November 2022

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

Interested Parties
Discussion Summary Memo

HRSA
Maternal & Child Health

Table of Contents

Contributing Authors

Meghan Woo, ScD, ScM
Rebecca Fauth, PhD
Ellen Walker, MPH
Jennifer Norris, MPH

Acknowledgments

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 (TMIECHV) Program [ii]

As a requirement of their funding, MIECHV awardees and Tribal MIECHV grantees 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/Tribal MIECHV families, the current MIECHV/Tribal MIECHV performance measures do not capture the SSDOH, reductions in health disparities, or progress toward achieving health equity.

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 awardees 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 NORC is engaging a broad and diverse group of parties with an interest in the MIECHV/Tribal MIECHV measurement systems (e.g., "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.

Methods

Between February 2022 and August 2022, NORC worked with interested parties through: 1) six initial meetings and one follow-up meeting with 26 different awardee teams; 2) two large-group and three individual interviews with Technical Expert Panel (TEP) members; and 3) a virtual affinity group session at the 2022 Start Early National Home Visiting Summit with home visiting researchers, practitioners, families, policymakers, and advocates.

Findings

This memo summarizes key themes identified through the HEAL-PM engagement activities as well as relevant examples for each finding. Key themes identified through engagement activities include:

- ***Awardees are using health equity frameworks and strategies to capture health disparities and understand health equity.*** Participants shared that they use several health equity frameworks to guide their health equity work , such as *How to Embed a Racial and Ethnic Equity Perspective in Research* and *Shifting the Lens: Why Conceptualization Matters in Research on Reducing Inequality*. Other participants

shared innovative approaches for measuring health disparities and progress toward achieving health equity. These emerging strategies include measuring client-reported experiences of care, collecting demographic information of home visitors, and collecting qualitative data using community-engagement strategies.

- *Community-level data offer important information.* Community-level data (e.g., SSDOH data) help contextualize performance measure data, inform program planning, and identify families most in need of services. However, considerations should be made for how to increase access to data while minimizing burden to awardees.

- *Awardees use a variety of data analytic methods to measure health disparities and also experience data challenges.* Some teams are using innovative strategies to assess health disparities and use a variety of data sources to bolster performance measure data. Most teams are in the early stages of this work and face challenges with data quality, data access, and conducting analyses due to small numbers when data are disaggregated.

- *The usefulness of MEICHV/Tribal MIECHV Program data varies by type and level.* Awardees agreed that access to individual-level data was more useful than access to model, county, and state-level data. Tribal-level data was also identified as useful for Tribal MIECHV Program needs.

- *Some MIECHV/Tribal MIECHV performance measures need re-evaluation.* Interested parties perceived some MIECHV/Tribal MIECHV performance measures (e.g., safe sleep, breastfeeding, and substance use) as not culturally responsive to the diverse communities served by MIECHV/Tribal MIECHV Programs. These measures require re-evaluation.

- *Awardees are interested in receiving additional technical assistance and resources to better document and assess health disparities and progress toward achieving health equity.* Awardees mentioned the need for improving data quality and access to data sources, conducting analyses of health disparities, increasing access to MIECHV/Tribal MIECHV data, and supporting MIECHV/Tribal MIECHV data collection in a culturally responsive way.

Future Directions

In the next phase of the HEAL-PM project, NORC will develop a range of recommendations to guide updates, alternatives, or flexibilities to the existing MIECHV/Tribal MIECHV Programs' performance measurement systems. Our discussions with interested parties and other project activities (i.e., environmental scan) will inform these recommendations and will include ways to assess SSDOH and community-level factors, innovative data collection and analytic strategies to address health equity and health disparities, and strategies for improving the cultural responsiveness of the performance measures.

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 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 funding recipients (awardees) and Tribal MIECHV grant funding recipients (grantees), referred to collectively in this memo as awardees,[1] collect and report data on program performance. The MIECHV Program performance measurement system[2] requires 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).[3] They also must report on a total of 19 performance measures[4] across six benchmark areas (see **Appendix A** for a list of benchmark areas, constructs, and brief descriptions of each measure).

For the Tribal MIECHV Program, ACF, with the input of tribal grantees and technical assistance providers, created a standardized set of performance measures.[5] 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.

---

[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] 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

[3] 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.

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

[5] 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 Programs' performance measures is to describe the populations served and program performance, inform continuous quality improvement (CQI) activities, and continuously monitor and provide oversight to awardees.[6] 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 other 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),[7] and how they may affect the health and well-being of MIECHV/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 responsiveness[8] 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 concerns.

HEAL-PM project overview

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

---

[6] NORC uses "awardees" to refer to participants from the MIECHV and Tribal MIECHV Programs, respectively.

[7] 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).

[8] 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 Program performance measures 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 technical assistance (TA) must be considered when promoting the collection and assessment of MIECHV/Tribal MIECHV Program data within a health equity framework?

To answer these questions, NORC is conducting the following activities:

- **Engaging with interested parties,** including MIECHV state/jurisdiction awardees, Tribal MIECHV grantees, and nationally recognized subject matter experts to identify: 1) how awardees collect and measure health disparities and SSDOH among populations served, and 2) key areas of interest or concern related to the cultural sensitivity of existing performance measures.

- **Conducting an environmental scan** of peer-reviewed and gray literature to assess the current state of practice related to integrating a health equity lens in early childhood systems performance measurement.

- **Identifying a continuum of recommendations** for updates, alternatives, or flexibilities to the existing MIECHV/Tribal MIECHV Program performance measurement system, aligned with a health equity framework that integrates SSDOH.

- **Describing key areas for internal and external TA** and determining the supports needed to carry out actionable steps and address potential barriers for adopting proposed recommendations in the MIECHV/Tribal MIECHV Program performance measurement system.

In this document, we describe our methods and key findings from our interested party engagement activities conducted in Year 1 (September 2021—September 2022)) of the HEAL-PM project.

Methods

Overview of approach

Any changes to the MIECHV/Tribal MIECHV Program performance measures to better integrate a health equity framework and the SSDOH could have wide-ranging implications for a broad and diverse group of parties. These interested parties include, but are not limited to, those who collect, clean, report, analyze, and utilize the data. It is critical to engage this community in a meaningful process to solicit, capture, and share their unique perspectives. Within this context, NORC engaged with three groups of interested parties between February 2022 and August 2022: 1) MIECHV awardees and Tribal MIECHV grantees; 2) nationally recognized subject matter experts, and 3) participants from an affinity group session of the National Home Visiting Summit. We briefly describe these activities below.

