the anticipated cost of staff time needed to complete the program data collection tool and support participant recruitment. There are no other total annual cost burdens to respondents or record keepers resulting from the collection of information.

### A.14 Annualized Cost to the Federal Government

HRSA is funding this information collection. The estimated cost for activities covered in this submission is \$490,269. This includes designing data collection instruments, collecting all data and analyzing data.

In addition, costs to the federal government include the cost of federal staff time for project oversight and development. This includes approximately 10% of a federal program analyst at Grade 15, Step 3 (\$75.89 per hour for 208 hours) for a total cost of \$15,785.12.

### A.15 Explanation for Program Changes or Adjustments

This is a new data collection requirement and no changes have been made.

### A.16 Plans for Tabulation and Publication and Project Time Schedule

Table 5 provides the estimated time schedule for the information collection, data analysis, and publication. The planned analyses do not include any complex analytical techniques. For this information collection, planned analyses include descriptive statistics that summarize findings (e.g., percentage, mean, median, range, or standard deviation), thematic coding using a priori themes based on the topics included in the interview and focus group protocols, with additional themes generated based on the data, and social network analysis of the community service provider surveys to examine the structures and patterns among service providers within each community.

Findings from the planned analyses will be presented in two briefs and five community profiles. The two briefs will include analysis of data gathered from this information collection and secondary data analysis of existing sources. These products will be applicable for a broad audience, including MIECHV awardees, home visiting and other community program administrators, technical assistance providers, and policymakers, and will be widely disseminated.

The community profiles will summarize the results of the case study analysis for each of the five selected communities and will include analysis of data gathered from this information collection along with secondary data analysis of existing sources. The profiles will highlight the disproportionality of COVID-19 in the community compared to U.S., the existing health inequities in the community, an understanding of coordination and collaboration among community service providers comprising local systems of care including home visiting programs, and a presentation of families' stories that inform how home visiting programs can continue to adapt and respond to COVID-19 and how home visiting can support families in times of crisis.

**Table 5. Estimated Time Schedule for Project Activities**

Activity	Expected Timeline
Data collection	Between September 2022-February 2023 data collection will occur in each community. Timeline may vary for individual community.
Analysis	Beginning in January 2023, information will be analyzed.
Publication	By June 2023, findings from this analysis will be presented in publications (briefs) and other public facing products (community profiles).

### A.17 Reason(s) Display of OMB Expiration Date Is Inappropriate

No request for an exemption from displaying the expiration date for OMB approval is being sought. The OMB number and expiration date will be displayed on every page of the data collection protocols.

### A.18 Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification statement.

## B. Collections of Information Employing Statistical Methods

### B.1 Sampling

In 2020, the MIECHV Program reached 32 percent of all U.S. counties, including 41 percent of all urban counties and 27 percent of all rural counties (51% of counties served were rural).<sup>13</sup> Although MIECHV awardees generally designate geographic service areas at the county level, some awardees are focused on serving tribal communities (in addition to the Tribal MIECHV grantees that are awarded directly to tribal communities). For this project, communities in 5 counties with MIECHV-funded home visiting programs will be selected to participate in case studies.

To inform the selection of counties for case study locations, the project team will rely on several analyses of secondary data sources. First, the team will conduct a temporal analysis of COVID-19 cases, deaths, hospitalization rates, and vaccination rates to help determine how COVID-19 has impacted counties over time. Second, the team will create the County Response Index to Support Equity in Home Visiting (County RISE-HV). The County RISE-HV Index will include social determinants of health indicators that were present in counties before the COVID-19 pandemic, with particular attention to those most relevant to home visiting-related outcomes, which can help elucidate how well counties were prepared to respond to the COVID-19 public health emergency.

