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Health Equity Assessment Leveraging Performance Measurement (HEAL-PM) Enhancements in the Maternal, Infant, and Early Childhood Home Visiting Program

Interested Parties Summary Memo

Year 2 Engagement

Table of Contents

Executive Summary	1
Methods.....	2
Findings	2
Background and Project Overview	4
Background on the MIECHV and Tribal MIECHV Programs	4
Context for the HEAL-PM Project	5
HEAL-PM Project Overview.....	5
Continuum of Recommendations Overview.....	6
Engagement Sessions Overview	8
Convening and Moderating Meetings	8
Analysis	9
Summary of Findings	10
Overarching Feedback on the Continuum of Recommendations.....	10
Prioritization of Draft Continuum Recommendations.....	11
Strategy-Specific Feedback	13
Approach 1: Capturing the Lived Experiences of Families.....	14
Approach 2: Incorporating Community-Level Demographic and SSDOH Data	20
Approach 3: Tracking Disparities in Outcomes and Services Using Demographic Data	24
Training and Technical Assistance to Support Implementation	27
Conclusions and Next Steps	28
Appendix A. MIECHV Performance Measures	30
Appendix B. Tribal MIECHV Performance Measures	32
Appendix C. Continuum Approaches and Strategies	34
Approach 1: Capturing the Lived Experience of Families:	34
Approach 2: Incorporating Community-level Demographic Factors and the SSDOH.....	34
Approach 3: Tracking Disparities in Outcomes and Services Using Demographic Data	34
References	36

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Executive Summary

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, administered by the Health Resources and Services Administration (HRSA), provides voluntary, evidence-based home visiting services to pregnant people and parents with children up to kindergarten entry. Participating families live in communities that face greater risks and barriers to achieving positive maternal and child health.ⁱ In partnership with HRSA, the Administration for Children and Families (ACF) supports tribal organizations in developing, implementing, and evaluating home visiting programs in American Indian and Alaska Native communities through the Tribal MIECHV Program.ⁱⁱ

As a requirement of their funding, MIECHV and Tribal MIECHV funding recipients, referred to collectively in this memo as awardees,¹ collect and report data on program performance. While HRSA's mission prioritizes addressing health disparities, and there is also a growing call to capture the impact of the structural and social determinants of health (SSDOH) on the health and well-being of MIECHV and Tribal MIECHV families, the current performance measures fall short of these aspirations. There are no measures or reporting requirements that specifically address SSDOH or measure progress toward achieving health equity.²

The Health Equity Assessment Leveraging Performance Measurement (HEAL-PM) Enhancements in the Maternal, Infant, and Early Childhood Home Visiting Program project seeks to examine how the MIECHV/Tribal MIECHV performance measurement systems can better monitor and understand how document, assess, and advance health equity in home visiting. NORC at the University of Chicago is a non-profit research organization that HRSA has contracted with to conduct the HEAL-PM project. As part of this work the study team engaged a broad and diverse group of parties with an interest in the MIECHV/Tribal MIECHV performance measurement systems ("interested parties") to identify: 1) how awardees collect and measure health disparities and SSDOH among home visiting families; 2) key areas of interest or concern related to the cultural sensitivity of the existing performance measures; and 3) challenges and technical assistance needed to support awardees in collecting and assessing performance measures data to document health disparities and SSDOH. Based on meetings with interested parties and an environmental scan conducted over the past year, the study team provided preliminary recommendations for revising the MIECHV/Tribal MIECHV performance measurement systems to show how the programs are contributing to health equity. The study team then held follow-up meetings with interested parties to request feedback on these recommendations. This memo summarizes feedback on preliminary recommendations.

¹ Recipients of MIECHV Program funding are historically referred to as awardees by HRSA while those that receive grants for the Tribal MIECHV program are referred to as grantees by ACF. For this memo, we will use the term awardees when referring to both groups. We will use the term grantees when discussing meetings or findings that only apply to Tribal MIECHV grantees.

² HRSA defines health equity as the absence of disparities or avoidable differences among groups in health status and health outcomes. <https://www.hrsa.gov/about/organization/bureaus/ohe/index.html#:~:text=What%20is%20health%20equity%3F,disease%2C%20disability%2C%20or%20mortality.>

Methods

The study team held discussions with interested parties who collect, clean, report, analyze, and use the MIECHV/Tribal MIECHV Program data. From each group, the team requested feedback on draft recommendations and proposed changes to MIECHV/Tribal MIECHV performance measures. The study team met with three groups of interested parties in March 2023: 1) MIECHV awardees and Tribal MIECHV grantees, 2) home visiting model developers, and 3) participants from an affinity group session of the National Home Visiting Summit.

Findings

Interested parties shared the following overarching feedback on the preliminary recommendations:

- The **intended impacts of each recommended strategy need to be identified**. That will help interested parties better understand how to implement them.
- The MIECHV/Tribal MIECHV **performance measures may not be the most appropriate place for HRSA to focus health equity efforts**.
- The MIECHV and Tribal MIECHV Programs should have **flexibility to implement new performance measure requirements**. That will maximize the usability of each strategy for the variety of populations served by the programs.
- Recommendations in the Continuum should **minimize awardee data collection and reporting burden**.
- Changes to the performance measures **will take time to implement** and should be rolled out slowly and with consideration for other concurrent changes in reporting requirements.
- Home visitors have a **limited ability to impact the SDDOH and health equity** due to the one-on-one nature of home visiting.
- **Strategy-specific feedback**. Interested parties' provided feedback on how recommendations aligned with current program activities as well as challenges and considerations for implementing each strategy. Feedback on implementation was organized into four general themes: 1) timing of implementation, 2) resources required to support implementation, and considerations regarding 3) data collection, and 4) data analysis.

Prioritization. Awardees ranked the usability, feasibility, and burden associated with implementing each strategy. Model developers were also asked to rank the usability of each strategy. All interested parties identified the three strategies they thought should be prioritized for implementation.

- There was consensus among interested parties that Strategies 1A: Incorporate a Family Experiences of Care Measure and 1C: Improve the Cultural Responsiveness of the MIECHV Performance Measures would be the most useful and should be prioritized for implementation.
- Strategies 1B: Incorporate Home Visiting Workforce Measures and 3B: Tailor Racial and Ethnic Categories at the MIECHV/Tribal MIECHV Program Level were further prioritized for implementation by awardee teams and Home Visiting Summit participants but were ranked as low priority for model developers.

- While Strategy 3A: Disaggregate MIECHV/Tribal MIECHV Performance Measure Data by Race and Ethnicity was considered a low priority for awardees, model developers identified it as one of the top three strategies for prioritization.
- Strategies 2A: Provide Awardees with Community-Level SDOH and Demographic Data and 3A: Disaggregate MIECHV/Tribal MIECHV Performance Measure Data by Race and Ethnicity were seen as highly burdensome to implement and were considered the lowest priority for implementation by awardees.

Training and TA. Awardees are interested in receiving additional resources to facilitate implementation of recommended strategies including: 1) training and resources to support the collection and analysis of new data requirements, 2) communication materials that explain the importance and usability of new performance measures for awardees, model developers, and HRSA, and 3) training to collect data using culturally responsive methods.

Background and Project Overview

Background on the MIECHV and Tribal MIECHV Programs

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, administered by the Health Resources and Services Administration (HRSA), provides voluntary, evidence-based home visiting services to pregnant people and parents with children up to the age of kindergarten entry. Participating families live in communities that face greater risks and barriers to achieving positive maternal and child health.ⁱⁱⁱ In partnership with HRSA, the Administration for Children and Families (ACF) supports tribal organizations in developing, implementing, and evaluating home visiting programs in American Indian and Alaska Native communities through the Tribal MIECHV Program.^{iv}

As a requirement of their funding, MIECHV and Tribal MIECHV funding recipients, referred to collectively in this memo as awardees,³ collect and report data on program performance. The MIECHV/Tribal MIECHV performance measurement systems⁴ require awardees to collect and report data annually in Form 1 on service usage and program participants' demographic characteristics such as age, gender, education level, and housing status and select clinical indicators (i.e., type of health insurance coverage and usual source of medical and dental care).⁵ They also must report on a total of 19 performance measures⁶ across six benchmark areas on Form 2 (see **Appendix A** for a list of benchmark areas, constructs, and brief descriptions of each measure).⁷

For the Tribal MIECHV Program, ACF, with the input of tribal grantees and technical assistance (TA) providers, created a standardized set of performance measures.⁸ These measures require grantees to collect several types of data related to implementation and improvements for families participating in the program. Currently, grantees annually report on a total of 15 performance measures: 12 core performance measures and three of 11 additional flex measures, selected by grantees (see **Appendix B** for a list of benchmark areas, constructs, and brief descriptions of the core and flex measures). Grantees additionally use Form 1 (described above) to report relevant demographic performance measures.

³ Recipients of MIECHV Program funding are historically referred to as awardees by HRSA while those that receive grants for the Tribal MIECHV program are referred to as grantees by ACF. For this memo, we will use the term awardees when referring to both groups. We will use the term grantees when discussing meetings or findings that only apply to Tribal MIECHV grantees.

⁴ The MIECHV Program performance measures were redesigned in 2015 to align with other federal program performance measures, including those used for other maternal and child health programs. Source: Labiner-Wolfe, J., Vladutiu, C.J., Peplinski, K. et al. Redesigning the Maternal, Infant and Early Childhood Home Visiting Program Performance Measurement System. *Matern Child Health J* 2018;22::467–473. <https://doi.org/10.1007/s10995-018-2486-1>

⁵ Form 1 is used by awardees to collect demographic performance measures. Health Resources and Services Administration Maternal and Child Health. (2022, May). *The Maternal, Infant, and Early Childhood Home Visiting Program - Form 1 Demographic, Service Utilization, and Select Clinical Indicators Toolkit*, May. 2022. mchb.hrsa.gov. Retrieved October 3, 2022, from Available at: <https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/form-1-performance-measurement-toolkit.pdf>. Accessed October 3, 2022.

⁶ In Fiscal Year 2022, two additional optional measures focused on substance use screening and completed substance use referrals were added to the performance measures.

