Attachment A3: 60-day FRN Public Comments and Responses

Health Resources and Services Administration (HRSA) Evaluation of the Maternal and Child Health Bureau (MCHB) Pediatric Mental Health Care Access (PMHCA) and Screening and Treatment for Maternal Mental Health and Substance Use Disorders (MMHSUD) Programs Project

Date JBS Received Comment	Commenter	Comment	Date JBS Responded	Response
7/30/24	Benjamin D. Hoffman, MD, FAAP	**Necessity and Utility of the Proposed Information Collection for the Proper Performance of the Agency's Functions** AAP recognizes that there is significant variance in the structure, funding, history, and implementation of PMHCA programs across all states and territories and hopes the collected data will be comparable across the multitude of PMHCA programs while still considering these differences.	7/31/2024	JBS has constructed a detailed Program Implementation Database that captures detail on individual PMHCA and MMHSUD awardees' programs, combining data from various sources, including awardee applications and narrative reports, survey data, HRSA-required reporting measures, and evaluation capacity-building calls. This Database allows us to record and analyze key differences such as program structure, funding, history, size, reported implementation facilitators and barriers, and target population.
		Ways to Enhance the Quality, Utility, and Clarity		1. After consideration of definitions from the

Date JBS Received Comment	Commenter	Comment	Date JBS Responded	Response
		of the Information to be Collected 1. Additionally, we recommend that HRSA consider using “mental and behavioral health” in place of “behavioral health” as well as “infant, child, and adolescent” instead of “child and adolescent” in any survey language. These relatively simple changes will improve comprehensive data collection across the full range of populations and services that PMHCA programs engage. 2. AAP recognizes that training and education are part of the federal PMHCA program goals, and we are interested in whether and how programs are successfully enacting this goal in practice. We recommend that HRSA clearly define what PMHCA program activities are considered training for the purpose of the program evaluation. Our members expressed some confusion about what this may refer to, so additional clarity will likely improve data fidelity. 3. AAP has some potential concerns about HRSA’s plan to assess changes over time in participating health practitioners’ capacity to address patients’ mental and behavioral health and access to mental and behavioral health care through screening. While relationships with PMHCA programs can improve primary care providers’ familiarity with different mental and behavioral health treatment paths, PMHCA programs are not necessarily intended or prepared to train providers on how to conduct mental and behavioral health screenings. PMHCA programs are typically most valuable after a primary care provider has identified the need for mental or behavioral health interventions and consults the PMHCA program for further care, not in conducting initial screenings. 4. To the extent feasible, it is important that the data collection is optimized for the various		American Medical Association, American Psychiatric Association, the National Alliance on Mental Illness, the Substance Abuse and Mental Health Services Administration, and the World Health Organization as well as input of from the PMHCA Impact Study External Partner Group (EPG) from a separate impact study, "behavioral health" was selected as the most parsimonious and accepted term. The "child and adolescent" terminology is not used in the surveys for the HRSA Evaluation of the MCHB PMHCA and MMHSUD Programs Project. 2. For the program evaluation, we collect survey data from health professionals and practices on the number of trainings attended and modality for training received from the PMHCA and MMHSUD programs (i.e., in-person training event, webinar, self-study with program resources, video conferencing, learning collaborative [e.g., Project ECHO, Project REACH], other training modality). HRSA also collects data on the total number of providers trained as well as the number of trainings held by topic, mechanism used (e.g., in-person, web-based), and type of training materials used. 3. For the evaluation, capacity is being operationalized as health professionals’ BH knowledge, skills, practice, and attitudes. Specific evaluation questions related to changes over time in access to behavioral health services have been revised to focus on change in knowledge and skills; screening, assessment, treatment, and referral; attitudes about providing behavioral health care; and how change over time differed based on (1) frequency and modality of program access and (2)

Date JBS Received Comment	Commenter	Comment	Date JBS Responded	Response
		participants engaging with the program models. We recommend that HRSA ensure that the data collection is conducted in a manner that is clear and relevant for the full range of anticipated survey and interview respondents, which vary from pediatric primary care providers to community resource partners and program champions. 5. AAP would also recommend that HRSA collect the data in such a way that insights can be gained regarding rural, urban, and suburban access to care. If appropriate, we would also be interested in information about the distance patients and families need to travel to access mental and behavioral care recommended by PMHCA teams. Are PMHCA programs considering potential barriers such as distance and travel time when issuing recommendations in a consultation? This is especially relevant for programs located in areas considered mental and behavioral health deserts. Thorough data collection about these barriers and others will contribute to improved understanding of the existing access gaps and better prepare HRSA and other stakeholders to take targeted actions to close those gaps.		treatment location, demographics, and treatment settings. These evaluation questions will be able to measure screening behavior change separately from other measures of provider capacity and describe how screening and other capacity measures differ in various contexts. 4. Different strategies will be used to optimize data collection for the various participants engaging with the program models. The respondent universe for the Health Professional (HP) and Practice-Level Surveys will comprise identified enrolled and/or participating HPs and practice managers from all 2021, 2022, and 2023 PMHCA awardees and 2023 MMHSUD awardees. The respondent universe for the Program Implementation Survey and semi-structured interview (SSI) will comprise program implementers (e.g., program directors [PDs]/principal investigators [PIs] from all 2021, 2022, and 2023 PMHCA awardees and 2023 MMHSUD awardees. The respondent universe for the Behavioral Health Consultation Provider SSI, Care Coordinator SSI, and Champion SSI will comprise 1 representative per stakeholder group for each of the 67 PMHCA and MMHSUD The Community-Based and Other Resources SSI will be a case study with up to 50 community-based and other resources representatives across all 67 PMHCA and MMHSUD programs. 5. HRSA is collecting data in the HP Survey about the setting(s) in which HPs' patient populations live and in the Practice-level (PL) Survey about practice setting, with response options for questions in both surveys including urban, suburban, rural,

Date JBS Received Comment	Commenter	Comment	Date JBS Responded	Response
				frontier. The PL Survey also collects whether the practice is located in a federally designated medically underserved area and a federally designated rural area. Finally, both the HP Survey and the PL Survey collect the zip code of the primary clinical practice setting. Specific data on travel to access mental and behavioral care are not collected, though we collect qualitative data from Care Coordinator SSIs. Relevant data from the Care Coordinator SSIs include (1) barriers or challenges to making referrals and it is possible that travel may be one of the barriers identified, (2) types of resources they have connected with to support clients and the geographic areas in which the resources cover, (3).their systems or databases used for managing resources and specific information for each resource, which may include location of services and if the resource provides telehealth services, and (4) the types of support offered to facilitate a successful referral and it is possible that taking into account travel time to resources prior to making referrals would be an identified strategy discussed by care coordinators.

Date JBS Received Comment	Commenter	Comment	Date JBS Responded	Response
		Use of Automated Collection Techniques or Other Forms of Information Technology to Minimize the Information Collection Burden AAP supports the use of easily accessible automated collection techniques as these technologies lower the collection burden and, when the techniques include objective measures, increases the validity of the measures.		The evaluation of the MCHB PMHCA and MMHSUD programs will follow a multimethod approach. Data collection methodologies for this evaluation will use surveys (i.e., web-based, email) and virtual SSIs (e.g., Microsoft Teams, Zoom). All technology used for the survey administration (i.e., web-linked survey administered via email and via survey platform) will meet federal requirements for Section 508 accessibility. We selected the data collection methods for the evaluation because they will reduce participant burden while providing the evaluation with necessary data. Offering a web-based survey reduces burden to participants by eliminating the time it takes to write responses on a paper-based, mail-in survey. In addition, having participants respond to an online survey eliminates the time needed to mail back a paper-based survey. This reduces the burden for respondents participating in interviews via a web-based platform (e.g., Microsoft Teams, Zoom) because they will not have to write down responses to the questionnaires or travel to participate in an in-person interview. Using protected electronic data is the most secure form of data management because it eliminates the possibility of either paper documents or data being lost in transit or delivered to an incorrect location.

Date JBS Received Comment	Commenter	Comment	Date JBS Responded	Response
7/30/24	Ashaki M. Jackson, MFA, Ph.D.	**The necessity and utility of the proposed information collection for the proper performance of the agency's functions** The MAMA'S PROMISE team (referred to as PROMISE throughout) finds the proposed mixed evaluation plan to be extensive. While tools are not yet available, the approach – to evaluate practitioners' and implementation staffs' workflows – seems to be robust in understanding how grantees provide services.	7/31/2024	The evaluation design includes outcome and process evaluation, using a mixed-methods design, with primary and secondary quantitative and qualitative data collection activities across all HRSA MCHB awardees. In addition, data are collected from various program stakeholders including awardee PDs/PIs); enrolled/participating HPs and practices; program champions; community resource partner representatives; behavioral health consultation providers, and care coordinators.