Finally, the team will generate a list of counties with MIECHV-funded programs that will be used to identify case study locations. This list will include multiple “profiles” of counties with MIECHV-funded programs based on the identified temporal patterns, County RISE-HV index scores, and demographic data. Profiles will enable the team to group counties with similar characteristics and to differentiate groups of counties with different characteristics from one another. Counties with tribal communities will be integrated into these profiles (but designated in some way so that they can be easily identified).

Within each profile, the team will order counties by their County RISE-HV scores, starting with the most vulnerable counties (represented by a “low” score on the County RISE-HV). The team will then utilize the County RISE-HV data to identify approximately 10 counties that are or have been COVID-19 hot spots, have existing MIECHV-funded programs, and have a range of characteristics that represent a diversity of settings and experiences. Information about these counties will include rates of COVID-19 cases, deaths, hospitalizations, and vaccinations indicating disproportionality compared to other counties as well as by race/ethnicity, number of MIECHV-funded programs, and select settings and experiences (e.g., population size, socioeconomic status).

As the team identifies and narrows the list of counties down to 5 to 10 potential locations, priority will be given to selecting a mix of urban and rural counties, racial and ethnic disparity rates, diversity of home visiting program sizes and any other considerations HRSA has for the case study locations (e.g., length of MIECHV funding, types of home visiting models used). This means, for example, the team would not select five urban case study locations or five case study locations that have similar population sizes. The team will also ensure that at least one case study location with programs funded by the Tribal Home Visiting Program is included in the case studies. It is important to recognize that the number of MIECHV programs and sites varies by state and county—in some parts of the nation, like Vermont, a single home visiting model is used in every county, whereas other counties like Los Angeles County, California, have multiple MIECHV programs, sites, and home visiting model types within the same county. If counties that fall in the latter category make our top 10 county list, the team foresees focusing in on a smaller geographic region within the county (e.g., definite sections of a city that are cohesive and identified as separate communities, like a district or a neighborhood) as the case study location.

Once the potential case study locations are identified, the team will meet with the MIECHV Project Director (both state and Tribal) for the identified case study location’s state and let them know we want to invite a community in their state to participate in a case study. If interested, the team will meet with the Project Director, LIAs, and local leaders, to learn more about participating in the activities. The team will share recruitment materials to engage with local community and home visiting program leaders and explain the project and ask about their interest in participating. Participation is not required.

If a community does not wish to participate, or additional information is uncovered that would not make them a good fit for this work due to feasibility (e.g., ongoing research conflicting with the project timeline, complications with staff availability to participate due to COVID-19-related deployment or furloughs), the project team will select a replacement case study location. The team assumes that the sequence of the recruitment steps will generally be the same as those outlined above for each case study location. However, there may be variation by location in terms of the number of meetings, participants engaged during recruitment, amount of follow-up, timeline to go through the recruitment process, and approval of case study location by HRSA and the state or Tribal MIECHV awardee. A total of 5 case study locations will be selected for participation.

## B.2 Procedures for Collection of Information

All data collection activities are completely voluntary. This is a descriptive study and there is no required or pre-specified sample size needed. There will likely be variation in the number of home visiting programs and study participants in each community (e.g., some selected communities may have fewer home visitors). Therefore, the anticipated sample size for each data collection activity will vary.

For the community interview protocol, the first interview for each case study will be with the MIECHV awardee state or Tribal lead or their designee. The study team will already have been in touch with this person as part of the case study selection process. The team will use these initial interviews to generate a list of additional key informants who should also be interviewed. In collaboration with the MIECHV lead and LIA staff, the study team will identify the best way to reach out to these informants (e.g., if an email should be sent by the MIECHV lead directly or by the study team). MIECHV leads participating in key informant interviews may also support the identification of potential participants for focus groups.

For all other data collection activities, the MIECHV-funded home visiting program(s) in each community will be our main source of recruitment. Once the home visiting programs have been identified, the research team will work closely with program staff to identify families and staff who may be interested in participating in the study. Families enrolled in home visiting would be eligible to participate in focus groups if they had been enrolled for at least 6 months and therefore had an established relationship with their home visitor and familiarity with the program and services provided. Once eligible participants have been identified, they will be informed about the study via flyers (printed and digital) and word-of-mouth from agency staff.