⁷ Form 2 is used by awardees to collect benchmark performance measures. Health Resources and Services Administration Maternal and Child Health. (2022, May). *The Maternal, Infant, and Early Childhood Home Visiting Program - Form 2 Performance Indicators and Systems Outcomes Toolkit*, May. 2022. mchb.hrsa.gov. Retrieved July 6, 2023, from Available at: <https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/form-2-performance-measurement-toolkit.pdf>. Accessed July 6, 2023.

⁸ ACF redesigned the Tribal MIECHV performance measures in 2015 to standardize data collection and reporting based on feedback from grantees and lessons learned from the first five years of the program. Source: Lyon, K., Geary, E., Sparr, M., Buckless, B., Salvador, M., & Morales, J. Tribal Maternal, Infant, and Early Childhood Home Visiting: A Report to Congress (OPRE Report #2015-88). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, 2015.

Context for the HEAL-PM Project

The overall purpose of the MIECHV/Tribal MIECHV performance measures is to describe the populations served and program performance, inform continuous quality improvement activities, and continuously monitor and provide oversight to awardees.⁹ Given HRSA’s mission “to improve health outcomes and achieve health equity through access to quality services, a skilled health workforce, and innovative, high-value programs”^v and in light of recent calls to better describe and understand health disparities and how social programs contribute to achieving health equity, HRSA and ACF are reassessing their approach to performance measurement by investing in the Health Equity Assessment Leveraging Performance Measurement (HEAL-PM) Enhancements in the Maternal, Infant, and Early Childhood Home Visiting Program project.

While HRSA’s mission includes the call “to improve health outcomes and address health disparities through access to quality services, a skilled health workforce, and innovative, high-value programs,” no MIECHV measures or reporting requirements focus specifically on programs’ reduction in health disparities related to race, ethnicity, social class, gender identity, disability status, or other relevant sociodemographic, geographic, or structural factors. In addition, no measures or reporting requirements currently exist to specifically measure progress toward achieving health equity, which is defined as the absence of disparities or avoidable differences among groups in health status and health outcomes.^{vi}

HRSA and ACF also increasingly recognize the need to capture the impact of community-level factors, including the structural and social determinants of health (SSDOH),¹⁰ and how they may affect the health and well-being of MIECHV and Tribal MIECHV families. Performance measures that do not include the context in which a family lives, where home visiting services are delivered, and resources that are available may not provide sufficient context to appropriately interpret performance measure data.

Finally, awardees have raised concerns about the cultural sensitivity and responsiveness¹¹ of some performance measures, including whether they are appropriately and respectfully assessing outcomes for the diverse populations served by the MIECHV and Tribal MIECHV Programs.

The HEAL-PM project is examining all of these areas.

HEAL-PM Project Overview

NORC at the University of Chicago (the study team), in partnership with HRSA and ACF, is conducting the HEAL-PM project. The goal of HEAL-PM is to examine how the MIECHV/Tribal MIECHV performance measurement systems can integrate a health equity framework to understand and monitor how awardees are documenting, assessing, and advancing health equity in home visiting.

⁹ NORC uses “awardees” to refer to participants from the MIECHV and Tribal MIECHV Programs, respectively.

¹⁰ For the purposes of this project, when discussing the social and structural determinants of health, we will be using the following definitions. **Social determinants of health** (SDOH) are the conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes (CDC, 2020). The **structural determinants of health**, in contrast, are defined as the root causes of health inequities and include all social and political mechanisms that affect whether the resources necessary for health are distributed equally or unjustly in society according to race, gender, social class, geography, sexual identity, or another socially defined group of people (Solar & Irwin, 2010).

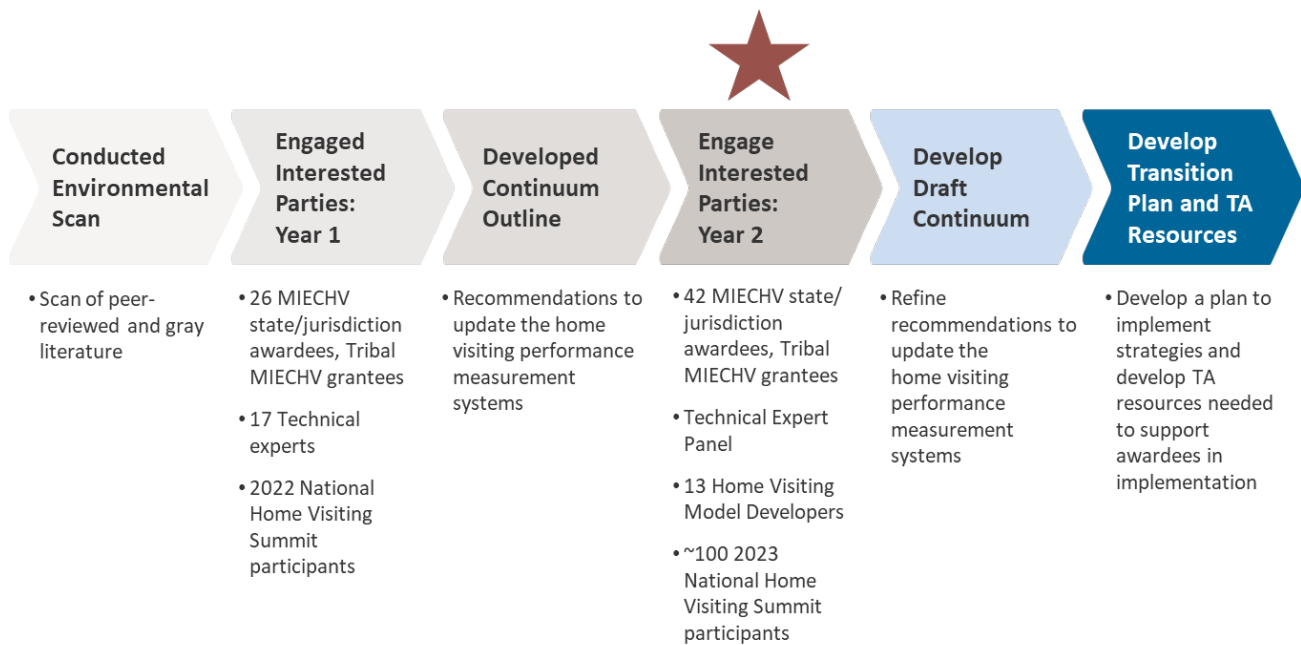
¹¹ For the purposes of this project, we are defining **cultural responsiveness** as valuing the lived experiences of others and honoring their cultural context (Cerna et al., 2021).

This project seeks to answer three key questions:

1. How can the SSDOH be used to provide context to MIECHV/Tribal MIECHV performance measure data, using a health equity measurement framework?
2. How can performance measures better reflect HRSA’s commitment to advancing health equity within the existing statutorily defined benchmark areas?
3. What aspects of data collection and TA must be considered when promoting the collection and assessment of MIECHV/Tribal MIECHV Program data within a health equity framework?

To address these questions, the study team is conducting the following activities between September 2021 and September 2023.

Exhibit 1: Timeline of HEAL-PM Project Activities



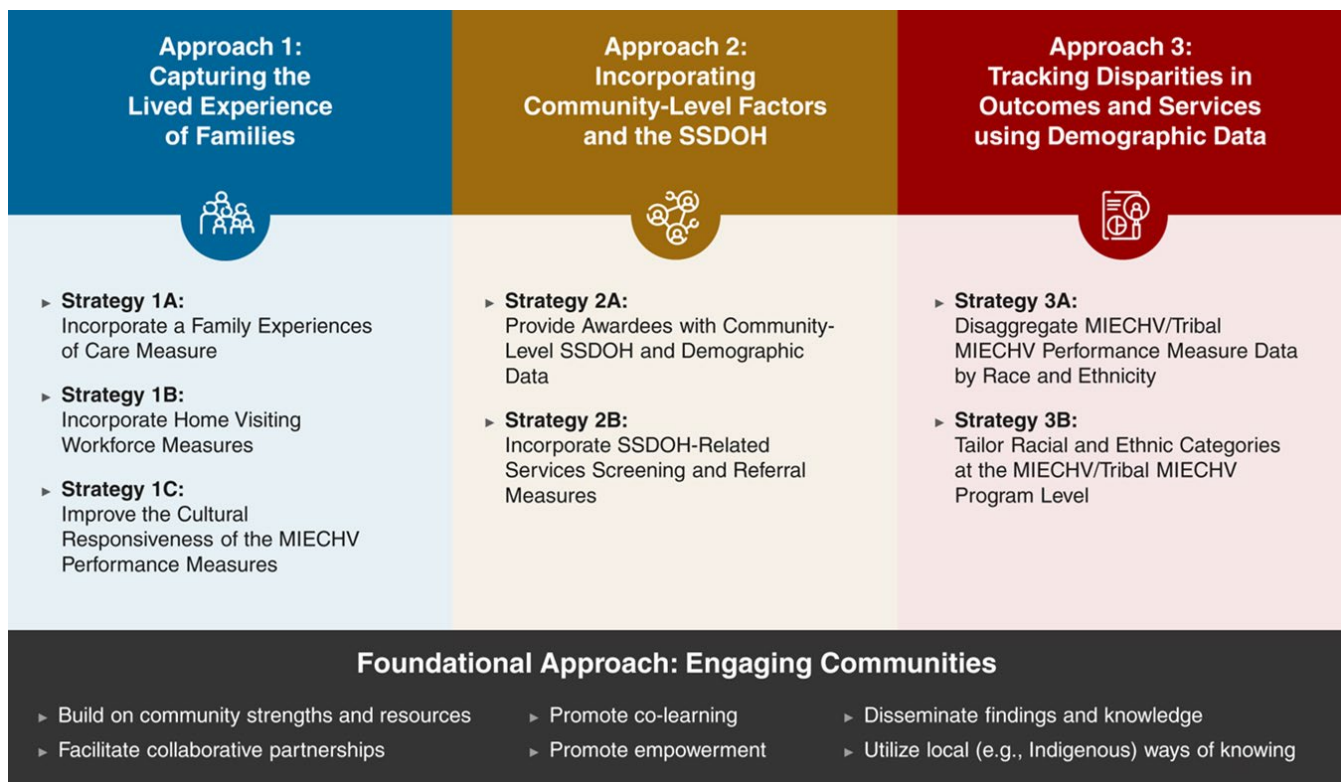
In this document, we describe our engagement activities and key findings from interested party engagement activities conducted in Year 2 (September 2022—September 2023) of the HEAL-PM project. More information about methods and key findings from Year 1 project activities (i.e., the environmental scan and interested party engagement) can be found on HRSA’s [website](#).

Continuum of Recommendations Overview

The HEAL-PM study team is in the process of developing a Continuum of Recommendations (referred to throughout this document as “the Continuum”). The goal of the Continuum is to provide HRSA and ACF with a range of recommendations to update the MIECHV/Tribal MIECHV performance measurement systems to reflect the complex, integrated, and overlapping structures and systems that contribute to health equity.

As shown in Exhibit 2, the study team has identified three key approaches to incorporate health equity into the performance measurement systems. Informed by health equity frameworks such as the Social Ecological Model^{vii} and iterations of the Healthy People 2030 Framework,^{viii} these three approaches aim to address gaps identified through activities conducted in Year 1 of the project. Within each approach, individual strategies offer a range of recommendations for how to implement these approaches with the goal of incorporating health equity within the current performance measurement systems. (See Appendix C for a description of each approach and strategy). Exhibit 2 also demonstrates that engaging communities is foundational to incorporating health equity into the performance measurement systems. In reflection of this, the study team has identified opportunities for community engagement throughout the Continuum. The purpose of Year 2 engagement activities was to gather feedback on the draft Continuum from those who are closest to the performance measurement systems including awardees and model developers.

Exhibit 2: Preliminary Continuum of Recommendations to Incorporate Health Equity into the MIECHV/Tribal MIECHV Performance Measurement Systems



Engagement Sessions Overview

Convening and Moderating Meetings

The study team's proposed changes to the MIECHV/Tribal MIECHV performance measures could have wide-ranging implications for a broad and diverse group of interested parties. These interested parties include, but are not limited to, those who collect, clean, report, analyze, and use the data. HRSA, ACF, and the study team believe it is critical to engage these parties in a meaningful process to solicit and share their unique perspectives. Accordingly, the study team engaged with three groups of interested parties in March 2023 to gather feedback on the draft Continuum: 1) MIECHV awardees and Tribal MIECHV grantees, 2) home visiting model developers, and 3) participants from an affinity group session of the National Home Visiting Summit. We briefly describe the engagement activities in Exhibit 3.

Virtual meetings with interested parties were held via Zoom's videoconferencing system. The study team provided logistical support for the awardee and model developer meetings including conducting outreach to awardees and model developers, scheduling meetings, hosting conference technology, and developing meeting summaries. Prior to the meetings, the study team emailed invitations to all MIECHV and Tribal MIECHV Program awardees and members of the Model Alliance. The invitation included meeting dates and times, an agenda, meeting objectives, and background information about the HEAL-PM project and draft Continuum. Awardees and model developers who expressed interest in attending a meeting were then issued a formal Outlook invitation. Each meeting was facilitated by two experienced facilitators. They presented information about the Continuum including a description of each strategy, how it would address health equity, and how it could be incorporated into the MIECHV/Tribal MIECHV performance measurement systems. Participants were then given the opportunity to provide feedback on each strategy through a facilitated discussion as well as written comments on Jamboard, Google Workspace's online collaborative white board. Each Jamboard remained opened for a week after each meeting to allow participants time to consult with their colleagues and provide additional feedback. Meetings concluded with final polls asking awardees to rate the usability, feasibility, and level of burden associated with each strategy as well as identify highest priority strategies for implementation.

The National Home Visiting Summit workshop session was also held virtually via Zoom and was coordinated by Start Early Events, the conference organizer. Three facilitators led the session and presented a condensed overview of the HEAL-PM project and Continuum. At the end of the presentation, feedback on the Continuum was gathered through a facilitated discussion and prioritization polls. A Jamboard was also distributed at the end of the session so that participants could leave additional feedback on the Continuum after the session ended.

Exhibit 3: Engagement Meeting Objectives and Number of Teams and/or Participants in Attendance

Meeting	Meeting Objectives	Number of Teams and/or Participants
Four MIECHV/Tribal MIECHV Awardee Meetings, each 90 minutes in length	<ul style="list-style-type: none"> • Identify the level of feasibility and burden associated with implementing each strategy • Understand how useful each strategy is for improving or addressing health equity • Identify the types of TA and other resources awardees require to implement each strategy • Gather preferences for how to incorporate each proposed strategy into the MIECHV/Tribal MIECHV reporting system (i.e., reported through the annual performance measures or another mechanism) • Identify priorities for implementation from the awardee perspective 	Meeting 1: 4 Teams (8 participants) Meeting 2: 7 Teams (8 participants) Meeting 3: 9 Teams (21 participants) Meeting 4: 4 Teams (5 participants)
One Model developer Meeting, two hours in length	<ul style="list-style-type: none"> • Understand how useful each strategy is for improving or addressing health equity • Identify the types of TA and other resources model developers require to implement each strategy • Understand how proposed strategies will impact home visiting model management information systems or data provided to awardees • Identify which proposed strategies are already being implemented by home visiting models and how HRSA can minimize duplication and awardee burden • Identify priorities for implementation from the model developer perspective 	Meeting: 10 Models (13 participants)
National Home Visiting Summit affinity group session	<ul style="list-style-type: none"> • Understand the feasibility and burden associated with implementing each strategy • Identify the types of TA or other resources required to implement each strategy • Identify priorities for implementation from the broader home visiting community 	~100 participants

Analysis

The study team analyzed transcript-style meeting notes from the awardee and home visiting model developer meetings, as well as responses submitted through the Jamboards. During analysis, the team identified themes, patterns, and interrelationships relevant to the project's key research questions. Analysis of meeting notes and Jamboard feedback was done using a combined inductive and deductive approach. Before the meetings, the team created codes based on knowledge of the subject matter and anticipated themes in the feedback. As the team reviewed and analyzed meeting materials, they also updated codes to incorporate new and emerging themes. After the team coded the data, they identified patterns and summarized key themes.

Summary of Findings

In this section, we present findings from the HEAL-PM engagement activities conducted in March 2023. We first present overarching feedback on the Continuum, reflections on usability, feasibility, and burden, and prioritization of the strategies by the different groups of interested parties. We then present feedback on each strategy including how the strategy is aligned with current activities as well as challenges and considerations for implementation that were identified by interested parties.

Overarching Feedback on the Continuum of Recommendations

Feedback collected from MIECHV/Tribal MIECHV interested parties on the Continuum fell into the following key themes:

- **Identify intended impact.** Across all strategies, awardees agreed that identifying how each strategy benefits MIECHV and Tribal MIECHV communities and helps them achieve their goals would make it easier to implement the recommendations. Understanding why a strategy is being implemented and clearly communicating that goal were identified as key priorities for awardees.
- **Meaningful connection between health equity and data collection.** Echoing concerns shared in the first year of engagement, awardees questioned whether the MIECHV/Tribal MIECHV performance measures were the most appropriate place for HRSA to focus health equity efforts. Awardees shared that reporting alone would not be enough to meaningfully incorporate health equity within the MIECHV and Tribal MIECHV Programs. *“[New performance measures] are not fruitful unless [they are] connected to a programmatic element.”* Awardees suggested that instead of adding specific data collection requirements, it may be more helpful to allow awardees to identify the types of data that would be most meaningful for their teams. For example, some awardees thought that collecting data on SDDOH resource needs (e.g., Strategy 2B) would be useful. Others, however, thought that collecting these data would not be useful given that there are limited resources within their community to address identified needs. Some awardees also suggested that these types of data collection activities could be better incorporated through other awardee activities such as continuous quality improvement projects.

“... sometimes I feel like there are a lot of data questions and sometimes I don’t know what we are trying to do.”
– Awardee
- **Allow flexibility in performance measures.** Awardees shared that the usability, feasibility, and burden of new performance measures will vary across states given the variation in populations served by the MIECHV and Tribal MIECHV Programs. They further suggested that awardees be allowed flexibility to implement new performance measure requirements. For example, awardees suggested flexibility in the selection of demographic indicators that are most meaningful for disaggregation (beyond race and ethnicity). They also suggested being allowed to select from a menu of health equity-focused options, based on which strategies would be most meaningful for their programs. This flexibility resembles the process used by Tribal MIECHV which allows grantees to select from a list of “flex measures.” Taken together, awardees believed greater flexibility in implementation of new performance measure requirements would increase usability and reduce unnecessary burden.
- **Minimize data collection and reporting burden.** MIECHV awardees, home visiting model developers, and participants from an affinity group session of the National Home Visiting Summit noted the importance of

collecting additional data that would allow them to meaningfully understand disparities that exist within the populations they serve. However, they also expressed concern that the recommendations in the Continuum would add to existing data collection and reporting burden. They noted that including additional data collection and reporting requirements can make it challenging for local implementing agencies (LIAs) to know which data should be prioritized for collection and reporting. Therefore, they suggested that HRSA and ACF consider: 1) which existing performance measures could be eliminated if new measures are added, 2) ways to align MIECHV and home visiting model data collection requirements to minimize burden and reduce duplication, and 3) consider how to improve the usefulness of the data already being collected before adding new requirements.

“Generally speaking, I think any additional data collection by sites should be limited to only the most important. They are already overburdened with reporting. There are things we already collect that we could look at differently (like disaggregating data), but there would be initial costs involved with creating new reporting to get the data out of the system.”

– Awardee

- **Allow adequate time for implementation.** Awardees noted that any changes to the performance measures will take time to implement. As a result, changes to the performance measurement systems should be rolled out slowly and with consideration for other concurrent changes in reporting requirements, such as any changes that *“home visiting models make to their standards [or] fidelity elements.”*
- **Limited impact of home visiting models on health equity.** Awardees and model developers expressed concerns that home visitors have a limited ability to impact the SSDOH and health equity. They shared that home visitors connect to individuals one-on-one and their program funding is limited and often does not cover wider community services. Therefore, they cautioned against reporting SSDOH data in the performance measurement systems as this may imply that there is a direct connection between home visiting and community-level factors.

Prioritization of Draft Continuum Recommendations

To identify the highest priority recommendations for implementation, at the end of each meeting, the study team asked awardees to rank the usability,¹² feasibility,¹³ and level of burden¹⁴ associated with each strategy.¹⁵ Model developers were asked to only rank the level of usability of each strategy. Due to time constraints, Summit participants were not polled. Usability, feasibility, and burden were ranked on a scale of 1 to 5. Burden was reverse coded, therefore 1 (or light blue) indicated low feasibility/usability and high burden and 5 (or dark blue) indicated high feasibility/usability and low burden. Exhibit 4 presents the results of these rankings.

There was consensus among awardees and model developers that Strategies 1A and 1C are the most useful for implementation, however Strategy 1A was also seen as highly burdensome and not very feasible to implement. Strategies 3A and 3B were seen as the most feasible to implement and could be fairly useful for both awardees and model developers. Strategies 2A and 2B were seen as highly burdensome to implement. Strategy 2A was

¹² Usability was defined as the extent to which the information collected can be used to address/improve health equity.








¹³ Feasibility was defined as the extent to which the information required to report the measure is available/retrievable.


¹⁴ Burden was defined as how burdensome it would be to collect and report the information. In Exhibit 4, the burden scale was reverse coded.

¹⁵ Awardees were not asked to rate the feasibility and burden of Strategy 1C: Improve the Cultural Responsiveness of the MIECHV Performance Measures because the details of what changes would be made to the performance measurement system have not yet been determined.

also viewed as the least useful for both awardees and model developers. Strategy 2B was viewed as least useful for model developers, but moderately useful for awardees.

Exhibit 4. Usability, Feasibility, Burden Rankings

	AWARDEES			MODEL DEVELOPERS
	FEASIBILITY ¹	BURDEN ²	USABILITY ³	USABILITY ³
 STRATEGY 1A: Family Experiences of Care	2.8	3.8	3.9	3.8
 STRATEGY 1B: Home Visiting Workforce	3.2	2.8	3.2	3.1
 STRATEGY 1C: Cultural Responsiveness	N/A	N/A	3.8	3.4
 STRATEGY 2A: SSDOH Data	2.4	3.6	3.1	2.8
 STRATEGY 2B: SSDOH-Related Services	3.1	4.0	3.5	2.8
 STRATEGY 3A: Disaggregate Performance Measures	3.4	3.1	3.2	3.1
 STRATEGY 3B: Tailor Racial and Ethnic Categories	3.5	2.9	3.2	3.3

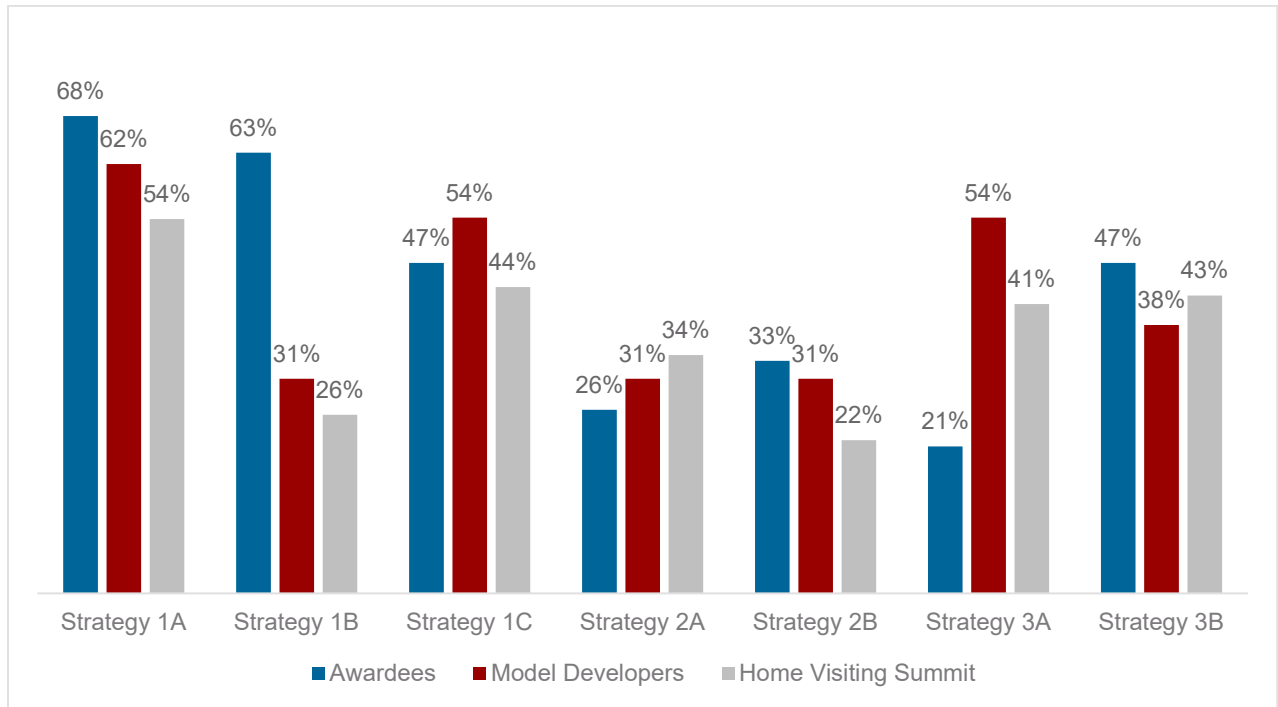
SCALE 1  5 NA
 1=low feasibility/usability, high burden
 5=high feasibility/usability, low burden

¹Extent to which the information required to report the measure is available/retrievable (1-5) where 1 is low and 5 is high feasibility

²How burdensome it would be to collect and report the information. Burden was reverse coded where 1 is high and 5 is low burden

³Extent to which the information collected can be used to address/ improve health equity (1-5) where 1 is low and 5 is high usability

The study team also asked all interested parties to prioritize their top three strategies for implementation. Exhibit 5 presents the results of this prioritization. There was consensus among awardees, model developers, and Home Visiting Summit participants that Strategies 1A and 1C should be prioritized for implementation, with Strategy 1A being most recommended across awardees, model developers, and Home Visiting Summit participants. The majority of awardee participants (12 of 19 that completed the prioritization question) also prioritized Strategy 1B for implementation. Over half of model developer participants (9 of 13) also prioritized Strategy 3A for implementation whereas very few awardees (4 of 19) prioritized it for implementation. Among all interested parties, Strategies 2A and 2B were considered lowest priority for implementation.

Exhibit 5. Interested Parties Prioritization of Draft Continuum Strategies

Note: N= 19 awardees, 13 model developers, and 82 participants in the Home Visiting Summit

Strategy-Specific Feedback

In this section, we present feedback on each strategy including how the strategy is aligned with current activities as well as implementation challenges and considerations that were identified by interested parties. Challenges and considerations for implementing each strategy are reported under four general themes:

- Timing for implementation
- Resources needed for implementation
- Data collection considerations
- Data analysis considerations

Approach 1: Capturing the Lived Experiences of Families

Strategy 1A: Incorporate a Family Experiences of Care Measure

Summary of Feedback

Across all engagement sessions, Strategy 1A received the most positive feedback. Most participants thought that Strategy 1A was highly usable, important for addressing health equity, and should be prioritized for implementation (see callout box).¹⁶ Although interested parties identified few challenges with incorporating Strategy 1A into the MIECHV/ Tribal MIECHV performance measures, they rated the level of burden associated with implementing this strategy as high. Awardees shared considerations for implementation (described in greater detail below) and a suggested revision to the proposed strategy. Rather than report a measure summary score of family engagement or satisfaction with services, awardees suggested it would be lower burden to report on the percent of families who gave feedback on their experiences with home visiting services.

Awardee Rankings

Usability:	High
Feasibility:	Low
Burden:	High
Prioritization:	High

Relationship to Current Activities

Strategy 1A aligns with current efforts to understand family experiences in home visiting. Some awardees and model developers shared that they are already collecting data related to family experiences of care and encouraged HRSA and ACF to try to leverage these ongoing data collection activities. Specifically, interested parties shared:

“This aligns with our project on family engagement and there is a lot of value in understanding the family experience.”

– Awardee

- As part of their participation in the Maternal Early Childhood Sustained Home Visiting Program (MECSH), some awardees use the MECSH Parent Satisfaction Questionnaire for data collection. To administer this survey, a link to an online survey is provided to the client via a QR code clients scan with their phone. Results are not linked to a client, but to the home visiting agency.
- One awardee uses a program experience survey administered at discharge to record families’ experiences with services. Since not all families will take the survey, there is a concern about the accuracy of survey results.
- Awardees participating in the Nurse-Family Partnership home visiting model have their home visitors fill out an encounter form on each visit with a family. This form indirectly assesses family experiences with services by asking for the nurse visitor’s observations about the way the client engaged with the visit, and what types of materials were presented to and discussed with the client, among other types of data.

¹⁶ Rankings (“high”, “medium”, “low”) were determined by awardee polling. The top two highest ranked strategies for usability/feasibility and the two lowest coded strategies for burden using the reverse code are labeled as “high”. The two lowest ranked strategies for usability/feasibility and highest coded strategies for burden are categorized as “low”. The remaining strategies are labeled as “medium”.

Considerations for Implementation

Awardees and model developers offered several considerations for implementing Strategy 1A that related to the timing of implementation, data collection activities, and the ways in which the data will be analyzed and interpreted.

- **Timing.** Awardees and model developers shared questions about the timing for collecting these data as well as the amount of time it will take to implement this strategy.
 - Awardees expressed uncertainty about the most appropriate time to collect this information. For example, awardees suggested these data could be collected: at discharge, at a single time point in the program (i.e., the six-month mark), or at multiple time points. Awardees urged HRSA to consider when to collect data on family experiences in care so that it is least burdensome.
 - Model developers also cautioned that it will take time to implement changes to data systems to report and integrate the collection of data on family experiences of care.
- **Data collection.** Awardees and model developers shared several considerations for collecting data related to family experiences of care.
 - Model developers and awardees noted that these data are already collected by some interested parties. Leveraging and standardizing data collection instruments (i.e., program and home visiting model data forms) can reduce burden on home visitors.
 - Awardees suggested that anonymous surveys could encourage more candid reflections of the home visiting experience than data collected by home visitors.
 - Model developers added that, rather than requiring all awardees to administer an entire survey, they could select relevant questions from an approved survey to reduce burden and increase usability.
 - Awardees noted that when designing data collection instruments, it is important to capture gaps in services and reasons why services have not been accessed or received.
- **Data analysis.** Awardees and model developers shared considerations for analyzing data related to family experiences of care.
 - Awardees requested guidance on reporting missing data, particularly when families exit the program without completing this survey.
 - Model developers thought that home visitors may have concerns about implementing this strategy because they feel they are being evaluated. Clear communication about the objectives of this strategy and how the data will be used is important and would facilitate implementation.

Challenges

Only one challenge was identified related to incorporating a family experiences of care measure into the MIECHV/Tribal MIECHV performance measurement systems.

- **Resources.** Awardees shared that implementing this strategy would increase burden related to data collection and staff training and result in awardees feeling the need to compensate families for having to answer multiple surveys. They further shared that they currently lack funds to compensate families and that these resource constraints should be considered when implementing this strategy.

Strategy 1B: Incorporate a Home Visiting Workforce Demographic Measure

Summary of Feedback

While Strategy 1B was considered a high-priority strategy by awardees, model developers and Home Visiting Summit participants thought that it should not be prioritized for implementation. Awardees also noted that they needed more information on how the data collected in this strategy would be used before they could fully understand the possible benefits and challenges of adopting it. Awardees further shared that before implementing this strategy, it would be important to engage communities to understand which home visitor demographic factors are most important. They also encouraged HRSA and ACF to consider the messaging of this strategy to limit unintended consequences, such as creating the perception that higher home visitor educational attainment equates to higher quality services.

Awardee Rankings

Usability:	Medium
Feasibility:	Medium
Burden:	Low
Prioritization:	High

Relationship to Current Activities

Strategy 1B aligns with current efforts to collect home visitor demographic data, particularly by model developers. A few model developers shared that they already have experience collecting these data:

- Child First collects demographic data on home visitors but includes a consent question. Home visitors must opt in before the model can use their data in analyses.
- Parents as Teachers collects information on home visitor race and ethnicity, gender, education, and language. Most of these data are currently stored in the model's data portal rather than LIAs' data systems.
- Maternal Infant Health Outreach Worker program is a community health worker model. Hired staff are intended to reflect the service population, but demographic data are not tracked except when sites are going through the model accreditation review.¹⁷

Examples of home visitor demographic indicators currently collected by interested parties

- Age
- Race
- Ethnicity
- Gender
- Language used when conducting home visits
- Primary language
- Education level
- City/town of residence
- Years of experience

Considerations for Implementation

Awardees, model developers, and Home Visiting Summit participants offered several considerations for implementing Strategy 1B that relate to the timing of implementation, data collection approach, and the analysis and interpretation of data.

¹⁷ Further exploration is needed to understand how the demographic data is used in the model accreditation process.

- **Timing.** One awardee shared that implementing this strategy would take time because any new home visitor demographic surveys would need to meet human resource requirements related to collecting employee’s demographic information.
- **Data collection.** Interested parties shared several considerations related to the collection of home visiting workforce demographic data.
 - Awardees noted that demographic data on the home visiting workforce may already exist, such as through coordinated state evaluations, and should be considered before new data collection tools are created.
 - Awardees suggested that home visitor demographic data could be collected through annual surveys.
 - Model developers suggested that demographic data should be collected on home visitor program leadership staff as well as home visitors to identify whether staff at all levels are reflective of equitable hiring practices and the communities they serve.
 - A Home Visiting Summit participant shared that it would be helpful to also include the home visiting workforce’s lived experiences as part of data collection in this strategy.
- **Data analysis.** Awardees also shared considerations related to analysis of these data:
 - Awardees requested guidance on interpreting data and clarification if awardees would be required to review alignment between demographic characteristics of home visitors and families served by a given program.
 - Awardees also noted that suppression rules would need to be developed for programs with small teams of home visitors.

“We currently collect home visitor demographics. This would be easy for us to report.”

- Awardee

Challenges

Awardees and model developers identified several challenges to implementing Strategy 1B that related to data collection and the ways in which the data would be analyzed and interpreted.

- **Data collection.** Awardees and model developers shared the following concerns related to collecting demographic data on home visitors.
 - Some models and awardees were concerned about added burden. They noted that programs and models would need to create new data collection forms so that staff can voluntarily report their demographic information and ensure that data is collected consistently and uniformly.
 - Awardees and Summit participants said that home visitors may not feel comfortable sharing demographic data and may be wary of how this information will be used in home visitor hiring practices.

“To implement this strategy, the home visiting workforce would have to be willing to participate – and there may be hesitation towards providing personal demographics and lived experiences, as they could be worried it would be used against them in some way.”

- Home Visiting Summit participant

- Model developers voiced the concern that home visiting staff may not want to disclose their demographic information to their employer due to privacy concerns and concerns about misuse of data.
- **Data analysis.** Awardees and model developers also shared concerns related to analysis of these data:
 - Awardees and model developers expressed concerns about the potential for a large volume of missing or outdated data and the added administrative oversight needed to reduce missing data.
 - Regarding the need to aggregate home visitor demographic data, awardees said that while collecting these data at the LIA level would be possible, the data would become less meaningful at the state level because of the heterogeneity of communities across states.
 - Model developers noted that there may be a large range in home visiting demographic factors among models (e.g., models that have specific educational requirements for home visitors compared to models that employ community health workers) that could make it challenging to interpret results.

Strategy 1C: Improve the Cultural Responsiveness of the MIECHV Performance Measures

Summary of Feedback

During engagement sessions, interested parties emphasized the importance of improving the cultural responsiveness of the MIECHV performance measures and data collection processes and believed that this strategy should be prioritized for implementation. As with Year 1 engagement feedback, awardees shared the performance measures they believed are most important to prioritize for reassessment (see callout box).¹⁸ Interested parties again emphasized the need for local adaptations to the performance measures to ensure that they are aligned with local cultures' goals and priorities. An awardee specifically noted the need to revise questions related to Safe Sleep to focus the performance measure on mitigating risks for adverse outcomes and providing universal education to families. Awardees additionally advocated for the inclusion of qualitative data, with one noting that it would be a "*really important component*" to improve the cultural responsiveness of the current performance measures. They noted that the inclusion of open-ended text boxes and qualitative data fields¹⁹ would allow awardees to provide additional context that could inform their quantitative performance measure data.

Awardee Rankings

Usability:	High
Feasibility:	N/A
Burden:	N/A
Prioritization:	Medium

"LIAs would appreciate that their concerns about cultural responsiveness are being heard and addressed."

– Awardee

¹⁸ Awardees were not asked to rate the feasibility and burden of Strategy 1C: Improve the Cultural Responsiveness of the MIECHV Performance Measures because the details of what changes would be made to the performance measurement system have not yet been determined.

¹⁹ Awardees can provide contextual information related to each performance measure using the Notes section for each Form 1 and Form 2 measures. *MIECHV Data & Continuous Quality Improvement*. Retrieved July 6, 2023. Available at: <https://mchb.hrsa.gov/programs-impact/programs/home-visiting/miechv-data-continuous-quality-improvement>

Relationship to Current Activities

Several interested parties shared that this strategy aligns with current thinking about needed changes to data collection efforts. Some programs and models said that they are in the early stages of adapting their data collection efforts to make them more culturally responsive.

- As part of their model-reporting requirements, MECSH provides awardees with a range of measures that they can select from depending on what is most relevant for their communities. They also provide options for data collection instruments that are more accessible and culturally responsive to the communities they serve, such as data collection forms translated in other languages, use of plain language, and emoji-based forms.

Performance measure constructs identified as high priority for reassessment

- Safe sleep
- Intimate partner violence screening
- Breastfeeding
- Tobacco cessation referrals
- Developmental screening
- Preterm birth
- Parent-child interaction
- Behavioral concern inquiries
- Child maltreatment

Considerations for Implementation

Awardees and model developers offered several considerations for implementing Strategy 1C that related to the timing of implementation, the resources needed for implementation, and collection of data.

- **Timing.** Awardees and model developers shared several considerations relating to the timing of implementation:
 - Awardees said that community engagement would require a minimum of one year in order to offer sufficient opportunities for meaningful engagement.
 - Model developers encouraged HRSA and ACF to consider the required timeframes for data collection of specific measures to improve the cultural responsiveness of the measures and reduce data collection burden on families.
 - Model developers also shared that if changes were made to the performance measures because of the re-assessment, models and awardees would also need adequate time to incorporate these changes into their data collection forms.
- **Resources.** Awardees and model developers also shared suggestions for resources to support the collection of data using culturally responsive methods and strategies.
 - Awardees viewed this strategy as an opportunity for TA providers to take a larger role in implementation, thereby removing the onus from the awardees and LIAs to identify or develop culturally responsive methods for data collection.
 - Model developers said that trainings should be provided to staff to ensure that performance measure data are being asked in culturally responsive ways.
- **Data collection.** Awardees and model developers shared a couple considerations related to improving the cultural responsiveness of the MIECHV performance measures:
 - Awardees said that any re-assessment of the existing measures should include the review and inclusion of culturally validated measures.

- Model developers suggested that MIECHV Programs be allowed greater flexibility in their reporting requirements so that they can tailor data collection activities only to data that are most meaningful to their communities.

Challenges

The details of changes that would be made to the performance measurement systems to improve their cultural responsiveness have not yet been determined. As a result, few challenges were identified for this proposed strategy.

- **Timing.** Awardees noted that the time needed for meaningful community engagement would be a challenge.
- **Data Collection.** Model developers noted that the variation in cultures served by the MIECHV Program may make it hard to identify measures that are culturally responsive to all families.

Approach 2: Incorporating Community-Level Demographic and SSDOH Data

Strategy 2A: Contextualize Performance Measure Data by Community-Level SSDOH and Demographic Data

Summary of Feedback

During engagement sessions, awardees and model developers generally thought that Strategy 2A would produce the least usable information. Awardees also rated this strategy as the least feasible to implement. Model developers and Home Visiting Summit participants agreed that Strategy 2A should not be prioritized for implementation. Overall, some interested parties thought that using HRSA-provided community-level demographic data and data that proxy the SSDOH would offer important context for understanding the process and outcome measures. However, it was generally ranked as low priority for implementation. All interested parties identified challenges associated with implementing this strategy.

Awardee Rankings

Usability:	Low
Feasibility:	Low
Burden:	Medium
Prioritization:	Low

Relationship to Current Activities

Strategy 2A aligns with current efforts by some home visiting models to contextualize home visiting outcome data using community-level demographic and SSDOH data.

- MECSH ordinarily requires awardees to report on the reach of the program within targeted demographic factors. However, they noted they have not been able to systematically gather these data to date due to the lack of community profile data. They said this strategy could help facilitate use and reporting of these data.
- NFP regularly accesses publicly available community-level data for research and evaluation purposes. This is done by the national service office, not local affiliates.
- Numerous awardees shared that Strategy 2A was similar to the data provided by HRSA and analyses required as part of the recent MIECHV Needs Assessment.²⁰

“We have started to include data collection such as food insecurity, adults with developmental delays, health care shortage areas, etc. It is difficult to find valid and reliable [screening] questions.”

– Awardee

Considerations for Implementation

Interested parties offered several considerations for implementing Strategy 2A that related to the timing and resources needed for implementation, collection of data, and analysis.

- **Timing.** Awardees shared suggestions for lowering the burden during the implementation of Strategy 2A.
 - Because administrative data sources (like the American Community Survey) are typically updated every three to five years and community-level factors are not likely to change year-to-year, some awardees recommended that this strategy be implemented every few years (like the timing of the MIECHV Needs Assessments) instead of annually.
 - Awardees also suggested a slow roll-out of this strategy with a few interested states selected to initially pilot this activity. This pilot process could refine the timing and guidance needed for implementation nationally.
- **Resources.** Home Visiting Summit participants noted that TA would be required to support awardees in using these data to advance health equity. They did not, however, provide examples of what type of resources would be useful.
- **Data Collection.** Awardees and model developers shared several considerations for data collection.
 - Some awardees noted that publicly available SSDOH data already exists and should be leveraged as part of this strategy, such as the Child Opportunity Index data.
 - There was a lack of consensus among awardees regarding the level of data that would be most useful. Some awardees thought that county-level data might not be granular enough to understand

²⁰ If implemented, Strategy 2A would involve HRSA providing SSDOH data that awardees could use to better contextualize downstream health status indicators, including those used to determine risk through the MIECHV Needs Assessment. As part of the most recent MIECHV Needs Assessment, HRSA provided data based on indices of risk in five domains: low socioeconomic status, adverse perinatal outcomes, child maltreatment, crime, and substance use disorder, based on nationally available community-level data. Retrieved July 6, 2023. Available at: <https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/miechv-territory-needs-assessment-update.pdf>

their community and would prefer zip code-level data. Other awardees said that they struggled with small numbers and the resulting data suppression to protect privacy even with county level data.

- Another awardee offered that data shared by zip code could be aligned with data collected on the MIECHV Form 4 quarterly report that provides data on families served.
- **Data analysis.** Awardees also shared considerations for analyzing data related to this strategy.
 - Some awardees said that state partners could support data analysis (specifically connecting Census data to local data).
 - Awardees also believed they would benefit from guidance on how to interpret results. For example, one awardee asked for clarification about whether HRSA’s goal was to determine if MIECHV Programs serve clients seen as “higher risk” based on community-level demographic factors.

Challenges

Interested parties identified several challenges associated with implementing Strategy 2A related to the timing and resources needed for implementation and the burden associated with analyzing these data.

- **Timing.** Awardees noted that addressing the SSDOH takes time to implement and see impacts. This long timeframe should be taken into account when implementing this strategy.
- **Resources.** Awardees and model developers expressed concern that linking SSDOH data to home visiting performance measure data and sharing this information with LIAs would be time and labor intensive for awardees.
- **Data analysis.** Awardees and Home Visiting Summit participants identified several challenges with analyzing these data.
 - Awardees thought that it would be a “*heavy lift*” to connect SSDOH and demographic data to MIECHV program data at the census tract level.
 - Awardees shared additional concerns about the usability of HRSA-provided data. Two noted that when analyzing data HRSA provided for the Needs Assessment, they did not find the data granular enough and substituted their state data because they believed it was higher quality.
 - A Home Visiting Summit participant said that using community-level data can lead to challenges with small numbers when analyzing or disaggregating due to low population sizes.

Strategy 2B: Incorporate SSDOH-Related Services Screening and Referral Measures

Summary of Feedback

Interested parties generally felt that Strategy 2B would be the most burdensome to implement. The usefulness of collecting data on SSDOH-related service needs and referrals was mixed, due in part to the availability of resources that address the SSDOH within communities. Some awardees appreciated the opportunity to report on resource needs within their community; however, others thought the burden of additional reporting outweighed this benefit. Some suggested that this strategy could be more useful if awardees reported on whether needs had been addressed,

Awardee Rankings

Usability:	Medium
Feasibility:	Medium
Burden:	High
Prioritization:	Low

not if referrals had been made. Overall Strategy 2B was rated as low priority for implementation among awardees, model developers, and Home Visiting Summit participants.

Relationship to Current Activities

Several awardees have found data on SSDOH-related resource needs to be useful and currently collect this information.

- One tribal grantee shared that Tribal MIECHV uses a family-centered needs assessment tool that assesses several client factors including health insurance status, food, and housing needs. To allow home visitors to build a relationship with the families they serve, they only conduct the screening six months after a family has been enrolled. Following these screenings, home visitors use tools from the family-centered screenings to make any necessary referrals. However, one grantee noted that screening for SSDOH-related services is challenging when there are not resources available in a community to address these needs (e.g., programs and services addressing housing needs, food insecurity, access to public transportation).
- Several awardees collect information on SSDOH-related needs to meet existing model requirements. For example, some awardees shared reporting this information as part of their NFP reporting.

“We know already what some of the biggest gaps are...The tools are not there, built into the system, to be able to address them.”

– Awardee

Considerations for Implementation

Interested parties offered several considerations for implementing Strategy 2B that relate to the timing of implementation and collection of data.

- **Timing.** Awardees discussed the ideal timing for assessing this information. One awardee suggested that screenings for resource needs could be administered at enrollment and then conducted annually.
- **Data collection.** Awardees, model developers, and Home Visiting Summit participants shared a couple of data collection considerations for implementation.
 - Awardees suggested that if assessment of resource needs are included as a performance measure, HRSA should include an option for when services are not available and referrals can therefore not be made.
 - Awardees noted that HRSA must define what qualifies as a referral prior to developing data collection tools.
 - Model developers suggested that having the flexibility to use SSDOH screening tools that already exist would minimize the burden of creating new data collection instruments.
 - Home Visiting Summit participants added that it is important to balance locally meaningful understandings of SSDOH with standardized definitions and measures.

Challenges

Awardees and model developers identified several challenges with this strategy related to the resources needed for implementation and data collection.

- **Resources.** Awardees and model developers noted that updating or creating new data tools would increase financial strain and would require additional staff training.
- **Data collection.** Awardees and model developers shared several challenges related to data collection.
 - Awardees noted that implementation of this strategy would add burden for home visitors by requiring them to track referrals and follow up with families to determine if connections to resources were made.
 - A few awardees expressed concerns about the unintended consequences of collecting data on SDOH needs when the appropriate services and resources are lacking in the community. One awardee noted that this can “amplify feelings of helplessness for the client.”
 - Model developers thought that relationship building between home visitors and families might be strained with the addition of more data collection requirements. This would also add an administrative burden to those that do not currently collect these data.

Approach 3: Tracking Disparities in Outcomes and Services Using Demographic Data

Strategy 3A: Disaggregate Performance Measure Data by Race and Ethnicity

Summary of Feedback

There were inconsistencies between the rankings of Strategy 3A and feedback provided through discussions with interested parties. While this strategy was generally viewed as highly feasible to implement through polling, during facilitated discussions, awardees and model developers identified several implementation challenges. In general, they believed it would be more feasible to disaggregate a targeted selection of performance measures rather than be required to disaggregate all MIECHV performance measures. Awardees also shared that this strategy could be more meaningful if the current race and ethnicity categories are revised to better reflect the identities of families served by MIECHV/Tribal MIECHV home visiting programs. Overall, this strategy was rated as low priority for implementation by awardees, but high priority by model developers.

Awardee Rankings

Usability:	Medium
Feasibility:	High
Burden:	Medium
Prioritization:	Low

“Race/ethnicity data need to be meaningful before disaggregation could be helpful, otherwise [this could be] potentially misleading/harmful.”

– Awardee

Relationship to Current Activities

Though awardees noted challenges with disaggregating performance measure data by race and ethnicity, several explained that they are currently implementing this activity because they believe the value of this activity outweighs the burden. Some model developers also viewed this strategy as important and currently include options for data disaggregation.

“This is a project we have planned for this year and anticipate will take significant staff time - but we think it's important to do.”

– Awardee

- NFP has recently introduced a feature in their automated reports that allows for disaggregation of model outcome measures by race and ethnicity data.
- Parents as Teachers’ data system allows Form 2 reports to be exported by race and ethnicity at the family level.
- One awardee said that they began disaggregating performance measure data by race and ethnicity but encountered challenges because of the ways in which race and ethnicity data gets collected by local implementing agencies across the state. Additionally, this state served several different home visiting models that all collect race and ethnicity data differently and this variability limited the usability of the data at the aggregate level. They now disaggregate performance measure data by other SSDOH factors (e.g., income and education).

Considerations for Implementation

Awardees and model developers shared the following considerations for analyzing data.

- **Data analysis.** Awardees requested guidance on how to address issues of missing demographic data given concerns with the quality of the MIECHV race and ethnicity data. Awardees noted that before disaggregating data by race and ethnicity can be useful, the race and ethnicity categories should be revised so that they are more meaningful for populations served. It is also important to allow states to choose the demographic indicators that would be most meaningful for disaggregation (beyond race and ethnicity) as this may vary by program and state. For example, one awardee thought that demographic indicators including food insecurity, developmental delays, and special healthcare needs would be more meaningful for disaggregation.
 - Model developers also noted that there may be data privacy concerns when disaggregating performance measure data by racial and ethnic subgroups with small numbers. HRSA will need to develop suppression rules and guidelines to support implementation of this strategy.

Challenges

Awardees and model developers shared several challenges to implementing Strategy 3A related to resources needed, data collection, and analysis.

- **Resources.** Awardees said that implementation of this strategy would involve changes to the way that data are collected and would result in increased time and costs to make these changes.
- **Data collection.** Model developers said that allowing awardees greater flexibility to report racial and ethnic data would increase burden on model developers when trying to aggregate these data.

- **Data analysis.** Awardees identified several data analysis challenges related to this strategy.
 - Disaggregating data by race and ethnicity at the state level may not be meaningful for LIAs because local demographics may be different than those at the state level.
 - Disaggregating data by race and ethnicity may be challenging for states with small race and ethnicity subpopulations.
 - Data interpretation should include other contextual data, not just data disaggregated by race and ethnicity as it can result in “*victim-blaming.*”

Strategy 3B: Tailor Racial and Ethnic Categories to Better Reflect MIECHV/Tribal MIECHV Programs

Summary of Feedback

Awardees generally thought that implementing Strategy 3B would be feasible and the additional data was a relatively low burden to collect and report. They rated this strategy as medium priority, but the data of low usability. One awardee noted that including self-reported data would be particularly valuable for Latinx families who often struggle with the standard categories not matching their identity. This strategy was tied for the third most prioritized strategy by awardees and fourth most prioritized strategy for model developers.

Awardee Rankings

Usability:	Low
Feasibility:	High
Burden:	Low
Prioritization:	Medium

Relationship to Current Activities

Interested parties believed that expanding racial and ethnic categories was important to ensure that families felt reflected in the racial and ethnic data collected by the MIECHV and Tribal MIECHV Programs. Some awardees and model developers said that they are considering changes to how they collect race and ethnicity data in an effort to better reflect the racial and ethnic identities of home visiting families.

“Overall, this flexibility would be welcome to make categories more relevant to our state.”

– Awardee

- One awardee team currently allows families to self-report their race and ethnicity. As part of this effort, they also allow families to select multiple racial and ethnic categories.
- Another awardee collects data on families’ tribal affiliation in addition to the required performance measure racial and ethnic categories. They use this information to inform their home visit planning and support materials.

Considerations for Implementation

Awardees shared a consideration for implementing Strategy 3B related to data collection.

- **Data collection.** Awardees suggested that, in addition to expanding the racial and ethnic categories, families should be allowed to select more than one race and/or ethnicity. Meanwhile, model developers suggested that instead of creating additional racial and ethnic categories, qualitative or open-ended text

boxes could allow families the option to self-identify if the provided race and ethnicity options were not a good fit.

Challenges

Awardees and model developers shared concerns regarding data collection requirements for this strategy.

- **Data collection.** Awardees and model developers noted that new racial and ethnic categories will need to be aligned with shifting Office of Management and Budget standards. Awardees added that even if tailored racial and ethnic categories were established for MIECHV/Tribal MIECHV reporting, awardees would have to aggregate these results into broader racial and ethnic categories to align with other large data sets.

Training and Technical Assistance to Support Implementation

Awardees identified the training and TA that would help them implement the recommendations that were suggested in the Continuum. These included:

- **Training on data collection, usage, and analysis.** In addition to the additional time and resources needed to implement the strategies, some awardees said that their teams would need training in the following areas:
 - Conducting data collection on family experiences of care (Strategy 1A)
 - Detailed data element definitions for home visiting workforce measures so reporting can be accurate (Strategy 1B)
 - Assistance on how to understand, process, and use data sets that include community-level SDOH and demographic data (Strategy 2A)
 - Building systems around data interoperability and wrap-around services (Strategy 2B)
 - Guidance on how to report missing data (Strategy 2B)
 - Guidance on reporting small cell sizes that are likely to result from data disaggregation (Strategy 3A)
 - Guidance on how to interpret and share disaggregated data that highlights health disparities and how to work with LIAs to provide needed context about that data for analysis (Strategy 3A)
 - General assistance on data analysis and disaggregating data including how to best share this information with LIAs and how to reduce disparities (Strategy 3A)
- **Resources to support the collection of data using culturally responsive methods.** Awardees requested data collection training and informational materials to improve the cultural responsiveness of the MIECHV/Tribal MIECHV data collection process including:
 - Training and support on best practices for collecting data in culturally responsive ways, especially on sensitive topics like lived experiences (Strategy 1A).

“It would be great if HRSA could develop specific instructions for developing reports for the known data system providers. Maybe an ongoing CoP for report developers.”

– Awardee

- Resources to improve interpretation services for families who would ensure staff awareness of culturally relevant practices and norms, depending on the specific culture of each family they work with (Strategy 1C).
- TA to identify and use culturally responsive measures that are also validated (Strategy 1C).

Conclusions and Next Steps

This summary memo describes key findings from the interested party engagement activities conducted in March 2023 of the HEAL-PM project. The purpose of these activities was to gather unique perspectives and feedback on the draft Continuum from a range of interested parties who would be impacted by changes made to the MIECHV/Tribal MIECHV performance measurement systems.

Interested parties shared feedback on each strategy including how the strategy is aligned with current activities as well as the usability, feasibility, and level of burden associated with each strategy. They also identified challenges and considerations for implementing each strategy related to the timing of implementation, the resources needed for implementation, data collection, and data analysis. The study team was able to draw the following conclusions from engagement sessions with awardees, model developers, and Home Visiting Summit participants:

- **Prioritization.** There was consensus among awardees, model developers, and Home Visiting Summit participants that Strategies 1A and 1C would be the most useful and should be prioritized for implementation. Strategies 1B and 3B were further prioritized for implementation by awardee teams and Home Visiting Summit participants but were ranked as low priority for model developers. While Strategy 3A was considered a low priority for awardees, model developers prioritized it as one of the top three strategies for implementation. Strategies 2A and 2B were seen as highly burdensome to implement and were the least useful. Across interested parties these strategies were considered the lowest priority for implementation.
- **Considerations for Implementation.** Interested parties shared a number of considerations that could guide the implementation of strategies in the draft Continuum, they include:
 - Level of burden was a key area of concern for awardees, model developers, and Home Visiting Summit participants. These interested parties encouraged HRSA and ACF to reduce existing performance measure requirements before adding new ones and to try to leverage data that is already being collected by awardees and model developers.
 - The amount of time needed for implementation was also discussed across interested parties. Providing awardees and models with sufficient time to adopt new performance measures and considering a slow or staggered roll-out of new requirements were all noted as key factors that could facilitate implementation.
 - Flexibility in the implementation of new requirements was also noted as an area of interest for awardees and model developers. In particular, awardees shared that they would like to select from a “menu” of equity-focused performance measures in an effort to reduce burden and ensure new performance measures are best aligned with individual MIECHV/Tribal MIECHV program goals and communities served.

- **Training and TA.** Areas for future discussion and resource development to facilitate implementation of these strategies include:
 - Training and resources to support the collection and analysis of new data requirements.
 - Communication materials that clearly state why new performance measure requirements are important, how the data can be used by awardees and model developers, and how it will be used by HRSA.
 - Data collection training and informational materials to improve the cultural responsiveness of the MIECHV/Tribal MIECHV data collection process.

Informed by findings from our interested party engagement, the study team will finalize the continuum of recommendations to guide updates, alternatives, or flexibilities to the existing MIECHV/Tribal MIECHV performance measurement systems. In collaboration with HRSA, the study team will use the Continuum to identify three to four high priority strategies to prioritize for implementation. The team will then develop a transition plan to guide implementation of these prioritized strategies for HRSA as well as a plan to develop TA and resources for awardees needed to support implementation of the strategies.

Appendix A. MIECHV Performance Measures

Appendix Exhibit A: Overview of Benchmark Areas, Constructs, and Descriptions for Current Performance Measures Reported by MIECHV Program Awardees Annually

Benchmark Area	Construct	Measure Description
Maternal and Newborn Health	1 Preterm Birth	<ul style="list-style-type: none"> Percent of infants who are born preterm
	2 Breastfeeding	<ul style="list-style-type: none"> Percent of infants who are breastfed at six months of age
	3 Depression Screening	<ul style="list-style-type: none"> Percent of primary caregivers who are screened for depression
	4 Well Child Visit	<ul style="list-style-type: none"> Percent of children who received the last AAP recommended visit
	5 Postpartum Care	<ul style="list-style-type: none"> Percent of individuals who received a postpartum care visit within 8 weeks of giving birth
	6 Tobacco Cessation Referrals	<ul style="list-style-type: none"> Percent of primary caregivers who reported using tobacco and were referred to tobacco cessation counseling or services
	1* Substance Use Screening	<ul style="list-style-type: none"> Percent of primary caregivers enrolled in home visiting who are screened for both unhealthy alcohol use using a validated tool within 6 months of enrollment
Child Injuries, Maltreatment, and Emergency Department Visits	7 Safe Sleep	<ul style="list-style-type: none"> Percent of infants who are always placed to sleep on their back
	8 Child Injury	<ul style="list-style-type: none"> Rate of injury-related visits to the Emergency department
	9 Child Maltreatment	<ul style="list-style-type: none"> Percent of children with at least one investigated case of maltreatment
School Readiness and Achievement	10 Parent-Child Interaction	<ul style="list-style-type: none"> Percent of primary caregivers who receive an observation of caregiver-child interaction using a validated tool
	11 Early Language and Literacy Activities	<ul style="list-style-type: none"> Percent of children with a family member who reported that they read, told stories, and/or sang songs with their child daily
	12 Developmental Screening	<ul style="list-style-type: none"> Percent of children with a timely screen for developmental delays using a validated tool
	13 Behavioral Concern Inquiries	<ul style="list-style-type: none"> Percent of home visits where primary caregivers were asked if they have any behavioral concerns about their child
Crime or Domestic Violence	14 Intimate Partner Violence Screening	<ul style="list-style-type: none"> Percent of primary caregivers who are screened for IPV within 6 months of enrollment using a validated tool
Family Economic Self-Sufficiency	15 Primary Caregiver Education	<ul style="list-style-type: none"> Percent of primary caregivers without a high school degree or equivalent who subsequently enrolled in or completed high school or equivalent
	16 Continuity of Insurance Coverage	<ul style="list-style-type: none"> Percent of primary caregivers who had continuous health insurance coverage for at least 6 consecutive months for the most recent 6 consecutive months

Benchmark Area	Construct	Measure Description
Coordination and Referrals	17 Completed Depression Referrals 18 Completed Developmental Referrals 19 Intimate Partner Violence Referrals 2* Completed Substance Use Referrals	<ul style="list-style-type: none"> • Percent of primary caregivers referred to services for a positive screen for depression who receive one or more service contacts • Percent of children with positive screens for developmental delays who receive services in a timely manner • Percent of primary caregivers with positive screens for IPV who receive referral for information for IPV • Percent of primary caregivers referred to services for a positive screen for substance use who receive more service contacts
Form 1	Demographic Performance Measures	<ul style="list-style-type: none"> • Unduplicated count of New and Continuing Program Participants served by MIECHV • Unduplicated count of Households served by MIECHV • Index Children by Age • Participants by Ethnicity • Participants by Race • Adult Participants by Marital Status • Adult Participants by Education Attainment • Adult Participants by Employment Status • Adult Participants by Housing Status • Primary Language Spoken at Home • Household Income in Relation to Federal Poverty Guidelines • Program Staff Demographics (i.e., age, gender, race/ethnicity, educational attainment) • Unduplicated Count of Home Visiting Staff Full Time Equivalent

Appendix B. Tribal MIECHV Performance Measures

Appendix Exhibit B: Overview of Benchmark Areas, Core Constructs, and Descriptions for Current Performance Measures Reported by Tribal MIECHV Program Awardees

Benchmark Area	Construct	Measure Description
Implementation	1 Receipt of Home Visits	<ul style="list-style-type: none"> Percentage of recommended home visits received by families enrolled in the home visiting program during the reporting period
	2 Home Visit Implementation Observation	<ul style="list-style-type: none"> Percentage of recommended home visits where home visitors are observed for implementation quality and receive feedback from their supervisors during the reporting period
	3 Reflective Supervision	<ul style="list-style-type: none"> Percentage of recommended individual and/or group reflective supervision sessions received by home visitors and supervisors during the reporting period
I - Maternal and Newborn Health	4 Depression Screening	<ul style="list-style-type: none"> Percent of primary caregivers enrolled in HV who are screened for depression using a validated tool within 3 months of enrollment
	5 Substance Abuse Screening	<ul style="list-style-type: none"> Percent of primary caregivers enrolled in HV who are screened for substance abuse using a validated tool within 3 months of enrollment and at least annually thereafter
	6 Well Child Visit	<ul style="list-style-type: none"> Percent of the AAP-recommended number of well-child visits received by children enrolled in home visiting during the reporting period
	1* Breastfeeding	<ul style="list-style-type: none"> Percentage of women enrolled prior to child's birth who initiate breastfeeding
	2* Postpartum Care	<ul style="list-style-type: none"> Percent of mothers enrolled in HV prenatally or within 30 days after delivery who received a postpartum visit with a health care provider within 8 weeks (56 days) of delivery
	3* Immunizations	<ul style="list-style-type: none"> Percent of children enrolled in HV who receive all AAP-recommended immunizations during the reporting period
II - Child Injuries, Maltreatment, and Emergency Department Visits	7 Child Injury Prevention	<ul style="list-style-type: none"> Percentage of primary caregivers enrolled in home visiting who are provided with training on prevention of child injuries
	4* Screening for Parenting Stress	<ul style="list-style-type: none"> Percentage of primary caregivers who are screened for parenting stress using a validated tool within 3 months of enrollment and at least annually thereafter
	5* Safe Sleep	<ul style="list-style-type: none"> Percentage of primary caregivers educated about the importance of putting infants to sleep on their backs, without bed-sharing and soft-bedding
	6* Child Injury	<ul style="list-style-type: none"> Rate of injury-related visits to the ED or urgent care since enrollment among children enrolled in HV
III - School Readiness and Achievement	8 Parent-Child Interaction	<ul style="list-style-type: none"> Percent of primary caregivers enrolled in HV who receive an observation of caregiver-child interaction by the home visitor using a validated tool
	9 Developmental Screening	<ul style="list-style-type: none"> Percentage of children enrolled in HV screened at least annually for developmental delays using a validated parent-completed tool
	7 Early Language and Literacy Activities	<ul style="list-style-type: none"> Percent of children enrolled in HV with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child daily.

Benchmark Area	Construct	Measure Description
IV - Crime or Domestic Violence	10 Intimate Partner Violence (IPV) Screening	<ul style="list-style-type: none"> Percentage of primary caregivers enrolled in HV who are screened for IPV using a validated tool within 6 months of enrollment and at least annually thereafter
V - Family Economic Self-Sufficiency	11 Screening for Economic Strain	<ul style="list-style-type: none"> Percentage of primary caregivers who are screened for unmet basic needs (poverty, food insecurity, housing insecurity, etc.) within 3 months of enrollment and at least annually thereafter
VI - Coordination and Referrals	12 Completed Depression Referrals 8* Completed IPV referrals 9* Completed Depression and Parenting Stress Referrals 10* Completed Substance Abuse Referrals 11* Completed Economic Strain Referrals	<ul style="list-style-type: none"> Percentage of children enrolled in HV with positive screens for developmental delays (measured using a validated tool) who receive timely services and a follow up Percentage of primary caregivers screening positive for intimate partner violence who receive a timely referral for services and a follow up Percent of primary caregivers screening positive for depression or parenting stress using a validated tool who receive a timely referral for services and a follow up Percent of primary caregivers screening positive for substance abuse using a validated tool who receive a timely referral for services and a follow up Percent of primary caregivers with unmet basic needs who receive a timely referral for services and a follow up
Form 1	Demographic Performance Measures	<ul style="list-style-type: none"> Unduplicated count of New and Continuing Program Participants served by MIECHV Unduplicated count of Households served by MIECHV Index Children by Age Participants by Ethnicity Participants by Race Adult Participants by Marital Status Adult Participants by Education Attainment Adult Participants by Employment Status Adult Participants by Housing Status Primary Language Spoken at Home Household Income in Relation to Federal Poverty Guidelines

Note: * indicates a flex measure. Awardees must select 3 measures from this list to report on. Two measures must be selected from items 1—7 and one measure from items 8—11.

Appendix C. Continuum Approaches and Strategies

Approach 1: Capturing the Lived Experience of Families:

GOAL: Approach 1 addresses the broader call in the home visiting and family support fields to better understand how and why families engage in programs, to maximize program benefits and promote more equitable service provision. This approach will help determine whether the MIECHV and Tribal MIECHV Programs are meeting the needs of families and measuring their experiences in culturally responsive ways.

- **Strategy 1A:** Captures lived experiences of home visiting families by assessing experiences in care such as satisfaction with services, respect in the home visitor interaction, and family engagement in services.
- **Strategy 1B:** Incorporates systematic data collection on the home visiting workforce to contextualize families' lived experiences and engagement with home visiting services.
- **Strategy 1C:** Proposes a process to improve the cultural relevance and responsiveness of the MIECHV/Tribal MIECHV performance measures to ensure they are reflective of the lived experience of the families served and are collected using culturally responsive methods.

Approach 2: Incorporating Community-level Demographic Factors and the SSDOH

GOAL: Approach 2 moves the MIECHV/Tribal MIECHV performance measurement systems beyond individual level health outcomes and risk behaviors to incorporate the structural, institutional, and social factors that drive health inequities. This approach leverages existing SSDOH data sources and tracks screening and referrals to SSDOH services to identify root causes of inequities and possible points of intervention.

- **Strategy 2A:** Uses community-level demographic data and data that proxy SSDOH to contextualize MIECHV Form 1 and Form 2 data and align home visiting service allocation, enhancements, and adaptations.
- **Strategy 2B:** Incorporates screening for families' financial strain and basic resource needs to capture the critical role home visiting plays in connecting families to resources and services that address the SSDOH (e.g., nutrition assistance, financial assistance, housing, and transportation).

Approach 3: Tracking Disparities in Outcomes and Services Using Demographic Data

GOAL: Approach 3 aims to capture progress towards improving health equity and reductions in health disparities by tracking trends in outcomes and access to services using demographic factors known to be key drivers of systemic and structural inequities. It also incorporates equitable practices for disaggregating data by allowing for the breakdown of race and ethnicity into finer and more tailored categories. This approach will unmask disparities that can be hidden when data are reported in aggregate, improve data quality, and identify communities that may be underserved by home visiting.

- **Strategy 3A:** Disaggregates existing MIECHV/Tribal MIECHV performance measures by race and ethnicity (or other relevant demographic indicators) to allow HRSA to document and track changes in health disparities over time and to ensure trends for subgroups are not masked by the wider population.
- **Strategy 3B:** Allows awardees flexibility to tailor the MIECHV/Tribal MIECHV racial and ethnic categories to better reflect the racial and ethnic identities of the families they serve. This strategy will allow HRSA and awardees to explore trends and drive improvement in enrollment, service utilization, and outcomes for newly identified racial and ethnic subgroups.

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