Date JBS Received Comment	Commenter	Comment	Date JBS Responded	Response
		The accuracy of the estimated burden PROMISE considers the estimated burden feasible with a timeline and ample lead time to alert participants. We do question, however, what options a grantee might have if they do not employ a likely respondent. For example, PROMISE does not currently staff a Champion. Are evaluation questions and the related estimated burden eliminated for that staff, or will the evaluation team ask similar questions of other staff, increasing their time burden?		If the grantee does not employ a likely respondent, their program will not be required to participate in that data collection activity. For example, grantees were not required to have program champions (and for data collection purposes, we have requested that the identified program champions not be employed by the awardee programs). However, in talking with awardees over time, many discussed the value of having a program champion supporting program implementation and sustainability. Again, as noted above, if there is no program champion (or other likely respondent), the program will not be required to participate in that data collection.
		Ways to enhance the quality, utility, and clarity of the information to be collected PROMISE offers these initial thoughts without full awareness of the evaluation tools:		1. Patient-level data collection is not included in the scope of the HRSA Evaluation of the MCHB PMHCA and MMHSUD Programs Project. 2. To prepare likely respondents for the evaluation surveys, we have

Date JBS Received Comment	Commenter	Comment	Date JBS Responded	Response
		1. We find the breadth of roles included in the evaluation promising to more broadly understand how roles contribute to optimal implementation. It is unclear, however, how participants' voices will be reflected in this evaluation, if at all. PROMISE considers it important to ask patients: a. The extent to which they think their provider sought the most accurate, current intervention for their care; b. The extent to which patients knew and were comfortable with their diagnoses being discussed to aid their care; c. Perceived care quality for their diagnoses; and d. Clarity of information shared by their provider if the PROMISE hotline consultation, for example, yielded a change in care management. We believe that care receipt and a patient's perception thereof is part of implementation. We should note that PROMISE is housed in a data-driven unit where participants are familiar with study participation. Compensation for their time (e.g., gift cards) is a standard that we build into our budgets. 2. Related to evaluation implementation: to prepare *likely respondents* for the evaluation, it would be useful for the evaluation team to brand HRSA-MMHSUD programming in marketing leading up to evaluation activities so that providers can more easily respond to		developed a promotion packet of materials with branding guidance and customizable messages for awardees to use to (1) increase HP and practice engagement with their programs and (2) encourage participation in evaluation surveys. These materials include emails, PowerPoint slides, graphics, and social media messages. Additionally, the HP, Practice-Level, and Program Implementation Surveys will be customized for each program with the program name and logo, as applicable.

Date JBS Received Comment	Commenter	Comment	Date JBS Responded	Response
		questions. Given the numerous grant-funded programs throughout the region, the evaluation team and grantees might mention verbally and/or in materials that services are part of a HRSA-MMHSUD initiative so that when the evaluation team recruits participants will be more easily able to identify the HRSA-MMHSUD grantee (e.g., PROMISE) and engage in conversation.		
		The use of automated collection techniques or other forms of information technology to minimize the information collection burden 1. We welcome software and strategies that will help the evaluation while being minimally invasive to daily activities. Availability polls that automatically create calendar appointments on days evaluation participants note they are available; QR codes embedded in email invitations that lead to surveys; automatic email and calendar reminders; online text that is accessible to screen readers; and the option to audio record verbal responses to be transcribed later by the evaluation team are also helpful tools that shorten the logistical time required for evaluation activities. 2. Peripherally, we would like to offer that shared grantee software to collect provider and patient data of interest would have been useful to this effort. Just as HRSA Healthy Start has ChallengerSoft software available to its grantees for use via purchase of a license, HRSA MMHSUD might consider one standard software build that allows grantees to purchase user seats.		1. The evaluation of the MCHB PMHCA and MMHSUD programs will follow a multimethod approach. Data collection methodologies for this evaluation will use surveys (i.e., web-based, email) and virtual SSIs (e.g., Microsoft Teams, Zoom). All technology used for the survey administration (i.e., web-linked survey administered via email and via survey platform) will meet federal requirements for Section 508 accessibility. We selected the data collection methods for the evaluation because they will reduce participant burden while providing the evaluation with necessary data. Offering a web-based survey reduces burden to participants by eliminating the time it takes to write responses on a paper-based, mail-in survey. In addition, having participants respond to an online survey eliminates the time needed to mail back a paper-based survey. This reduces the burden for respondents participating in interviews via a web-based platform (e.g., Microsoft Teams, Zoom) because they will not have to write down responses to the questionnaires or

Date JBS Received Comment	Commenter	Comment	Date JBS Responded	Response
				travel to participate in an in-person interview. 2. As noted above, survey data collection for the evaluation of the MCHB PMHCA and MMHSUD programs will be primarily through web-linked survey administered via email and via survey platform. Data that awardees are required to collect to meet HRSA reporting requirements as part of the cooperative agreements are collected through HRSA's Electronic Handbooks (EHB).