### **B3. Methods to Maximize Response Rates**

All data collection activities are completely voluntary. To maximize response rates, all staff will be trained on the data collection procedures and procedures and on principles of respondent cooperation. Other ways the research team plans to maximize response rates include having designed instruments with questions that are easy to answer and have been pre-tested by appropriate participants for each respective protocol. At the time of data collection, all staff will ensure the confidentiality of responses as appropriate, provide detailed information about the study, provide an overview to the importance of the study for advancing home visiting's role in addressing health equity, and provide information about receiving an incentive for participation. In addition, every effort will be made to establish a supportive and respectful relationship with participants, and participants will be reminded that they are free to refrain from answering questions or excuse themselves from participating at any time.

For web-based data collection, email reminders will be sent at two time points to encourage survey completion. For in-person data collection, email or text reminders will be sent to remind participants of the appropriate data and time of their focus group or interview.

### **B4. Pre-testing of Procedures and Methods**

All of the data collection protocols have been pre-tested with the appropriate participants for each respective protocol. No approval was needed for pre-testing because each protocol was conducted with 9 or fewer families, community leaders, community service providers, or home visiting staff. The purpose of pre-testing protocols was to gather feedback from participants on questions (e.g., ease of understanding each question) and test out the flow of the protocols. Feedback from participants was used to revise questions that were unclear or difficult to answer, add clarification around questions and terminology used, and cut questions to ensure the estimated burden was not exceeded. Additionally, pre-testing the survey in an online platform allowed for testing of skip logic. Table 6 provides an overview of the revisions made for each data collection form.

**Table 6. Data Collection Protocol Revisions**

Form Name	Revisions Resulting from Pre-testing	Revisions Resulting from Public Comment
<b>Community Interview Protocol</b>	<p>Cut questions from ‘Home visiting response to COVID-19’ due to participant burden and due to overlap in community focus group guide and survey instrument.</p> <p>Reduced questions in ‘Community strengths and challenges’ to reduce participant burden.</p>	<p>Reduced questions about participants’ familiarity with state and community-level policies and their impact on families.</p>
<b>Family and Community Focus Group Guide</b>		
Family Focus Group Guide	<p>Added disclaimers to ensure participant comfort in answering sensitive questions (e.g., around COVID-19 vaccinations).</p> <p>Added clarification around terminology (e.g., structural racism).</p> <p>Cut questions around enrollment to reduce participant burden.</p> <p>Revised ‘Family network mapping activity’ to reduce participant burden.</p>	<p>Reduced overall length of guide to reduce participant burden.</p>
Community Focus Group Guide	<p>Cut questions from ‘Experiences during COVID-19’ to reduce participant burden and due to overlap with the survey instrument.</p> <p>Revised ‘Provider systems mapping activity’ to reduce participant burden.</p>	<p>Reduced overall length of guide to reduce participant burden.</p>

Form Name	Revisions Resulting from Pre-testing	Revisions Resulting from Public Comment
<b>Community and Home Visitor Survey Instrument</b>	<p>Added additional response options to better understand range of experiences. Added additional open-ended question at the end of the survey for participants to elaborate on survey items.</p> <p>Revised items and instructions for clarity across survey.</p> <p>Added item about referral practices that was removed from Community Interview Protocol.</p> <p>Cut questions from 'Organizational Collaboration' to reduce participant burden.</p>	<p>Added response options to questions.</p> <p>Revised wording on questions to ensure clarity. Ensured consistent terminology used across survey.</p>
<b>Program Data</b>	<p>Revised to include terminology included in HRSA Form 1 data collection.<sup>1</sup></p> <p>Added questions to clarify each program's existing data categories.</p> <p>Increased estimated burden for completion.</p>	<p>Added response options to questions.</p> <p>Revised wording on questions to ensure clarity.</p> <p>Clarified timeframe for reporting period.</p>