Awardee meetings

The primary objective of the awardee meetings was to capture key perspectives from those closest to the performance measures and data, including:

- How awardees currently collect and measure health inequities, the SSDOH, and community strengths among populations served; how and what type of data they would like to collect to capture these constructs in the future; and the appropriate and feasible level (e.g., individual, household, community) for data collection and reporting
- Key areas of interest or concern related to the cultural sensitivity and responsiveness of existing performance measures
- Challenges and technical assistance needed to support awardees in the collection and assessment of performance measure data

Identification and recruitment

In collaboration with HRSA/ACF, NORC identified and organized 26 different awardees/grantee teams to participate in six initial meetings and one follow-up meeting[9] (see Exhibit 1 below). NORC recruited these groups based on their ability to capture a range of perspectives in terms of awardee type, project role, special populations served, region of operation, and level of experience utilizing health equity frameworks and measures that capture the SSDOH.

Awardee engagement

Through these virtual meetings, we collected feedback on how awardees currently collect and measure health disparities and the SSDOH among populations served, how and what type of data they would like to collect to capture these constructs in the future, and the appropriate and feasible level (e.g., individual, program, local implementing agency, or state level) for data collection and reporting. Awardees also identified key areas of interest or concern related to the cultural sensitivity and responsiveness of existing performance measures.

Exhibit 1: Awardee meeting description and attendees

Awardee Meetings	Description	Number of Teams in Attendance
MIECHV Awardees Meeting (n=5)	MIECHV awardees with varying experiences measuring health equity and the SSDOH.	Meeting 1: 5 Teams Meeting 2: 3 Teams Meeting 3: 3 Teams Meeting 4: 3 Teams Meeting 5: 6 Teams

---

[9] In accordance with NORC's contract for the HEAL-PM project, we held seven awardee meetings in Year 1. NORC will hold an additional eight awardee meetings in Year 2 of the contract.

Awardee Meetings	Description	Number of Teams in Attendance
Tribal MIECHV Grantees Meeting (n=1)	Grantees funded by the Tribal Home Visiting Program who could provide insight on the unique needs, strengths, and barriers to collecting health equity and SSDOH data for tribal populations.	Meeting: 6 Teams
Follow-up Meeting (n=1)	Awardees who participated in a prior meeting participated in a two-hour follow-up call to discuss project topics more in depth.	Meeting: 6 Teams

Technical expert panel engagement

To round out and inform the awardee meetings, NORC gathered a technical expert panel (TEP) to provide guidance on project activities, including best practices for measuring health equity and the SSDOH; recommendations and considerations for using multilevel data to monitor health equity in home visiting outcomes; and strategies for adapting, adjusting, or updating performance measures to be more culturally responsive.

Identification and recruitment

NORC provided HRSA/ACF with a list of 15-20 potential TEP members and descriptions of their areas of expertise for consideration. TEP members were grouped generally by their areas of expertise (i.e., MIECHV performance measures, health equity and the SSDOH, maternal and child health in tribal communities, data systems and administrative data). Once HRSA/ACF approved the final list of nominees, NORC emailed an invitation along with introductory materials (including explanation of role, estimated time commitment, and expected honorarium) and a request for participation. If a nominee was unavailable. NORC recommended replacements with similar expertise to ensure that the TEP had at least 10-12 members. In total, NORC recruited 17 technical experts to serve as part of the TEP.

TEP engagement

Technical experts will participate in up to six engagement sessions over the 24-month project period, including virtual large and small group meetings, key informant interviews, and asynchronous feedback sessions. As of August 2022, NORC has engaged the TEP through two virtual meetings and three individual TEP interviews with health equity and tribal grantee experts.

National Home Visiting Summit affinity group session

In March 2022, NORC and HRSA facilitated a virtual affinity group session at the 2022 Start Early National Home Visiting Summit. The session targeted researchers, practitioners, families, policymakers, and advocates. Session participants discussed how data and performance measures can be used to address health equity and how home visiting performance measures can be made more culturally responsive to families from diverse backgrounds. In breakout sessions, participants responded to three question prompts focused on how to

incorporate community-level data and health equity into the MIECHV/Tribal MIECHV performance measures and how to improve the cultural responsiveness of the measures. Participants entered their responses into a shared Google document accessible to all participants. In total, 11 breakout groups entered responses into the shared document.

Analysis

The NORC team analyzed transcript-style meeting notes from the awardees and TEP meetings, as well as responses submitted through the shared affinity group Google document, to identify themes, patterns, and interrelationships relevant to the project's key research questions. As a first step in analysis, the team developed an a priori codebook based on the overarching project questions and meeting discussion guides. The codebook included common codes for the awardee meetings, TEP engagement sessions, and affinity group session so that themes could be examined across meeting types. The team used NVivo qualitative analysis software to review and code the data using the a priori codebook. The NORC team also incorporated new themes that emerged from the data as analyses progressed. The coded data were reviewed in NVivo, and key themes were summarized.

Summary of Findings

In this section, we present key findings from the HEAL-PM engagement activities conducted through August 2022.

Health equity frameworks and measurement considerations

To understand how key interested parties are currently thinking about and measuring health equity, NORC asked awardees and TEP members to share health equity frameworks and definitions they currently use or are being considered in their work.

Health equity frameworks used by awardees and TEP members

Frameworks used by TEP members and awardees

- How to Embed a Racial and Ethnic Equity Perspective in Research
- PhenX Social Determinants of Health Toolkit, Shifting the Lens: Why Conceptualization Matters in Research on Reducing Inequality
- A Language Justice Framework for Culturally Responsive and Equitable Evaluation
- The Racial Equity Institute's Groundwater Approach.

During engagement sessions, awardees and TEP members shared the health equity definitions, frameworks, and measurement systems they currently use to guide their work (see text box above for examples of frameworks used by TEP members and awardees). A TEP member and an awardee team both shared that their local departments of health are developing health equity policies to be used across agencies within the departments. The awardee team said they have used this framework to inform MIECHV planning. Awardees and TEP members also shared challenges they've faced incorporating health equity frameworks, including struggling over which of the many health equity definitions to use or how to implement these definitions into their work in the most meaningful way based on needs and desires of local communities. One awardee team noted that they are in the

early stages of exploring this topic and are gathering resources but have not yet used them to inform their work. Another team shared that they are struggling to decide which definition of health equity to use.

Health equity measurement trends

Interested parties shared current practices and innovative methods for measuring health equity. We identified three emerging health equity measurement trends: assessing client-reported experiences of care, capturing and monitoring home visitor demographic data, and collecting data that better captures community perspectives and context.

> "At the [Children's Equity Project] we … look at equitable systems with 3 dimensions: we look at access … and then we look at [client] experiences … and then what are the outcomes that are resulting from these programs.… Where are the disparities?"
>
> -TEP member

Assessing client-reported experiences of care

TEP members and Home Visiting Summit participants shared that a growing trend in health equity measurement is to capture client-reported experiences of care, such as families' perceptions of services received or the quality of the family's relationship with their home visitor. This interest was also shared by awardees. Two examples are summarized below:

- The Health Equity Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN) is incorporating a standardized level of respect measure in their quality improvement work. This measure was adapted from the Mothers on Respect index[vii] and is being used as a proxy for health equity.
- The Children's Health Equity Project measures three dimensions of health equity: access to care, client-reported experiences of care, and outcomes of programs. To measure progress toward achieving health equity, they monitor disparities in access to services and changes in the experiences-of-care measures.

Capturing and monitoring home visitor demographic data

Collecting the demographic information of home visitors is another emerging measurement practice. Several participants shared that, from a health equity standpoint, it is important to have home visiting teams represent the communities they serve—particularly on factors such as race and ethnicity, community of residence, and primary language. They believed that families who see themselves reflected in the home visiting workforce would feel more comfortable and report better experiences and engagement with services.

> "I want to do some research and analysis on what our workforce looks like in comparison to the families that we're serving and ensuring that we have a representative population of home visitors."
>
> -Awardee

Several awardee teams are required to collect or have access to home visitor demographic data through their home visiting program model. However, most teams do not currently link their workforce and MIECHV data and are unable to systematically monitor the representativeness of their home visiting teams.[10] One team did report collecting home visitor information (i.e., demographics and skill set) and linking this to family recruitment and retention at the local implementing agency (LIA) level.

However, while some teams expressed that they would like to be able to have regular access to home visitor demographic data, others shared concerns that it is challenging to keep these data updated due to staff turnover. One TEP member also cautioned that while home visitor demographic data can provide important contextual information, matching home visitor demographics to their communities should not be equated with achieving health equity.

Collecting data that better captures community perspectives and context

Participants also discussed the importance of collecting data that better captures community perspectives and context and emphasized the importance of engaging in participatory research and evaluation practices throughout the MIECHV/Tribal MIECHV Programs to capture these types of data. They also noted that health equity approaches should be tailored to prioritize what health equity means to each community. For example, following the completion of the MIECHV needs assessment, one state created a health equity advisory group to identify specific subpopulations in need of services. The advisory group is staffed with representatives from the community and can advise on service allocation and data collection activities. This group ensures that services, data collection, and engagement meet the needs of the community. Other awardees also shared that they rely on qualitative data to supplement and provide greater context to their quantitative performance measure data.

> **Health Equity Measurement Trends Identified by MIECHV/Tribal MIECHV Interested Parties**
> - Assess client reported experiences of care
> - Capture and monitor home visitor demographic data
> - Collect data that better captures community perspectives and context

Challenges to incorporating health equity into performance measurement systems

Several TEP members and awardees discussed challenges with using existing MIECHV/Tribal MIECHV performance measures to assess health equity. For example, one awardee noted that work designed to improve health equity would likely take years to show true impact, making it unlikely that awardees will be able to see measurable changes within the duration of a home visiting grant.[viii] To measure impacts within a shorter timeframe, awardees are limited to measuring intermediate outcomes, such as equitable access to services. TEP members also questioned whether the MIECHV/Tribal MIECHV performance

> "I don't know if it's fair to say that an expectation of home visiting is that we will improve health equity in a way that can be measured."
>
> -TEP member

---

[10] Home visitor demographic data is collected through Tribal MIECHV Form 1, but this is not linked to performance measure data collected through Form 2. Source: https://omb.report/icr/202204-0970-021/doc/120929900

measures were the most appropriate place to incorporate measures of health equity, given the relative size and scope of the programs within state or tribal systems compared to the systemic level factors that cause health inequities.

In addition, while some TEP members and awardees have found measures of client-reported experiences of care and home visitor demographics useful for program monitoring purposes, many questioned whether they should be formally added into the MIECHV/Tribal MIECHV measurement systems as performance measures. TEP members and awardees almost universally agreed that the value in collecting these data is to inform program planning and to contextualize existing performance measure data. They suggested that these data would be particularly useful for LIAs who are implementing program activities and could use this information to improve engagement, service delivery, and retention in services. The majority of awardees, however, did not believe these measures should be used to formally measure and track performance. They expressed concern that this information could be used punitively against programs and argued that this information is likely not useful to HRSA/ACF if collected at a national level. This viewpoint was not universal, however. One awardee shared that it may be useful for HRSA to collect these data and identify any national trends in client-reported experience of care or home visitor demographics across different population subgroups. This awardee noted these data could be a powerful tool to uncover disparities and identify more equitable practices for delivering home visiting services. Another awardee shared the opinion that if collecting this information is deemed a priority by HRSA/ACF, the only way to ensure it is universally implemented is by making it a required performance measure. This awardee believed that programs are unlikely to add optional data collection requirements, even if the information is viewed as useful, because they do not want to add burden to home visitors and families. This awardee further suggested that if HRSA decides to add new performance measures, other measures should be taken away to minimize burden.

Some awardees teams and TEP members were concerned about possible data collection burden on both home visitors and participants if new measures are introduced. One awardee team shared that LIAs were unenthusiastic about collecting additional demographic and patient-reported experiences of care data since it was not required by HRSA, and families were already overburdened by MIECHV data collection requirements. This team requested guidance on how to relay the importance of collecting these data to LIAs. Other teams were amenable to new measures if others were removed, to reduce burden on awardees and LIAs. Finally, awardees also questioned how HRSA would use information on client experiences of care and wanted reassurance that results would be used to support them in their efforts to measure progress toward achieving health equity, rather than used punitively.

Community-level factors

Given the growing recognition of the need to capture the community-level factors that have an impact on the health and well-being of MIECHV and Tribal MIECHV families, awardees shared the SSDOH and community strengths that they believe have the most impact on the families they serve, if they currently measure these factors (and if so, how), and challenges encountered when measuring them.

Most impactful community-level factors for home visiting families

Awardees discussed the community-level factors that most impacted the communities and families they serve. There were some similarities in factors, and some variations, between the MIECHV and Tribal MIECHV Programs. For example, teams from both programs shared that limited access to health care, affordable housing, and transportation impacted families. However, tribal grantees serving rural populations additionally shared that some of their families live in mobile homes, and there is a general sense of isolation and a lack of upkeep of these areas, which has been exacerbated by COVID-19. They also discussed that lack of employment opportunities in areas where tribal families live as a major community-level factor impacting the health and well-being of Tribal MIECHV families.

Community-level factors identified as most impactful for families served:

- Limited access to health care
- Affordable housing
- Transportation
- Food insecurity
- Technology/broadband access
- Mental health and substance use needs

Importance of measuring community-level factors

After sharing the community-level factors that impact the families and communities served by the MIECHV/Tribal MIECHV Programs, awardee teams discussed whether they currently use data that capture these factors.

SSDOH

Most participants emphasized the importance of using data that capture SSDOH to contextualize MIECHV/Tribal MIECHV performance measure data. For example, one awardee noted that structural factors such as the availability of employment opportunities and, among people who are employed, job type impact people's ability to breastfeed or pump. These factors must be considered when interpreting the breastfeeding performance measure data. Additionally, another awardee noted that because they serve a large and diverse area including both urban and rural communities, not all families served by their MIECHV Program have equal access to resources such as primary care health services and public transportation. Using data that captures disparities in access to services helps this awardee contextualize and understand differences in performance measures (e.g., differences in children who receive recommended well-child visits).

Community strengths

While most conversations around the SSDOH focused on community-level deficits, awardee teams also said it is important to recognize community strengths. These teams noted that the current performance measure approach to data collection is "*westernized*," with a focus on performance that may not be viewed as a priority for all families and does not capture the community-level factors that may positively impact the health and well-being of MIECHV/Tribal MIECHV families. When asked to provide examples of strengths of their communities, Tribal MIECHV grantee teams shared that access to green spaces, strong community engagement, and support and resources provided by early childhood collaborative teams as key strengths they would like to see highlighted about their communities.

However, when we asked if awardees were interested in collecting data on community strengths, responses were mixed. One team was concerned about the potential burden of collecting these types of data and encouraged HRSA/ACF to look into existing administrative data sources that capture similar measures. Another awardee team noted that while they believed understanding community strengths is important, they were not sure how HRSA would use data on community strengths if it were collected.

Data access and use

Awardees reported a range of experience using data sources that capture community-level factors like the SSDOH. As part of the most recent MIECHV needs assessment, HRSA provided MIECHV awardees with county-level SSDOH data that was used to identify priority populations in need of services. Some data-savvy awardees also discussed linking MIECHV Program data with state-level data sources, such as Title V Block Grant Program data (see Data Sources section below for more examples and information).

TEP members from the Home Visiting CoIIN also shared that some awardees were recently asked to collect a community history that included mapping the SSDOH within communities served by each program. These community histories helped guide program planning by identifying families and communities in need of services. The TEP members said this exercise served to "*solidify*" what many awardees knew their families were experiencing but had never documented.

Some awardees, however, shared that they did not have the capacity to conduct these types of analyses either due to inadequate resources (e.g., staff), lack of training, or lack of access to relevant data sources due to siloed data systems across state agencies.

> "I think our teams really did appreciate [collecting SSDOH data]. We did not frame it like you are going to move the Childhood Opportunity Index on your own, but it was a way of contextualizing and understanding … you are not responsible for reporting or moving this but it was a way to understand the experiences of your families and their needs."
>
> -TEP member

Challenges incorporating community-level factors into MIECHV/Tribal MIECHV performance measures

Many awardees struggled to say which data or measures that capture community-level factors like the SSDOH they would like to access. Some awardees shared that they believe they have access to all the data they need but do not have the bandwidth to use these data in a meaningful way. Several other teams noted that while they would like to have access to community-level data, they are conscious of not overburdening LIAs and families by adding to their MIECHV data collection requirements. To minimize the burden on LIAs, several TEP member advocated for improving data linkages between MIECHV/Tribal MIECHV performance measure data and existing administrative data sources so that awardees can better access community-level data without having to rely on primary data collection.

Additionally, while some teams were supportive of capturing community strengths, one team questioned if and how they would use these data in practice. To address this concern, one TEP member called for HRSA/ACF to develop TA and resource materials that emphasize the value of collecting data on community strengths and provide guidance on how to collect and use these types of data.

Lastly, while most participants agreed that having access to data and measures that capture community-level factors would help inform their MIECHV and Tribal MIECHV Programs' work, they questioned the use of incorporating these types of data as outcome measures of performance. As an alternative, one TEP suggested that HRSA/ACF focus the collection or use of community-level SSDOH data as part of CQI initiatives.

Data analytic methods and sources

Across the meetings with interested parties, NORC discussed methods used to measure health disparities and/or progress toward achieving health equity, data sources needed to do this work, and awardee data capabilities and preferences using these data.

Strategies for assessing health disparities and health equity

Most awardee teams are in the early stages of using or planning to use their MIECHV/Tribal MIECHV data to measure and document health disparities and progress toward achieving health equity within their programs. Some teams shared that they do not have adequate resources to conduct these analyses. For those that do, several teams use the results to identify high-need populations and gaps in services to guide outreach and service allocation. Teams reported using the following methods:

- Creating risk scores by combining demographic variables that identify populations that may need additional supports
- Conducting Geographic Information System Mapping (GIS mapping) by analyzing spatial data with demographics and other indicators
- Comparing performance measure outcomes by subgroups (e.g., racial/ethnic groups) using bivariate and multivariable analyses to identify disparities in outcomes

Data sources used

Awardee teams that regularly assess health disparities and progress toward achieving health equity used a variety of data sources. Several teams reported using data collected through MIECHV/Tribal MIECHV Forms 1 and 2 to develop risk scores or document health disparities for selected performance measure outcomes (e.g., depression screening or substance use) across demographic factors such as race and ethnicity. Others found the demographic data collected through MIECHV Form 1 to be less useful for their populations because the categories are not specific to the families they serve.

As discussed previously, some awardees, accessed additional data sources (e.g., state and administrative datasets) for more detailed demographic data. Others included more nuanced racial and ethnic categories in their data collection forms. For example, one awardee

Examples of additional data sources that awardees use

- State data sources
- Head Start Program data
- Women, Infants, and Children program data
- Title V Block Grant-funded program data
- Administrative datasets
- Pregnancy Risk Assessment Monitoring System
- the Behavioral Risk Factor Surveillance System
- Child Opportunity Index

shared that they are planning to do CQI work to disaggregate their MIECHV performance data by race and ethnicity. However, given differences between the categories included in Form 1 and those used by their state, they plan to engage the community to determine which racial and ethnic categories are most meaningful for their CQI work.

Challenges experienced when assessing health disparities and health equity

Throughout our conversations, interested parties shared challenges awardees experience when attempting to conduct analyses that assess health disparities and health equity. We describe these challenges below.

Data quality

Multiple awardees and TEP members noted that data quality, including missing data or data discrepancies, particularly around race and ethnicity data, limit their ability to assess health disparities. Awardees shared that many home visiting families do not find the current race and ethnicity categories to be reflective of their racial and ethnic identities. These discrepancies between Form 1[11] and how families self-identify result in missing or inaccurate data. Teams added that it would be useful for the performance measures to include a "participant refusal" response option so that these responses could be considered separately from missing data. Other awardees advocated for greater flexibility to allow programs to tailor racial and ethnic categories to the families they serve. For example, one awardee team shared that they find the MIECHV race categories are too broad to highlight meaningful differences within their population. As part of their CQI work they are trying to develop expanded racial categories that better capture the racial and ethnic identities of their families but noted challenges with determining which racial and ethnic categories should be included or excluded. This viewpoint was not universal, however. Other teams, particularly those from rural states, noted that more refined racial and ethnic categories would further exacerbate issues with small numbers in each category and limit their ability to use these data.

Several teams also discussed home visitor reluctance to ask families about sensitive topics or topics they felt were not culturally responsive. This also contributes to missing data (see Improving Collection of Performance Measure Data section below for more information). Teams shared that they have also struggled with staff turnover or analytic staff being diverted to work on COVID-19–related activities, resulting in inadequate resources to improve data quality, conduct analyses, or collect data beyond what is currently required by HRSA/ACF. In a few meetings, awardees noted that they are currently working with home visitors to improve the quality of the data they currently have before considering the addition of supplemental data sources.

"The other thing that we've discovered is that kind of the first step that you have to solidify is making sure that you have quality data that you're looking at that really tells you an accurate story, and once you have that you can look at questions like what are some things that we could do to improve some of these measures."

-Awardee

---

[11] Form 1 collects demographic performance data demographic performance data, including information about but not limited to gender, ethnicity, race, housing status, marital status, and languages spoken at home.

Data access

Several awardees also discussed challenges they experience accessing and analyzing their performance measure data. These challenges limit their ability to conduct analyses focused on health disparities and health equity. For example, one awardee implements multiple home visiting models which requires entering data into multiple systems. To access their data, they have to request data from each vendor, which can be time consuming.

Another grantee shared that they use Excel as their data management system, given the high cost of bespoke data management systems and analytic software programs. This hinders their ability to effectively manage their data and conduct more complex analyses. They also shared that it is challenging to access Tribal MIECHV -specific data from home visiting model management information systems that are commonly used by and geared toward MIECHV programs. This grantee explained that while they can disaggregate their data to some degree, they would prefer a data dashboard that produces data visuals and could be accessed by their home visitors.

Additionally, several awardees also requested greater access to the data they currently submit to HRSA so that they can compare their program data to similar state and national benchmarks.[12]

> "Those of us that work with the data are victims of our vendors' capacity.... Those data management systems that they use, we are victim to.... If we could build our own reports, if we could access our data in our own data management systems, that would be so much easier for us than to have to rely on what they can provide us."
>
> -Awardee

Levels of data most useful to awardees to understand families served

Participants discussed which levels of data (e.g., individual, LIA, or community-level) were most useful to MIECHV/Tribal MIECHV teams and LIAs and for what purpose. States currently submit aggregated state-level data to HRSA/ACF. However, several teams described wanting to disaggregate awardee data by LIA to help them identify community conditions or issues within an LIA that may impact program performance.

Some awardees are disaggregating their data at this level as part of their CQI work. For example, one team disaggregates depression screening data by LIA to identify potential health shortage areas in the community that may impact a home visitor's ability to make referrals. Another team holds annual workshops with their LIAs to discuss any areas with statistically significant differences in performance measures by race and ethnicity. This team believed that discussing potential LIA-level factors that may impact program outcomes helps LIAs understand what, if any, role they have in addressing these disparities. They further argued that MIECHV data that is only provided at the state level is less meaningful because it does not account for community-level variations.

> "I just wanted to note for the child maltreatment performance measure we link our data to our child welfare data to report on that particular measure, so without access to individual-level data, we wouldn't be able to do that."
>
> -Awardee

---

[12] HRSA currently provides all awardees with access to quarterly and annual performance data through data dashboards. In Year 2 of the HEAL-PM project, NORC will further explore what, if any, opportunities exist to improve the current data dashboards, including communication about their availability and ways to access these resources.

Most awardees generally agreed that having access to more granular data would be more useful for their programs' needs. Many awardees said they would like access to individual-level and LIA-level data. Fewer reported wanting model-level or another level of data. Many awardees noted that county-level data were not granular enough to be useful for programmatic purposes. Tribal MIECHV grantees shared that tribal-level data would be useful for their program needs. Not all teams agreed with the usefulness of more granular-level data, however. A few teams shared that disaggregating data at the LIA-level can result in issues with small numbers and suppressed data. One awardee from a rural area noted that even county-level data can pose challenges for them due to small numbers.

Although many awardees stated that they would prefer using more granular level data then what is currently available, they also shared the persistent challenges they experience with small numbers when using existing MIECHV/Tribal MIECHV reporting categories. As previously noted, the issue of small numbers came up repeatedly as a data analysis challenge awardees experience when analyzing MIECHV/Tribal MIECHV Program data. Teams shared that they are often limited in the subgroup analyses they can conduct and how finely they can disaggregate their data. Awardees also expressed uncertainty about the value of disaggregation if the results are not ultimately reportable due to suppression rules put in place to protect privacy. One team shared that their MIECHV data is analyzed by a different department within their state. Although they would like to request and use data with small numbers for CQI purposes, they struggle to convince the data team that there is value in conducting analyses with small numbers if it cannot be publicly reported.

> "In [awardee state] we lose county-level data when we start [disaggregating] … just because of such small numbers for everyone in a county, let alone breaking it down any further than that. So you know, in rural areas there is a loss the further you break things down."
>
> -Awardee

Given the tension between wanting more granular level data and limitations in analyzing small numbers, awardee teams discussed the need for training and guidance on working with small numbers. As part of these resources, awardees also requested communications from HRSA explaining the usefulness of conducting and using these data so that this information could be shared with team members and external partners.

A final topic of conversation related to the level of data that would be most useful to awardees focused on individual level data. When asked how they currently use or would like to use individual-level data, awardees shared that they could use these data to identify individuals and families who need additional supports and follow-up services. Other awardee teams shared that they use individual-level data to identify potential issues with data collection and train their LIAs on how to improve data quality.

NORC asked about sharing individual-level data with HRSA/ACF to power more comprehensive analyses looking at variability in performance measures on a national scale. Awardees responses were mixed. Some believed these analyses would produce important findings about potential disparities in performance at a national level. Others believed that families would have significant concerns about their individual-level data being shared with the federal government, which could impact family participation in services. TEP members also shared this concern, noting that requiring the submission of individual-level data may impact families' willingness to receive services and report any data into the MIECHV/Tribal MIECHV systems.

> "This did come out in [our] summary was the burden of data collection on … participants. And especially for sharing disaggregated data with the feds, there are the unintended consequences of people potentially not agreeing to receive services, and … we would rather have a family participate than just get their data and allow us to run a query."
>
> -TEP member

MIECHV/Tribal MIECHV data collection practices and cultural responsiveness of MIECHV/Tribal MIECHV measures

Participants discussed challenges they experienced collecting performance measure data, including challenges supporting home visitors when collecting data on sensitive topics and the cultural responsiveness of the MIECHV/Tribal MIECHV performance measures.

Measures identified as needing improvement

NORC asked awardees to identify performance measures they believed should be made more culturally relevant and responsive to the families served by the MIECHV/Tribal MIECHV Programs. Exhibit 2 includes a list of MIECHV/Tribal MIECHV measures that teams did not consider culturally responsive. Teams most commonly identified the safe sleep and breastfeeding measures as needing improvement.

Awardees cited a variety of reasons why they felt these measures were problematic, including a lack of inclusivity for diverse cultures' goals and priorities and concerns about appearing to judge families based on their responses. For example, when discussing breastfeeding, one awardee thought that there was a lack of acknowledgement of "expectations and norms that don't fit the Western ideal" within the current measure. Similar concerns were raised about the safe sleep performance measure, given that cultural norms around sleep practices such as co-sleeping that are common in non-western cultures sometimes conflict with the performance measure criteria.

Another awardee team noted challenges with the depression referral measures. To meet MIECHV performance measure criteria, programs must make referrals to evidence-based services. The awardee shared that some families sought out services that were not necessarily evidence-based because they better met their needs and were considered more culturally appropriate. As a result, they were viewed as not meeting performance measure criteria even though their families were being connected to needed services. The awardee recommended that HRSA make this performance metric more flexible to allow for inclusion of services that take into account family preferences.

Finally, several awardee teams and TEP members discussed the importance of acknowledging and recognizing community strengths through the MIECHV/Tribal MIECHV performance measures. One TEP member and several Tribal MIECHV teams noted that the current performance measures are deficit based and result in parents feeling like "they're failing their families."

Exhibit 2. MIECHV/Tribal MIECHV performance measures identified as not culturally responsive by awardee teams

Performance Measure Constructs	# of Awardee Teams (n=14)	# of Grantee Teams (n=6)
Intimate Partner Violence Screening	2	1
Breastfeeding	4	
Safe Sleep	5	1
Primary Caregiver Education	1	
Completed Developmental Referrals	1	
Parent-Child Interactions	1	
Early Language and Literacy Activities	1	
Tobacco Cessation Referrals	1	1

Note: We did not discuss the cultural responsiveness of specific MIECHV/Tribal L MIECHV performance measures in all meetings. Additionally, when the cultural responsiveness of measures was discussed, not all teams shared concerns about specific performance measures.

In addition to identifying performance measures that were viewed as not culturally responsive, participants also discussed challenges with some current demographic measures. Some awardees shared that the racial and ethnic measures are not representative of the communities they serve. They discussed the importance of having racial and ethnic categories that better represent home visiting families and their communities. As discussed in the data quality section above, to be more responsive to families, some awardees suggested developing broad racial and ethnic categories along with more detailed subcategories that would allow families to self-identify using more specific categories, but then could be aggregated up for any analyses that were performed across the MIECHV/Tribal MIECHV portfolios.

Improving data collection of performance measures

Several teams also discussed ways to make the data collection process more culturally responsive by developing trainings and resources that support LIAs and home visitors in the collection of performance measure data. One

awardee team discussed the importance of having translation support available to home visitors and families as well as offering materials and performance measure screening instruments in families' preferred languages. One Tribal MIECHV grantee echoed this challenge, noting that it is difficult to find evidence-based screening tools for tribal populations.

Additionally, several teams suggested that HRSA develop trainings for home visitors to help them feel more comfortable asking families about difficult topics, such as substance use or experiences with intimate partner violence. One team tries to do this by training their home visitors to administer data collection protocols that collect data in a way that is "more conversational and less judgmental". For example, when discussing early language and literacy activities with caregivers, home visitors were given probing questions that highlighted a broader range of activities (e.g., whether they sing with their children or listen to audio books) that can promote language and literacy, rather than only asking standard screening questions about reading to their child.

> "I mean it's come up several times over the years, but just the questions that we ask … that are required by MIECHV. Sometimes it's the assessment tool, maybe not being culturally responsive, but also just our home visitors themselves having the understanding of, or the historical trauma of certain populations … having the understanding of ways to ask the question, ways to ask these data points or retrieve that information in a way that is culturally responsive has been something that has come up recently."
>
> -Awardee

Awardees also discussed concerns home visitors have expressed about asking questions about sensitive subjects, such as intimate partner violence or substance use without having the time to build a trusting relationship with families. For example, home visitors have shared that they need time to build relationships with families before screening for substance use. Without this relationship building, home visitors could be seen as judgmental of their families. Families may also withhold information for fear of legal ramifications.

Instead, awardees suggested reframing the measures using a strength-based approach so that families feel comfortable sharing information on sensitive topics. For example, one grantee said that when discussing the substance use measure, they have trained their home visitors provide pamphlets and information to primary caregivers on the impacts that substance use may have on children. They think this approach of providing information and support upfront focuses the discussion on understanding and actions that can be taken to minimize potential harm rather than beginning the conversation with a focus on the primary caregiver's negative actions. These training strategies reflect the opinion of participants who noted the importance of flexibility when measuring and reporting outcomes based on the needs and desires of families served.

Technical assistance and resources

Awardees identified the TA and resources that would help them better use data to document and assess health disparities and advance health equity in their home visiting programs. These included:

- **More staff and resources to improve data quality and access data sources.** Awardee teams most commonly shared that to conduct analyses related to health equity and health disparities, they need trained staff to improve the quality of existing data and gain access to new administrative data sources. If new requirements are introduced, funding for additional staff and resources would be particularly important to reduce administrative burden.

- **Data analytic support, training, and resources to conduct analyses.** In addition to additional staff, some awardees shared that their teams need additional training and resources to conduct analyses related to assessing progress toward achieving health equity, health disparities, and community-level data. Awardees mentioned the following training and resources:

  - Best practices for accessing data sources that capture the SSDOH, including data sharing between state agencies, Tribal communities, and state agencies that includes examples of data use agreements and accessing administrative data.

  - Best practices and standardized examples of analyses HRSA/ACF recommend for tracking health disparities and progress toward achieving health equity. Examples could include proposed data sources, analytic methods, exemplar subgroup comparisons, and ways to disaggregate data. HRSA/ACF could present these analyses at the national level with the goal of programs replicated them at the local level.

  - Guidance and best practices for dealing with small numbers, including justification for the importance and usefulness of conducting analyses with small numbers that can be shared with partners and data vendors.

  - Guidance and best practices for interpreting data findings and visualizing data to document health disparities (including how to share data with LIAs in a user-friendly and actionable way).

  - Access to data from a comparison population that is not being served by a home visiting program to help demonstrate the impact of home visiting and determine a benchmark for performance.

- **Better and easier access to MIECHV/Tribal MIECHV data through data dashboards.** Awardees shared that they would like to have better access to data that is submitted to HRSA/ACF and home visiting models to see trends in their data over time as well as to see how their program compares to national or state benchmarks. A few teams advocated for the creation of a data dashboard that pulls data from all home visiting management information systems, including model data systems.[12]

> "A good one-pager for each performance measure that is geared towards that paraprofessional home visitor about why are we asking you to do this, why does this matter, what can you do about it, how could you ask about it.… [Home visitors] get training on their models, but they get almost no training around the performance measures.… Ultimately, the data will be better when the home visitor understands better why they're doing what they're doing."
>
> -TEP member

> "So, if we want to build up our data capacity to really dig into our data, we might not be able to do that, and we might need an epidemiologist or evaluators or CQI staff to really take a lead on that and engage our LIAs and home visitors in the process. But without additional resources, I worry that this all turns into an administrative burden when, in reality, like we should all be excited to do this work, and really it's important."
>
> -Awardee

- **Data collection training and informational materials to improve the cultural responsiveness of the MIECHV/Tribal MIECHV data collection process**. Awardee teams shared that their home visitors struggle to collect performance measure data from families because the screening questions often cover difficult topics and require establishing trusting relationships. Home visitors across awardee teams have requested additional training and support on best practices for data collection of sensitive information and collecting data in culturally responsive ways. Awardees also suggested that to gain buy-in from LIAs and home visitors, these materials explain the importance of collecting this information and why it is required by HRSA/ACF.

Conclusions and Next Steps

This summary memo describes key findings from the interested party engagement activities conducted in Year 1 of the HEAL-PM project. The purpose of these activities was to identify how MIECHV/Tribal MIECHV interested parties are collecting and measuring health disparities and SSDOH among home visiting families (or would like to collect and measure these constructs) and key areas of interest or concern related to the cultural sensitivity of the MIECHV/Tribal MIECHV performance measures. Across engagement sessions with MIECHV/Tribal MIECHV awardees, nationally recognized subject matter experts, and participants from an affinity group session of the National Home Visiting Summit, NORC identified the following themes:

- **Health equity frameworks.** TEP members and awardee teams shared that they use several health equity frameworks, such as _How to Embed a Racial and Ethnic Equity Perspective in Research_ and _Shifting the Lens: Why Conceptualization Matters in Research on Reducing Inequality_, to guide their health equity work. These frameworks provide guiding principles for incorporating health equity into home visiting services and evaluation of program activities.
- **Health equity measures.** MIECHV/Tribal MIECHV interested parties shared innovative approaches for measuring progress toward achieving health equity. These emerging strategies include measuring client-reported experiences of care, collecting demographic information of home visitors, and collecting qualitative data using community-engagement strategies. Interested parties advocated for using these measures and data to contextualize existing performance measure data.
- **Community-level factors.** Interested parties agreed that community-level data such as data that capture the SSDOH are important to contextualize performance measure data, inform program planning, and identify families most in need of services. Leveraging data linkages with existing administrative datasets could increase access to these data and minimize burden to awardees. Community-level factors identified as most impactful for MIECHV/Tribal MIECHV home visiting families:
  - Limited access to health care
  - Affordable housing
  - Transportation
  - Food insecurity
  - Technology/broadband access
  - Mental health and substance use needs
- **Data analyses to document health disparities.** Although most awardees are in the early stages of assessing health disparities, some are using innovative strategies such as creating risk scores, conducting GIS mapping, and comparing performance measure outcomes by subgroups. Awardees experienced the following challenges conducting these analyses:

- *Data quality.* Awardees struggled with missing or inaccurate data, which limited their ability to conduct analyses. Interested parties advocated for greater flexibility of some measures (e.g., racial and ethnic categories) to reduce missing or inaccurate data, as well as greater support for home visitors to improve data collection of sensitive topics.

- *Data access.* Awardees that implement multiple home visiting models experience challenges accessing their MIECHV/Tribal MIECHV Programs' data from multiple systems. For grantees, it is also challenging to access Tribal MIECHV -specific data from home visiting model management information systems commonly used by and geared toward MIECHV Programs. Awardees that do not use model management information systems rely on data management systems like Excel, which minimizes their analytic capabilities.

- *Data analysis.* Teams are often limited in the subgroup analyses they can conduct, how finely they can disaggregate their data, and how meaningful disaggregated data are due to small cell sizes.

- **Data sources.** Awardee teams that regularly assess health disparities and progress toward achieving health equity used a variety of data sources, including state (e.g., Head Start Program data) and administrative datasets (e.g., Child Opportunity Index), to supplement their MIECHV/Tribal MIECHV data.

- **Most useful level of data.** Awardees generally agreed that having access to more granular data (i.e., individual- and LIA-level data) would be more useful for their programs' needs. While model-level and state-level data were seen as less useful, Tribal MIECHV grantees shared that tribal-level data would be useful for their program needs. However, awardees also shared that using more granular data leads to challenges dealing with small numbers and suppressed data.

- **Cultural responsiveness of MIECHV/Tribal MIECHV performance measures.** Interested parties perceived that some MIECHV/Tribal MIECHV performance measures (e.g., safe sleep, breastfeeding, and substance use) are not culturally responsive to the diverse communities served by MIECHV/Tribal MIECHV Programs and require re-evaluation. Some participants advocated for incorporating performance measures that track community strengths. Home visitors also need increased support to collect performance measure data in culturally responsive ways.

- **TA and resources.** Awardees are interested in receiving additional TA and resources to better document and assess health disparities and progress towards achieving health equity, including:
  - More staff and resources to improve data quality, access data sources, and conduct analyses
  - Data analytic support, training, and resources to conduct analyses
  - Better and easier access to MIECHV/Tribal MIECHV data through data dashboards
  - Data collection training and informational materials to improve the cultural responsiveness of the MIECHV/Tribal MIECHV data collection process

In Year 2 (September 2021–September 2022) of the HEAL-PM project, NORC will continue to engage interested parties through eight awardee meetings and additional TEP engagement activities. Following these additional engagement activities, NORC will develop a continuum of recommendations to guide updates, alternatives, or flexibilities to the existing MIECHV/Tribal MIECHV Programs performance measurement systems. Informed by findings from our interested party engagement and an environmental scan, these recommendations will include considerations for assessing SSDOH and community-level factors, innovative data collection and analytic strategies to address health equity and health disparities, and strategies for improving the cultural responsiveness of the performance measures.

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 2 Breastfeeding 3 Depression Screening 4 Well Child Visit 5 Postpartum Care 6 Tobacco Cessation Referrals 1* Substance Use Screening	• Percent of infants who are born preterm • Percent of infants who are breastfed at six months of age • Percent of primary caregivers who are screened for depression • Percent of children who received the last AAP recommended visit • Percent of individuals who received a postpartum care visit within 8 weeks of giving birth • Percent of primary caregivers who reported using tobacco and were referred to tobacco cessation counseling or services • Percent of primary caregivers enrolled in home visiting who are screened for both unhealth alcohol use using a validated tool within 6 months of enrollment
Child Injuries, Maltreatment, and Emergency Department Visits	7 Safe Sleep 8 Child Injury 9 Child Maltreatment	• Percent of infants who are always placed to sleep on their back • Rate of injury-related visits to the Emergency department • Percent of children with at least one investigated case of maltreatment
School Readiness and Achievement	10 Parent-Child Interaction 11 Early Language and Literacy Activities 12 Developmental Screening 13 Behavioral Concern Inquiries	• Percent of primary caregivers who receive an observation of caregiver-child interaction using a validated tool • Percent of children with a family member who reported that they read, told stories, and/or sang songs with their child daily • Percent of children with a timely screen for developmental delays using a validated tool • 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	• 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 16 Continuity of Insurance Coverage	• Percent of primary caregivers without a high school degree or equivalent who subsequently enrolled in or completed high school or equivalent • 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	• 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	• 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

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	• Percentage of recommended home visits received by families enrolled in the home visiting program during the reporting period
	2	Home Visit Implementation Observation	• 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	• 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	• 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	• 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	• Percent of the AAP-recommended number of well-child visits received by children enrolled in home visiting during the reporting period
	1*	Breastfeeding	• Percentage of women enrolled prior to child's birth who initiate breastfeeding
	2*	Postpartum Care	• 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	• 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	• Percentage of primary caregivers enrolled in home visiting who are provided with training on prevention of child injuries
	4*	Screening for Parenting Stress	• 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	• 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	• 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	• 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	• Percentage of children enrolled in HV screened at least annually for developmental delays using a validated parent-completed tool

Benchmark Area	Construct		Measure Description
	7	Early Language and Literacy Activities	• 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.
IV - Crime or Domestic Violence	10	Intimate Partner Violence (IPV) Screening	• 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	• 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	• 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
	8*	Completed IPV referrals	• Percentage of primary caregivers screening positive for intimate partner violence who receive a timely referral for services and a follow up
	9*	Completed Depression and Parenting Stress Referrals	• 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
	10*	Completed Substance Abuse Referrals	• Percent of primary caregivers screening positive for substance abuse using a validated tool who receive a timely referral for services and a follow up
	11*	Completed Economic Strain Referrals	• Percent of primary caregivers with unmet basic needs who receive a timely referral for services and a follow up
Form 1	Demographic Performance Measures		• 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.

References

[i] Health Resources and Services Administration, Maternal and Child Health Bureau. The Maternal, Infant, and Early Childhood Home Visiting Program. Available at: https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview. Accessed August 30, 2022.

[ii] Administration for Children and Families. Tribal Maternal, Infant, and Early Childhood Home Visiting. Available at: https://www.acf.hhs.gov/ecd/tribal/tribal-home-visiting. Accessed January 20, 2022.

[iii] Health Resources and Services Administration, Maternal and Child Health Bureau. The Maternal, Infant, and Early Childhood Home Visiting Program. Available at: https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview. Accessed August 30, 2022.

[iv] Administration for Children and Families. Tribal Maternal, Infant, and Early Childhood Home Visiting. Available at: https://www.acf.hhs.gov/ecd/tribal/tribal-home-visiting. Accessed January 20, 2022.

[v] Health Resources and Services Administration. (2022, November). *About HRSA*. https://www.hrsa.gov/about. Accessed November 28, 2022.

[vi] Health Resources and Services Administration, Office of Health Equity. What is health equity? Available at: https://www.hrsa.gov/about/organization/bureaus/ohe/index.html#:~:text=What%20is%20health%20equity%3F,disease%2C%20disability%2C%20or%20mortality. Accessed August 23, 2022.

[vii] Vedam, Saraswathi & Stoll, Kathrin & Rubashkin, Nicholas & Martin, Kelsey & Hayes-Klein, Hermine & Miller, Zoe & Jolicoeur, Ganga. The Mothers on Respect (MOR) index: measuring quality, safety, and human rights in childbirth. SSM - Population Health 3. 2017. 10.1016/j.ssmph.2017.01.005.

[viii] Health Resources and Services Administration, Maternal and Child Health Bureau. The Maternal, Infant, and Early Childhood Home Visiting Program. July 2021. Available at: https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf. Accessed August 30, 2022.