<sup>1</sup>Form 1 is an annual MIECHV performance reporting form that collects information from awardees about participant demographics, home visiting service utilization, and clinical indicators such as health insurance coverage and usual source of health care. Form 1 can be accessed here: <https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/form-1-demographic-performance.pdf>

## B5. Consultants on Statistical Aspects of the Design

There were no individuals consulted on the statistical aspects of the design. The project received feedback on the study design from three project consultants and a community advisory board. Project consultants include Dr. Bitu Amani, Ms. Karen Howard, and Ms. Deborah Stark. Collectively, the consultants bring expertise related to family voice and engagement, epidemiology, racial and ethnic disparities and equity among home visiting program populations and policies, and racial disparities exacerbated by the COVID-19 pandemic. The community advisory board includes families participating in home visiting, community leaders, experts in public health, epidemiology, and social determinants of health, home visiting model developers, and home visiting program administrators and staff. The board brings a diverse range of experience and expertise in the areas of home visiting, public health, health equity, and COVID-19.

HRSA has contracted with Child Trends, a leading research firm specializing in early childhood, to conduct this project. Child Trends is responsible for the collection and analysis of all information described in this Information Collection Request.

- <sup>1</sup> U.S. Department of Health & Human Services, Administration for Children & Families, Health Resources & Services Administration (HRSA) Maternal & Child Health. (2021). *The Maternal, Infant, and Early Childhood Home Visiting Program* [Program brief]. <https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf>
- <sup>2</sup> U.S. Department of Health & Human Services, Administration for Children & Families, HRSA Maternal & Child Health. (n.d.). *Home Visiting*. <https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview>
- <sup>3</sup> David, M. C., & Ware, R. S. (2014). Meta-analysis of randomized controlled trials supports the use of incentives for inducing response to electronic health surveys. *Journal of Clinical Epidemiology*, 67(11), 1210-1221.
- <sup>4</sup> Crowne, S.S., Hegseth, D., Ekyalongo, Y., Cohen, R.C., Bultinck, E., Haas, M., Anderson, S., & Carter, M. (2021). *Findings from the First 5 California Home Visiting Workforce Study*. Bethesda, MD: Child Trends. <https://www.childtrends.org/publications/findings-from-the-first-5-california-home-visiting-workforce-study>
- <sup>5</sup> Swigonski, N. L., James, B., Wynns, W., & Casavan, K. (2021). Physical, mental, and financial stress impacts of COVID-19 on early childhood educators. *Early Childhood Education Journal*, 49(5), 799-806.
- <sup>6</sup> McFarlane, E., Burrell, L., Fuddy, L., Tandon, S. D., Derauf, C., Leaf, P., & Duggan, A. (2010). Association of visitors' and mothers' attachment style with family engagement. *Journal of Community Psychology*, 38, 541-556.
- <sup>7</sup> West, A. L., Berlin, L. J., & Harden, B. J. (2018). Occupational stress and well-being among Early Head Start home visitors: A mixed methods study. *Early Childhood Research Quarterly*, 44, 288-303.
- <sup>8</sup> <https://www.bls.gov/oes/current/oes119151.htm>
- <sup>9</sup> <https://www.bls.gov/opub/reports/womens-earnings/2019/pdf/home.pdf>
- <sup>10</sup> <https://www.bls.gov/oes/current/oes210000.htm>
- <sup>11</sup> <https://www.bls.gov/oes/current/oes210000.htm>
- <sup>12</sup> <https://www.bls.gov/oes/current/oes439199.htm>
- <sup>13</sup> U.S. Department of Health & Human Services, Administration for Children & Families, Health Resources & Services Administration (HRSA) Maternal & Child Health. (2021). *The Maternal, Infant, and Early Childhood Home Visiting Program* [Program brief]. <https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf>