

The Federal Home Visiting Program Demographic, Service Utilization, and Select Clinical Indicators and Performance Indicators and Systems Outcomes Frequently Asked Questions (FAQs) Updated October 2016

The Health Resources and Services Administration’s (HRSA) Maternal and Child Health Bureau (MCHB) revised the Home Visiting Program performance measurement system, which was approved by the Office of Management and Budget (OMB) in March 2016. This FAQ includes commonly-asked questions about the new requirements for the performance measurement system and is one of several technical assistance resources to support Federal Home Visiting Program grantees in adopting and implementing the new performance measures.

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FORM 1: Demographic, Service Utilization, and Select Clinical Indicators

General

- 1. Grantees will end data collection on previous Form 1 measures September 30, 2016 and begin data collection with new Form 1 measures October 1, 2016. How do we address clients who were enrolled under the previous system, but will continue to receive services after we roll out the new measures? Will we transfer those clients to the new system or collect information on both sets of Form 1 measures?**

A: Grantees will be required to begin data collection for continuing families using the revised measures on October 1, 2016. They will cease data collection using the old system and transfer all participants to the new measures. Participants who roll over to the new system will need to be reassessed annually using the new measures on or after October 1, 2016 and will be considered continuing enrollees. (5/6/16)

- 2. For Form 1, how should we report the status of enrollees and when are the data expected to be collected?**

A: All Form 1 data should be collected at the time of enrollment and updated annually thereafter. Below are a few scenarios that may be helpful when reporting enrollee status:

- If a woman is pregnant at the time she enrolls in the home visiting program, she should be counted as pregnant, even if she completes her pregnancy within the same reporting period. If she continues enrollment after pregnancy into subsequent reporting periods she would be counted as a female caregiver.
- If a woman is enrolled as a female caregiver and becomes pregnant in the same reporting period with a sibling of the enrolled index child, she will continue to be counted as a female caregiver since grantees will report her status at the time of enrollment.
- If a woman is pregnant at the time she enrolls and the index child is born during the reporting period, the index child is considered a new enrollee at the time of birth and should be counted in that reporting period. (5/6/16)

- 3. There are some entries that may change over time (education, employment). Should we use the most recent entry or the entry at enrollment? How often should data be collected on these entries as participants continue receiving services?**

A: For participants who are newly enrolled, Form 1 data should be collected at the time of enrollment. Data should be updated annually thereafter for participants continuing enrollment in subsequent reporting periods. It is up to grantees to establish procedures for updating Form 1 data on an annual basis. (5/6/16)

4. What is the frequency of data collection for Form 1 data?

A: Participants will be assessed at the time of enrollment and then annually thereafter. (5/6/16)

5. How will the data collection requirements for the Form 1 demographics align with data collection required by each of the models?

A: HRSA is working with models to identify how model data collection will align with the new performance measures. DOHVE is also collecting details on model data collection to provide grantees with a model developer data crosswalk to support grantees in organizing their data collection efforts. (5/6/16)

6. Are the terms “newly enrolled” and “continuing during reporting period” being considered in the same manner on Forms 1 and 4?

A: For the purposes of Form 1, new participants are participants who sign up to participate in the home visiting program at any time during the reporting period and who are served by a trained home visitor implementing services with fidelity to the model for whom at least 25% of his/her personnel costs are paid for with MIECHV funding.

For the purposes of Form 1, continuing participants are participants who were signed up and enrolled in the home visiting program prior to the beginning of the reporting period who were served by a trained home visitor implementing services with fidelity to the model for whom at least 25% of his/her personnel costs are paid for with MIECHV funding.

The definition of continuing participants differs slightly from Form 4 Table A.1 because of the cross-sectional nature of that table. You can access definitions and Frequently Asked Questions for Form 4 at: <http://mchb.hrsa.gov/programs/homevisiting/ta/resources/index.html>. (5/6/16)

7. For Form 1, do we only include those who had a home visit during the year? Or all who are enrolled, even if they never received a home visit?

A: In order to be reported on Form 1, all participants (new and continuing enrollees) must have received at least one home visit during the reporting period. (5/19/16)

Participant Demographics

- 8. For Table 2: Unduplicated Count of Households Served by MIECHV Home Visitors, is there a difference in the definition for the number of newly enrolled? The phrase “...and continued enrollment” is included in the current definition and does not include those who disenrolled.**

A: The definition has been updated to remove the phrase “...and continued enrollment.” All participants who were served during the reporting period should be reported in Table 2. (5/6/16)

- 9. For Table 3: Unduplicated Count of Participants and Households Served by State Home Visiting Programs, is this the only place we are reporting on the non-MIECHV participants?**

A: Yes. (5/6/16)

- 10. For Table 3: What is the intent of collecting information on non-MIECHV programs?**

A: HRSA’s intent for collecting participant information for non-MIECHV evidence-based and promising approach home visiting programs is to better document the reach of the Federal Home Visiting Program. Federal Home Visiting Program grantees use federal grants to leverage additional funding to expand their evidence-based home visiting services. Documenting the scope of those services will allow HRSA to better convey the complete scope of the Federal Home Visiting Program. (5/6/16)

- 11. For Table 3: Unduplicated Count of Participants and Households Served by State Home Visiting Programs, should other programs that are not MIECHV-funded or evidence-based also be included?**

A: Any evidence-based home visiting program or program that qualifies as a promising approach and is overseen by the same entity that receives the MIECHV grant should be included in Table 3. (5/6/16)

- 12. For Table 3: Unduplicated Count of Participants and Households Served by State Home Visiting Programs, we need to report on the participants and households in non-MIECHV funded home visiting programs within the same “supervising state agency” as the MIECHV program is being supervised by. In our state, we have multiple divisions in our state government. How do we know which state agencies to include in this table?**

A: Participants in evidence-based home visiting who are served by a home visitor who receives less than 25% of their personnel costs from MIECHV funds, but who is overseen by the same state entity responsible for administering the MIECHV grant should be reported on Table 3. The state entity responsible for administering the MIECHV grant is defined as the entity listed on the Notice of Award. In most states, this entity is the state department of health. (5/19/16)

- 13. For Table 3: Unduplicated Count of Participants and Households Served by State Home Visiting Programs, does HRSA want grantees to include only cases that remained open at the end of the reporting period, or do they want to include all cases that were open during the reporting period, even if the case closed before the end of the reporting period?**

A: Table 3 is intended to record an unduplicated cumulative count of participants and households. This would include all participants and households that were active at any point during the reporting period. (9/27/16)

- 14. For Table 3: Unduplicated Count of Participants and Households Served by State Home Visiting Programs, pregnant women/female caregivers may be counted differently by non-MIECHV programs. Does HRSA have any guidance on how to address this?**

A: Participant status should be recorded at the time of enrollment and updated annually thereafter. To the extent practicable, grantees should use HRSA definitions for participant type to report in Table 3. In cases where definitions vary across MIECHV and non-MIECHV funded programs, the grantee should use their best judgment to categorize participants and explain any variation in reporting definitions in the “Notes” section of Form 1. (9/27/16)

- 15. How is HRSA defining a “program that qualifies as a promising approach”? Will this be restricted to only non-EB models that have already been submitted to HomVEE for review? Is it any non-EB home visiting model?**

A: A home visiting service delivery model that qualifies as a promising approach is defined in the statute as the following: “the model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process.” (5/6/16)

- 16. For Table 8: Adults Participants by Marital Status, how should we report the marital status for a primary caregiver who is divorced and currently living with a partner: divorced or not married but living together with a partner?**

A: A divorced primary caregiver living with a partner should be categorized as separated/divorced/widowed. (9/27/16)

- 17. For Table 9: Adults Participants by Educational Attainment, can you clarify if the categories build upon each other? For example, a caregiver with technical training or certification already has a HS diploma/GED; are these mutually exclusive or can caregivers fit in more than one category?**

A: The categories for this table are mutually exclusive and build off of one another in an ordinal way. (5/19/16)

18. For Table 9: Adults Participants by Educational Attainment, can you clarify how to address a caregiver who is of high school age, but has not obtained his/her diploma?

A: The key terms for this table have been modified so that the definition for “Less than high school diploma” no longer says “individuals who are older than high school age.” Rather, any individual who did not complete a high school education should be counted in this category. (5/19/16)

19. For Table 12: Adults Participants by Housing Status, can you clarify the definitions for each category?

A: Table 12 is a tiered table. Grantees must first determine whether each adult participant is homeless, according to the definition provided in the Key Terms for Form 1. Grantees must then assess the current housing status of each adult participant. Definitions for the categories under “Homeless” are provided in the Key Terms. Grantees should categorize participants according to the category that most closely matches the participant’s housing status. (5/6/16)

20. For Table 12: Adults Participants by Housing Status, how should clients who rent or own homes in a trailer park be categorized?

A: The [McKinney-Vento definition](#) states that individuals are considered homeless if they are living in a trailer park due to a lack of a fixed, regular, and adequate nighttime residence:

The term homeless children and youths¹ —

(a) **means individuals who lack a fixed, regular, and adequate nighttime residence** (within the meaning of section 103(a)(1)); and

(b) includes —

(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; **are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations**; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C));

(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

As such, a participant must lack fixed, regular, and adequate nighttime residence prior to being categorized as homeless, no matter the type of housing they reside in. For more information, please see: <http://www2.ed.gov/policy/elsec/leg/esea02/pg116.html>.

(9/27/16)

21. For Table 12: Adults Participants by Housing Status, please explain the difference between public housing and housing vouchers.

A: Housing choice vouchers are administered locally by public housing agencies (PHAs). The PHAs receive federal funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program. The participant is free to choose any housing that meets the requirements of the program and is not limited to units located in subsidized housing projects. Since housing assistance is provided on behalf of the family or individual, participants are able to find their own housing, including single-family homes, townhouses and apartments. A housing subsidy is paid to the landlord directly by the PHA on behalf of the participating family. The family then pays the difference between the actual rent charged by the landlord and the amount subsidized by the program. For more information on housing choice vouchers, see: http://portal.hud.gov/hudportal/HUD?src=/topics/housing_choice_voucher_program_section_8.

Public housing provides safe and affordable rental housing for eligible low-income families. It is managed by local housing agencies who receive federal aid from HUD. Public housing is distinguished from privately financed housing, regardless of whether federal subsidies or mortgage insurance are features of such housing development. Further information on public housing can be found here:

http://portal.hud.gov/hudportal/HUD?src=/topics/rental_assistance/phprog. (9/27/16)

22. For Table 15: Priority Population Characteristics for Each Household, how do we account for duplication if families meet multiple priority populations?

A: All enrolled families should be represented in each row. (5/6/16)

23. For Table 15: Priority Population Characteristics for Each Household, does HRSA want us to report individual or family income?

A: Grantees should collect and report information on household income for this table. (5/6/16)

24. For Table 15: Priority Population Characteristics for Each Household, will this be limited to only newly enrolled families?

A: No, all participants should be included in Table 15. Participants should be assessed at program enrollment and annually thereafter. (5/6/16)

25. For Table 17: Family Engagement by Household, which families would be included under the category “enrolled but not currently receiving services”?

A: Programs should defer to home visiting model or program definitions for the purposes of this category. (5/6/16)

26. For Table 17: Family Engagement by Household, do grantees need to use all reporting categories? For example, if a case is required to be kept open by the model, can a grantee report a family as “currently receiving services” rather than “enrolled but not currently receiving services”?

A: Grantees are not required to use all categories if no enrolled household meet the definitions for a category. Grantees, following model guidance, should determine how to appropriately classify households as “enrolled but not currently receiving services,” if applicable. (9/27/16)

27. For Table 18: Unduplicated Count of Home Visitor FTE, are grantees expected to report on the number of FTE home visitors supported by grant funds over the entire reporting period, or are they supposed to report on the number of home visitor positions?

A: Grantees are expected to report on the cumulative FTE home visitors employed during the reporting period, not the number of positions filled. (5/6/16)

28. For Table 22: Index Children by Usual Source of Dental Care, is there an age cut off for index children? For example, what about for children who do not yet have teeth?

A: There is no age cut off for index children. The denominator includes all children, regardless of age or whether they have teeth. (5/19/16)

29. For Table 22: Index Children by Usual Source of Dental Care, can grantees use the pediatrician as the dental home until the child turns 12 months of age, or should they be reported as “do not have a usual source of dental care”?

A: No; the definition of a dental home indicates that it must be established with a licensed dentist. (9/27/16)

30. For Table 22: Index Children by Usual Source of Dental Care, if a family has a dental home established, but the index child has not had a visit, does this count as an established dental home?

A: Yes; as long as the dental home is continuously accessible. (9/27/16)

Insurance and Clinical Indicators

31. For Table 20: Participants by Type of Health Insurance Coverage, our Medicaid allows for retroactive insurance coverage. How should we take this into account for Table 20?

A: Grantees should assess insurance status at the time of enrollment and then annually thereafter. Grantees should report the known status at the time of assessment. (5/6/16)

32. For Table 21: Index Children by Usual Source of Medical Care, within one six month period, we will have multiple answers (e.g., have a physician but have also been seen in urgent care). Is there a hierarchy if multiple types of care occur for the same index child?

A: Grantees should report the *usual* source of care for the family at enrollment and annually thereafter. This table is not intended to document all sources of medical care during the reporting period. (5/6/16)

33. For Table 21: Index Children by Usual Source of Medical Care, where should urgent care be included?

A: Urgent care is a term describing the provision of immediate medical services in an outpatient setting for acute or chronic illness¹ and does not necessarily describe a particular setting of care. Urgent care may be provided in many of the categories outlined in Table 21. The grantee should attempt to determine which category provided in Table 21 most closely aligns with the setting for the provision of urgent care and classify it appropriately. If no category aligns closely, the index child should be counted in the “Other” category and details should be described in the “Notes” section. (5/6/16)

¹ American Academy of Urgent Care Medicine. “What is Urgent Care” accessed from <http://aaucm.org/about/urgentcare/default.aspx>

FORM 2: Performance Indicators and Systems Outcomes

General

34. Grantees will end data collection on previous performance measures September 30, 2016 and begin data collection with new performance measures October 1, 2016. How do we address clients who were enrolled under the previous system, but will continue to receive services after October 2016? Will we transfer those clients to the new system or collect information on both sets of performance measures?

A: Grantees will be required to begin data collection for continuing families using the revised performance measures on October 1, 2016. They will cease data collection using the old system and transfer all participants to the new performance measures.

For Form 2, grantees will need to be assessed with the new performance measures based on the eligibility criteria for each measure. This may result in some participants rolling over to the new measures not being assessed if they missed the data collection point and are no longer eligible for a given measure. (5/6/16)

35. If a family is enrolled in services but has been disengaged for the entire reporting period (no home visit is completed in the reporting period), should be they included in Form 2?

A: It is possible that participants could be included on Form 2 in a reporting period in which they did not receive a home visit for certain measures. For example, a primary caregiver who received a referral for depression services in a prior reporting period may complete the referral in a subsequent reporting period and should be included, even if a home visit was not completed during the subsequent reporting period. (9/27/16)

36. How should we address missing data? Should we only include participants for which we collected data in the denominator or should we include all eligible participants?

A: Only include participants with complete data in the calculation of the percentage or rate. Missing data will affect the accuracy of the data and could misrepresent program performance. Grantees are expected to take all necessary efforts in order to minimize missing data. This includes using proper data collection forms, training staff on data collection protocols, ensuring data are entered in proper data systems, and monitoring data quality and accuracy regularly. Missing data will be considered during the review of annual performance data. Grantees should consult with DOHVE Liaisons on how to account for missing data. (5/6/16)

37. Are we required to report on families served by home visitors who receive 25% or more of their funding from MIECHV?

A: Yes; all participants who are served by a trained home visitor implementing services with fidelity to the model for whom at least 25% of his/her personnel costs are paid for with MIECHV funding should be reported. (5/6/16)

38. How will the data collection requirements for the benchmarks align with data collection required by each of the models?

A: HRSA is working with models to identify how model data collection will align with the new performance measures. DOHVE is also collecting details on model data collection to provide grantees with a model developer data crosswalk to support grantees in organizing their data collection efforts. (5/6/16)

39. What is considered a validated tool?

A: A validated tool is an instrument that has been psychometrically tested for reliability, validity, sensitivity, and specificity. A reliable tool is both consistent and stable at measuring a construct. A valid one measures the concept it was intended to measure. Sensitivity represents the degree to which an instrument correctly identifies those individuals who have a specific condition. Specificity is the degree to which an instrument correctly screens out those individuals who do not have a specific condition.

Grantees need to ensure they follow the administration and training protocols of the tool they select to ensure they are being used appropriately. Some measurement tools have specific training requirements that need to be met before staff can administer the tool. Grantees should always select tools that ensure fidelity to the guidelines of the evidence-based home visiting model or model that qualifies as a promising approach, as applicable. (5/6/16)

40. Several measures ask for a validated tool (e.g. Measure 10: Parent-Child Interaction). Will a list of validated tools be provided to grantees?

A: HRSA does not endorse specific tools, but requires grantees to use validated tools to assess caregiver-child interaction and to screen families for maternal depression, intimate partner violence, and child developmental delays. Grantees have the discretion to select validated tools that are appropriate and in accordance with model guidelines. To support grantees in identifying validated tools, DOHVE has included examples of validated tools in DOHVE's *Form 2 Performance Indicators and Systems Outcomes Data Collection and Reporting Manual and Plan*. These examples do not constitute an endorsement of the instrument by the authors, the publishers, DOHVE, or HHS. (5/6/16)

41. Are there specific or required data sources for each construct?

A: Grantees should use self-report for all Form 2 measures except for Measure 9: Child Maltreatment. HRSA requires child maltreatment data to be collected from child welfare administrative records. For all other measures, self-report should be used unless the grantee would prefer to use data from another reliable source, like birth certificate data. (5/6/16)

42. For several measures, there are no instructions for the timing of data collection. At which time points should we collect data?

A: If the timing of the data collection is not specified, the grantee *may* collect data at or near the end of the reporting period (although more routine data collection may be preferred for some measures). This will require grantees to monitor which home visits will fall closest to the end of the reporting period for each family to ensure data collection is complete for each family.

For some measures, the timing of data collection is specified in the numerator and denominator definition of the measure. Grantees should follow the criteria specified in these measures. Additional information may be found in DOHVE's *Form 2 Performance Indicators and Systems Outcomes Data Collection and Reporting Manual and Plan*. (5/6/16)

43. How should we address measures that require the collection of numerous pieces of data (e.g. Measure 6: Tobacco Cessation Referrals)?

A: Grantees will need to meet all the criteria specified in the definition of the measure. For example, to be counted in the numerator of Measure 6, a primary caregiver needs to have been a user of tobacco or cigarettes at the time of enrollment and referred to tobacco cessation counseling or services within 3 months of enrollment. This will require the grantee to collect multiple data elements in order to assess this measure: (1) tobacco or cigarette use at the time of enrollment, (2) documentation of referral to tobacco counseling or cessation services, and (3) date of referral. For additional support in identifying the needed data elements, please see DOHVE's *Form 2 Performance Indicators and Systems Outcomes Data Collection and Reporting Manual and Plan* or check with your DOHVE TA Liaison. (5/6/16)

44. If we have a family with two primary caregivers, should we include one or both primary caregivers?

A: Only one primary caregiver should be reported per family. For home visiting models that allow programs to enroll more than one adult participant, only one adult participant per family may be the primary caregiver for the purposes of reporting. The adult participant identified as the primary caregiver is the participant that should be assessed. (5/6/16)

45. Does the denominator only include children or families enrolled during the reporting period?

A: The denominator for all performance measures should include participants who were enrolled in services during the reporting period. Participants who were enrolled in previous reporting

periods but did not receive services during the current reporting period will not be included in the denominator. (5/6/16)

46. How do we address participants who have been enrolled for different lengths of time at the end of each reporting period? Can the measurement period be defined so that it is consistent across grantees?

A: Different enrollment periods across participants are acceptable. Information should be collected within applicable specified time periods in accordance with measure definitions or at the home visit closest to the end of the reporting period. (5/6/16)

47. Are families reported on twice for the same measure if they remain eligible across multiple reporting periods?

A: Some measures are collected at one point in time per family, whereas families are assessed in multiple reporting periods for other measures, depending on the measure criteria. See DOHVE's *Form 2 Performance Indicators and Systems Outcomes Data Collection and Reporting Manual and Plan* for more information regarding data collection for each measure. (5/6/16)

48. How has the guidance regarding index children been updated?

A: Grantees are required to use model guidance for determining who should be included as an index child. Updated guidance indicates that grantees should include all index children in all relevant measures on Form 2, as opposed to only including one index child per family. Grantees who have trouble implementing this change immediately may phase it into their reporting. More details on the updated index child guidance can be found at: <http://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting/home-visiting-program-technical-assistance/performance-reporting-and-evaluation-resources>. (9/27/16)

49. Can we use the last home visit as a proxy for exiting from the program when there has been a period of inactivity?

A: If the denominator specifies inclusion criteria that are time-bound (e.g., participants enrolled for at least 6 months), then those criteria must be met in order to be included in the measure. For those participants that are dis-enrolled from the program due to inactivity, the last home visit may be used as the closure date after a period of inactivity (based on the assumption is that the family will not return to services). (5/6/16, rev. 9/27/16)

50. Are these measures the same as for the Tribal Home Visiting Program?

A: The Administration on Children and Families (ACF) has developed separate performance measures for grantees who receive funding under the Tribal Home Visiting Program, administered by ACF. (5/6/16)

Preterm Birth

51. We do not target prenatal enrollment and may subsequently have low numbers to report for this measure. How should we address potentially low numbers or no participants who meet the inclusion criteria?

A: Participants only need to be included in the reporting for a measure if the inclusion criteria for that measure are met. If a program model does not serve the target population for a measure (e.g., does not enroll participants prenatally), then there are no eligible participants to be included in the denominator. HRSA recognizes that some program models do not enroll participants prenatally. (5/6/16)

52. Will this measure include women up to and at 37 weeks or do they have to enroll before 37 weeks (i.e. 36 weeks and below)?

A: To be included in this measure, a primary caregiver must enroll before completing the 37th week of gestation (i.e. by 36 weeks, 6 days). Grantees must include all primary caregivers who are enrolled prenatally prior to completing 37 weeks (i.e. 36 weeks and 6 days or less) in the denominator. To be counted in the numerator, grantees must include all primary caregivers who deliver a live birth before 37 completed weeks of gestation (i.e. 36 weeks and 6 days or less). (5/6/16)

53. How is HRSA defining preterm birth or “37 completed weeks”?

A: Preterm birth is defined as a birth before 37 completed weeks of gestation (defined as up to 36 weeks and 6 days)². (5/6/16, rev. 5/19/16)

54. If a mother enrolled at 36 weeks and gives birth within the 36th week, would she still be considered in the numerator and denominator?

A: Yes; she will be included in the numerator and the denominator because she meets the criteria for both. (5/6/16)

55. If we have birth certificate information, should we use that or use self-report?

A: Grantees should use self-report for all Form 2 measures (except Measure 9: Child Maltreatment) unless the grantee would prefer to use data from another reliable source, like birth certificate data. (5/6/16)

² Behrman R, Stith Butler A. eds. Preterm Birth: Causes, Consequences, and Prevention. Washington, DC: The National Academies Press, 2007.

56. Are there any exceptions or exclusions for preterm birth with regards to women giving birth to multiples?

A: No; this measure applies to all births that meet the eligibility criteria as defined in the measure. Multiples should not be excluded. (5/6/16, rev. 5/19/16)

Breastfeeding

57. We do not target prenatal enrollment and may subsequently have low numbers to report for this measure. How should we address potentially low numbers or no participants who meet the inclusion criteria?

A: Participants only need to be included in the reporting for a measure if the inclusion criteria for that measure are met. If a program does not serve the target population for a measure (e.g., does not enroll participants prenatally), then there are no eligible participants to be included in the denominator. HRSA recognizes that some program models do not enroll participants prenatally. (5/6/16)

58. Does it count if an infant is breastfed consistently up until 5 months, but is not breastfed any amount at 6 months?

A: No; the infant must be breastfed any amount at 6 months of age to be included in the numerator for this measure. (5/6/16)

59. How do we address index children who are 6 months old and have been breastfed at 6 months, but have only been enrolled for 3 months?

A: To be included in this measure, mothers must have been enrolled prenatally, be enrolled for at least 6 months, and the index child must have reached 6 months of age. Therefore, an index child enrolled for only 3 months should not be included in this measure. (5/6/16)

60. How do we address mothers who could not continue breastfeeding at 6 months postpartum due to medical complications or difficulties?

A: Mothers who are not recommended to breastfeed due to certain medical conditions should be excluded from this measure. Medical exclusion criteria can be found at <http://www.cdc.gov/breastfeeding/disease/>. (5/6/16)

61. The numerator and denominator include the number of infants aged 6 to 12 months who are enrolled for at least 6 months. Is this based on the end of the reporting period or is this at any time?

A: To be included in this measure, the primary caregiver must have enrolled prenatally and the index child must be 6 to 12 months old during the current reporting period. Families that meet this criterion during the reporting period should be included in this measure. (5/6/16)

62. What is the window for data collection? What are the parameters to be included in the denominator?

A: This measure assesses breastfeeding that occurred when the index child was 6 months of age. The data may be collected when the index child is anywhere between 6 and 12 months of age, but must reflect whether breastfeeding occurs at 6 months of age for infants who's mothers were enrolled prenatally and were enrolled for at least 6 months. (5/6/16)

Depression Screening

63. Does the denominator need to be changed to capture both populations listed in the numerator? For example, instead of “number of caregivers enrolled for 3 months” in the denominator, it would be “number of caregivers not enrolled prenatally who have been enrolled 3 months and number of caregivers who enrolled prenatally who are at least 3 months postpartum”?

A: This performance measure was revised so that the inclusion criteria for the target population in the denominator match those of the numerator. The most up-to-date performance measures can be found at the following website:
<http://www.mchb.hrsa.gov/programs/homevisiting/ta/resources/index.html>. (5/6/16)

64. What if we are currently only screening pregnant (or postpartum) women? Do we need to expand our data collection to include all mothers?

A: Yes; grantees must screen all primary caregivers for depression. For programs that currently screen a narrower target population (e.g., pregnant mothers or postpartum mothers), data collection will need to be expanded to include all primary caregivers who meet the eligibility criteria. The screening is only required for one primary caregiver per family. (5/6/16)

65. Is there any flexibility to screen a mother who enrolls prenatally within 3 months of enrollment rather than waiting to screen within 3 months of delivery?

A: To be counted in the numerator of this measure, women who enrolled prenatally need to receive a screening within 3 months of delivery. For prenatal enrollees who enroll earlier than 3 months before delivery, a screening that occurs within 3 months of enrollment would not meet the criteria to be counted in the numerator. (9/27/16)

Well-Child Visits

66. When are data for this measure supposed to be collected?

A: Data regarding well-child visits may be collected by the grantees after each scheduled well-child visit or retrospectively at the end of the reporting period. This will require grantees to monitor which home visit will fall closest to the end of the reporting period for each family to ensure data collection is complete. (5/6/16)

67. Is this intended to measure whether children are up to date on visits according to American Academy of Pediatrics (AAP) schedule or whether they received their last expected visit according to the AAP schedule? For example, a child may not have received most of their intended visits but did receive their last expected visit according to the AAP schedule. Should they be counted in this measure?

A: This measure does not assess if the index child is up to date on well-child visits, but if the last recommended visit was completed based on the index child's current age. To determine if the recommended visit occurred, grantees should use the American Academy of Pediatrics (AAP)-informed intervals (as specified in DOHVE's *Form 2 Performance Indicators and Systems Outcomes Data Collection and Reporting Manual and Plan*), which are based on the AAP schedule (https://www.aap.org/en-us/Documents/periodicity_schedule.pdf) and depend on the index child's age. Index children will be counted in each reporting period in which they were enrolled for any length of time. (5/6/16)

68. What if a child was up to date on well-child visits as of their last home visit, but the family dropped out? Does it count if they were up to date on well-child visits as of their last home visit?

A: An index child should be included in the numerator for this measure if they had their last recommended well-child visit at the time of their last home visit. Programs should use the last completed well-child visit prior to the home visit. For example, following the AAP periodicity schedule, each index child should receive a well-child visit during the following intervals depending on their age: 3-7 days, 2-4 weeks, 2-3 months, 4-5 months, 6-7 months, 9-10 months, 12-13 months, 15-16 months, 18-19 months, 2-2.5 years, 3-3.5 years, 4-4.5 years. If the index child passes 6 months of age at the end of the reporting period and is expected to have received the 6 month well-child visit, but the last home visit was at 5 months of age, then the 4-month expected well-child visit should be used as the last completed well-child visit data collection point. (5/6/16)

69. Is there any flexibility around the AAP schedule? For example, what if a child has a well-child visit one week after the exact scheduled day? What are the parameters to be included in the denominator?

A: Index children will be counted in each reporting period in which they were enrolled for any length of time. Grantees should use the following intervals, which are based on the AAP schedule (https://www.aap.org/en-us/Documents/periodicity_schedule.pdf) and depend on the index child's age: 3-7 days, 2-4 weeks, 2-3 months, 4-5 months, 6-7 months, 9-10 months, 12-13 months, 15-16 months, 18-19 months, 2-2.5 years, 3-3.5 years, 4-4.5. These intervals allow for a window for the visits to occur. For instance, the 9 month visit could occur anytime between when the index child is 9 to 10 months of age. (5/6/16)

70. Does the 9-10 month window include 9 months 0 days through 10 months 30 days?

A: Yes, this measure includes a full two month window to allow for data collection. (5/19/16)

71. For some models, data collection regarding well-child visits may only occur every 6 months. As a result, if a child is 9 months of age at the time of reporting and the last home visit was at 8 months, yet the latest information the grantee has for the child is their 4-month visit, how should the grantee report this?

A: In this situation, the grantee would report the well-child information as missing. It is expected that they report on the expected well-child visit occurring prior to their last home visit in the reporting period. Since the last home visit occurred at 8 months, then the expected well-child visit occurring prior to that visit should be at 6 months. (5/19/16)

72. Is the denominator all index children enrolled or just those enrolled at the time of a recommended well child visit?

A: All index children enrolled in the home visiting program will be included in the denominator. (5/6/16)

Postpartum Care

73. If a woman meets the eligibility criteria for this measure but has her postpartum visit prior to enrollment, will she be included in the denominator?

A: Women should be excluded from the denominator if they meet the inclusion criteria but already had a postpartum visit prior to enrollment into home visiting. (5/19/16)

Tobacco Cessation Referrals

74. What does “at enrollment” mean when a family enrolled in a prior reporting period? Does the denominator include participants who indicated using tobacco at enrollment, even if they enrolled in a prior reporting period?

A: Yes; primary caregivers indicating tobacco or cigarette use at enrollment should be included in the reporting period in which they reached 3 months post-enrollment. This means that they could be screened for tobacco or cigarette use in one reporting period and reach 3 months post enrollment in the next. (5/6/16)

75. The performance measure definition refers to “primary caregivers.” We currently only screen pregnant (or postpartum) women for tobacco use. Do we need to expand data collection to include all primary caregivers?

A: Grantees should report tobacco or cigarette use for the primary caregiver only (only one primary caregiver per household). For grantees that currently limit data collection to a sub-

population of primary caregivers, then data collection should be expanded so that all primary caregivers are assessed for this measure. (5/6/16)

76. Will the denominator continue growing to include people who are enrolled every year? While the numerator only reflects one year?

A: This measure is collected at one point in time per family, at 3 months following enrollment. (5/6/16)

77. Do we need to ask the client about their tobacco use every year?

A: For the purposes of this measure, tobacco or cigarette use only needs to be assessed at enrollment. (5/6/16)

78. What is the definition of a referral for tobacco cessation counseling or services? Does this include just the provision of information or does the home visitor need to confirm the referral?

A: Home visiting models and programs determine what constitutes an appropriate referral for tobacco counseling or services in each community. (5/6/16)

79. If the primary caregiver reports using tobacco at the time of enrollment but reports that they have or are currently receiving tobacco cessation counseling or services, is the program still required to make a referral?

A: Referrals should be tied to positive screenings during program services. If a primary caregiver reports tobacco use at the time of enrollment, they should be counted in the denominator once they have been enrolled for at least 3 months. To be counted in the numerator, the programs should provide a referral in response to the positive screening within 3 months of enrollment. (5/6/16)

80. What is considered tobacco use? Do the use of betel nut, vaping, and tobacco use count?

A: Based on the referenced definition, tobacco or cigarette use consists of the following: combustibles (cigarettes, cigars, pipes, hookahs, bidis), non-combustibles (chew, dip, snuff, snus, and dissolvables), and Electronic Nicotine Delivery Systems (ENDS). Grantees must adhere to the referenced definition of tobacco substances, which corresponds with the CDC definition (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6325a3.htm>). (5/6/16)

Safe Sleep

81. How do we address monthly data collection with conflicting information? For example, the caregiver indicates safe sleep for 10 months and co-sleeping one time in the 11th month? Does this mean the participant should not be included in the numerator?

A: This measure may be assessed at numerous times throughout the reporting period. However, it is only required to be assessed once per reporting period. If measured at multiple points in time (such as by asking the primary caregiver during each visit), then the assessment completed closest to the end of the reporting period should be reported. (5/6/16)

82. What if a child sleeps in the same bed as a sibling?

A: An index child sleeping in the same bed as a sibling is considered bed sharing and would not constitute a safe sleep practice. (5/6/16)

83. We serve populations that regularly co-sleep as a cultural practice. How should we approach this measure with these families?

A: An index child sleeping in the same bed as a parent or sibling is considered bed sharing and should not be included in the numerator. While HRSA is sensitive to cultural practices regarding co-sleeping, this practice does not align with current public health recommendations regarding safe sleep. (5/6/16)

84. This measure requires the collection of multiple data points. Are there any recommendations for how to collect these data?

A: Safe sleep practices should be measured using primary caregiver-reported sleep practices throughout the index child's first year of life and may be measured once or at various times throughout the reporting period. In order to assess the measure accurately, the primary caregiver should be asked specifically if 1) she/he always places the index child to sleep on his/her back and 2) if she/he always places the index child to sleep without bed sharing or soft bedding. The primary caregiver needs to answer "yes" to both parts of the measure to be considered as having safe sleep habits. (5/6/16)

Child Injury

85. Does the numerator include emergency department visits during the reporting period or only since the participant's enrollment?

A: Emergency department visits should be reported for the time they were enrolled within the current reporting period. Visits from prior reporting periods should not be included if the participant enrolled during a previous reporting period. (5/6/16)

86. Older children may have more injury-related emergency department visits than infants due to their increased mobility. Will you take this into account?

A: HRSA understands that rates of child injury will vary due to a number of factors, including child age. However, reporting requirements specify that all nonfatal injury-related visits to the emergency department should be reported. (5/6/16)

87. Some hospitals have urgent care departments where they refer individuals before triaging to emergency department if necessary. Should grantees also report on urgent care visits?

A: No; urgent care visits should not be included in this measure. By definition, only injury-related emergency department visits should be reported. (5/19/16)

Child Maltreatment

88. Can child maltreatment be self-reported by the parent or are we required to use administrative data?

A: Data regarding child maltreatment must be collected using administrative data. (5/6/16)

89. Does the numerator include child maltreatment cases during the reporting period or only since the participant's enrollment?

A: This measure captures index children with at least one investigated case of maltreatment during the reporting period, regardless of the disposition or outcome of the investigation. This measure is reported for each reporting period for which the index child is enrolled. Data reported during each reporting period reflect the period of time enrolled during that reporting period only, not cumulatively across all years enrolled. Investigated cases will only be reported during the year in which they were opened; they will not be reported in subsequent years, regardless of the status of the case. (5/6/16)

90. Does the denominator only include children enrolled during the reporting period?

A: Yes; the denominator should include children or families who are enrolled during the current reporting period. Participants who were enrolled in previous reporting periods but did not receive services for any length of time during the current reporting period will not be included in the denominator. (5/6/16)

91. We collect data with a separate consent process for CPS data. We have previously limited the denominator to those who have signed a consent form. Is HRSA suggesting that those who did not sign a consent be in the denominator?

A: HRSA requires that all data that are reported on Form 2 be collected from participants who are voluntarily enrolled in the home visiting program and who have provided informed consent, no matter the source of the data. (5/6/16)

92. We serve two sovereign nations, so we have three different policies to follow including the policies from the child welfare agency. Do we need to collect data from all three entities?

A: Yes, data should be collected from all applicable administrative data sources so that child maltreatment data may be reported for all children or families who are enrolled during the reporting period. (5/6/16)

93. Should we include cases that are investigated or only those that are assessed?

A: This measure captures index children with investigated cases of maltreatment, regardless of the disposition or outcome of the investigation. Therefore, only include cases that are investigated. (5/6/16)

94. In our state, screened-in reports are referred to as assessments and not investigations. Does HRSA want us to report the number of assessments?

A: Overall, HRSA considers this a multi-step process: suspected, investigated, and substantiated maltreatment. The focus of this measure is on the second step – investigated. HRSA realizes states have different terminology for the steps in this process. For the purposes of this measure, investigated cases are cases with an allegation of maltreatment that were screened-in for investigation or assessment and further received an investigation. (A screened-in report is one that is accepted for investigation or assessment based on the state’s screen-in criteria.) (5/19/16)

95. If a case is reported and investigated, but no maltreatment found, would that be reported in the investigation?

A: Yes; this measure captures index children with investigated cases of maltreatment, regardless of the disposition or outcome of the investigation. (5/6/16)

96. If a grantee does not have a signed agreement with their child welfare agency before October 1, 2016, should this data be reported as missing or should grantees use self-reported data?

A: Data needs to be available for all eligible participants in the reporting period by the end of the reporting period on 9/30/2017. Retrospective data collection and matching is acceptable for this measure. (9/27/16)

Caregiver-Child Interaction

97. We previously struggled to complete observations of caregiver-child interactions for children under 6 months because they are not as mobile or interactive during home visits. Can children under a particular age be excluded from this measure?

A: Grantees have discretion to select their own caregiver-child interaction observation tool as long as they use a validated tool, adhere to the training and administration requirements of the tool,

and continue to adhere to model guidelines. Therefore, grantees should only include index children within the target age range(s) of the tool(s) that are used. (5/6/16)

98. We currently have multiple LIAs using different caregiver-child observation tools and each tool has a different target age range for each child. Do we need to use the same observational tool and the same target age range across all our LIAs?

A: No; grantees do not need to use the same observational tool and target age range across all LIAs. Grantees are only required to track that at least one observation of caregiver-child interaction occurred with a validated tool in the reporting period, regardless of the tool used by each LIA. (5/6/16)

99. Does the denominator include only a single caregiver per household?

A: This measure captures the interaction between the primary caregiver and the index child. There may only be one primary caregiver per household (regardless of the number of caregivers enrolled). (5/6/16)

100. What is the desired age range for assessing parent-child interaction?

A: The desired age range will depend on the validated tool that grantees select to assess caregiver-child interaction. Grantees should adhere to the administration requirements of the tool they select and only include index children within the target age range(s) of the tool(s) that are used. (5/6/16)

101. Can grantees use select subscales rather than a full parent-child interaction tool?

A: If individual subscales are used instead of the full tool, then the subscale needs to be reliable and valid on its own. (9/27/16)

102. The guidance for when the caregiver-child interaction tool should be used is dependent on which tool is selected. The PICCOLO does not seem to have guidance as to how frequently it should be used. Do we at the state make this determination?

A: Yes; the state should make the determination about when the tool is implemented within the defined target age range and the validated ages for the instrument. Grantees should administer the PCI measure when the child reaches the target age. The target age is determined by the grantee and must be consistent with the tool administration protocol. (9/27/16)

Early Language and Literacy

103. Are there any restrictions on the age of the child for this measure?

A: No; there are no age restrictions for including children in the early language and literacy measure. (5/6/16)

104. When and how often should these data be collected?

A: Grantees may collect data as frequently as they choose, provided that they assess early language and literacy activities with families at least once during each reporting period. Grantees assessing index children's language and literacy at multiple age ranges should report data collected from the assessment completed closest to the end of the reporting period. (5/6/16)

105. Since this measure includes multiple criteria, are there any recommendations for how to collect these data?

A: To accurately assess this measure, caregivers should be asked if their index children were 1) read to, 2) told stories to, and/or 3) sang songs to every day during a typical week. Note that the measure asks parents to reflect on a typical week and then to report if at least one of the activities occurred each day during the week. Any combination of these activities over the week meets the criteria. Although this measure may be collected at multiple data collection intervals, the data collection time point completed closest to the end of the reporting period should be used for reporting on the measure. (5/6/16)

106. If families are enrolled through two reporting periods, will they be counted multiple times?

A: Yes; and those families should receive at least one assessment during each reporting period. (5/6/16)

107. In many families, a combination of individuals (e.g., mother, father, grandmother) may collectively conduct these activities with the child on a daily basis, though each individual may only do this a few days per week. Does it matter who reads, sings, or tells stories to a child, as long as these activities occur daily?

A: No, the only requirement is that it is a family member. It can be a different family member day to day. (5/19/16)

Developmental Screening

108. Do index children have to receive one screening within each of the AAP-recommended age groups or do they only have to receive at least one screening that fell within an AAP-recommended age group?

A: Index children within the target age must receive at least one screening at an AAP-recommended age during the reporting period. (5/6/16)

109. We currently assess index children multiple times at multiple age ranges. Which age range should we include?

A: Index children should be screened at the AAP-recommended ages of 9-months, 18-months, and 24- or 30-months. Grantees may choose to screen at additional ages but are expected to report on screenings at these specified ages. For families whose index children are being assessed at multiple ages within a reporting period, grantees should report on screenings at the AAP-recommended ages that are completed at the assessment closest to the end of the reporting period. (5/6/16)

110. Is there a window for completing a screening that is acceptable?

A: Grantees will need to screen index children for developmental delays at each AAP-recommended age. The AAP recommends that, at a minimum, standardized developmental screening tools should be administered at 9-months of age, 18-months, and 24- or 30-months. AAP guidelines can be found on <http://pediatrics.aappublications.org/content/118/1/405.full>. Grantees should ensure index children are screened at the AAP-recommended ages within the administration window of the selected tool. For example, a tool may require the 9-month screener to be administered between the window of 8 months 0 days and 9 months 30 days. (5/6/16)

111. Some of the models require developmental screenings be conducted during times that do not align with the AAP recommendations. Can we use multiple screenings during that interval?

A: Grantees may choose to screen at additional ages but are expected to report on screenings at the AAP-recommended ages. If grantees choose to screen at additional ages beyond the AAP recommendations, only data about screenings based on the AAP recommendations should be reported. (5/6/16)

112. How should grantees account for children who were within the screening range, yet did not have a screen because the screening range covers two reporting periods? For example, a child may be 18 months at the time of reporting, yet the child may be screened up to 18 months and 30 days of age.

A: The full period of time for a specified screening tool (i.e., “screening range”) needs to have elapsed by the end of the reporting period in order for a child to be recorded as a “no” in the numerator and for that child to be counted in the denominator.

For a child who receives a screening within the specified screening tool's window is recorded as a "yes" in the numerator, even if the screening is received before the end of the screening range, and that child is included in the denominator regardless of whether the entire window elapsed by the end of the reporting period. (5/19/16)

113. How should grantees handle children born prematurely? Should they use a different version of the screener or wait until they are at the adjusted age to administer the screener? For example, should a 9-month-old with an adjusted age of 8-months be assessed using the 8-month version of the ASQ or should they wait to be assessed with the 9-month version of the ASQ when they are actually 10 months old?

A: Grantees should follow the implementation instructions for the screening tool they have chosen to administer. Many developmental screening tools provide guidance on adjusting for premature birth. (9/27/16)

Behavioral Concerns

114. Is there guidance on when and how often to collect these data?

A: This measure requires that home visitors document if they did or did not ask the primary caregiver about developmental, behavioral, or learning concerns during **each postnatal home visit**. (5/6/16)

115. If this is not asked at every home visit or missed on a single home visit, is this construct considered not met for a family?

A: The measure reports the proportion of all postnatal home visits where home visitors asked primary caregivers about behavioral concerns. Therefore, all postnatal home visits will be counted in the denominator and only those where the assessment occurred will be included in the numerator. (5/6/16)

116. Should this be limited to caregivers with an index child of a certain age since behavioral concerns may vary by age?

A: There are no age restrictions for collecting data on behavioral concerns. This question should be asked at all postnatal home visits regardless of the index child's age. (5/6/16)

117. If an adult participant is pregnant, will home visits during pregnancy count?

A: No; this measure excludes prenatal home visits. (5/6/16)

Intimate Partner Violence Screening

118. Is the screening required once per reporting period, or once during the family's length of enrollment?

A: For the purposes of reporting, the screening should occur once during the first 6 months of enrollment. (5/6/16)

119. Home visitors are confused about using the IPV screening when the person is not in an intimate partnership. Do we exclude participants who are not in an intimate partnership?

A: All primary caregivers should be screened for IPV, regardless of their relationship status. The definition of IPV includes any "person with whom one has a close personal relationship" and can be found at <http://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html>. (5/6/16)

Primary Caregiver Education

120. How should we address the education status of participants who are enrolled for multiple years?

A: Primary caregivers who did not have a high school degree or equivalent at enrollment will be assessed for this measure during each reporting period for which they are enrolled. This measure may be assessed in multiple reporting periods per primary caregiver. Primary caregivers who are eligible to be included in the denominator will be included in each annual report until the conditions in the numerator have been met. This means that a primary caregiver may be included in more than one annual report. However, once the condition in the numerator is met, the primary caregiver will not be assessed in subsequent reporting periods. In other words, if a primary caregiver completes a high school degree or equivalent in a prior reporting period, they will not be counted in the current reporting period. (5/6/16)

121. What is considered an "equivalent" for a high school degree?

A: Grantees must adhere to the Department of Education definition of recognized equivalent of a high school degree.
(<http://www2.ed.gov/policy/highered/reg/hearulemaking/2009/hsdiploma.html#red>) (5/6/16)

122. Many of our participants already have a high school degree, can we count an alternate education requirement? For example, enrolling in continuing education such as college?

A: No; participants who already have a high school degree or equivalent do not meet the eligibility criteria for this measure which focuses on enrollment in, continuous enrollment in, or completion of a high school degree or equivalent among those who did not have a high school degree or equivalent at the time of enrollment into the home visiting program. (5/6/16)

123. May this be asked once per year retrospectively (e.g. in September) instead of at every visit?

A: Yes; this measure may be assessed at or near the end of the reporting period rather than at each visit. (5/6/16)

124. How do we address a caregiver who obtained their degree in a previous reporting period (2016-2017), but was not captured until the following reporting period (2017-2018)? Can this information be counted for the next reporting period?

A: A caregiver should be included in the denominator until s/he meets the specifications required for the numerator. In the example provided, it is acceptable to include this caregiver in the numerator of the 2017-2018 reporting period rather than in the 2016-2017 reporting period when the degree was obtained. (5/19/16)

125. How should grantees address caregivers who are currently in middle school or who are not high school age or older?

A: Any participant who does not have a high school degree or equivalent at enrollment should be included in the denominator for this measure. A primary caregiver enrolled in middle school would count in the denominator because they did not have a high school degree at enrollment, but not in the numerator until they enrolled in high school. (9/27/16)

Continuity of Insurance Coverage

126. How is HRSA recommending states measure continuous enrollment?

A: Continuous enrollment in health insurance for 6 consecutive months may be assessed in several ways, either 1) retrospectively at the end of the reporting period by directly asking primary caregivers how many months they have had continuous health insurance coverage (e.g., no gaps in coverage) each reporting period, or 2) through routinely checking the health insurance status for each month to determine whether or not the primary caregiver maintained health insurance for 6 consecutive months during each reporting period. The latter approach allows for programs to support families in obtaining eligible coverage earlier during their enrollment in the program. (5/6/16)

127. Do the cumulative 6 months need to be within the current reporting period? What if the 6 months overlap with another reporting period?

A: The 6 consecutive months of health insurance coverage may overlap reporting periods and do not need to occur in the same reporting period. (5/6/16)

128. Who should be included in the denominator: a) any family that is enrolled for at least 6 months during the reporting period, or b) any family that enrolled in home visiting for at least 6 months, regardless of the length of time enrolled during the reporting period?

A: Any family that enrolled for at least 6 months, regardless of the length of time in a reporting period should be included. They only become eligible in the reporting period in which they reach 6 months of enrollment. (5/19/16)

Completed Depression Referrals

129. What is included for “recommended services for depression”?

A: Recommended services for depression should be defined by home visiting models or state guidance about what constitutes a referral. For caregivers that screen positive for depression, the home visitor should provide the caregiver a referral to recommended services for depression. (5/6/16)

130. Should the denominator definition include “within 3 months of enrollment or within 3 months of delivery”?

A: For consistency with the depression screening measure the denominator for completed referrals should be the number of primary caregivers enrolled in home visiting who had a positive screen for depression within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally) and were referred for services. This has been clarified in the performance measures, which can be found at the following website: <http://www.mchb.hrsa.gov/programs/homevisiting/ta/resources/index.html>. (5/6/16)

131. Is this “ever” received services? Or within a certain time frame?

A: There is no specified time frame for when the receipt of services needs to be met, as long as it occurred after the positive screen and referral for services. It is possible that the receipt of recommended services for depression would fall into a different reporting period than the screening and/or referral for services. As such, the denominator and numerator do not need to include an identical target population as Measure 3 since the depression screening can take place in a previous reporting period from the receipt of services. (5/6/16)

132. Can we exclude those who have already been referred to depression/mental health treatment services by another provider prior to screening?

A: For those participants who screen positive for depressive symptoms but are already receiving services for depression, the program does not need to provide a referral. If the program does not make a referral, the participant does not need to be counted in this measure. (5/6/16)

133. Will participants continue to be included in the denominator if they refuse a referral to services?

A: Participants should be included in the denominator if they refuse a referral and will remain in the denominator until they receive services at which point they will also be included in the numerator. (5/19/16)

134. If a site is implementing Mothers and Babies, does this count as an evidence-based service? If services were delivered using an evidence-based curriculum in-house, will this count as a completed referral?

A: Yes; referring clients to Mothers and Babies would be considered an in-house referral. (9/27/16)

Completed Developmental Referrals

135. Why does receiving developmental guidance from a home visitor count as a “completed developmental referral”?

A: In order to be counted in the numerator, one of three conditions must be met:

(a) Received individualized developmental support from a home visitor: This is a home visitor-delivered, specific developmental promotion to address the area of concern. This can include more frequent screening, activities by model curriculum, ASQ activities, and CDC materials to target the developmental skill or domain for which there was a concern or positive screen.

(b) Received a referral to early intervention services and received an evaluation or individualized service plan within 45 days of that referral: This refers to index children with developmental and behavioral concerns that meet the criteria for referral to Part B or Part C early intervention services. The criteria for referral to Part B and Part C early intervention services vary by state and locale. Each program will need to learn what the local criteria are for referring index children to Part B and Part C early intervention services and identify index children that meet those criteria.

(c) Received a referral to other community services and received services from that provider within 30 days: This includes any services available that provide developmentally-enhancing support to index children and families that do not fall under the funding/reimbursement system for Part B or Part C early intervention services. Examples include drop-in centers, parent-child groups, early literacy supports, and parent training. This may also include early childhood mental health treatment. (5/6/16)

136. Is this “ever” received services? Or within a certain time frame?

A: Grantees may include participants who received services within the time frames specified for the conditions in the numerator. While the receipt of individualized developmental support from a home visitor does not have a specified time frame, receipt of services following a referral to early intervention services needs to be completed within 45 days and the receipt of services following a referral to other community services needs to be completed within 30 days. (5/6/16)

137. What is the window between a positive screen and a referral in order to be counted?

A: While there is no window between the positive screen and the date of the referral, there is a window between the referral and the completion of services for early intervention and other community services as specified in the definition of the numerator. (5/6/16)

138. For “completed referrals”, is the positive screen required during the reporting period or does it include a positive screen at any time?

A: The positive screening does not have to occur in the same reporting period as the completed referral. (5/6/16)

139. If an index child screens positive for developmental delays but is already enrolled in services, do we have to provide another referral?

A: If an index child screens positive for developmental delays, they must be included in this measure, regardless of if they are already enrolled in services. One of three conditions must be met by the program to be counted in the numerator. If an index child is already enrolled in services, they may still receive a referral for one of the other services specified in the three conditions. For example, if an index child is already receiving early intervention services (condition b), then the program may provide individualized developmental support from the home visitor (condition a). (5/6/16)

140. There are three conditions specified in the numerator. Please clarify if the numerator definition indicates that one of the three components need to be met (a or b or c)? Or that either the first two components need to be met or the third component needs to be met (a and b or c)?

A: Any one of the three conditions can be met in order to count in the numerator: a) received individualized developmental support from a home visitor, or b) were referred to early intervention services and receive an evaluation within 45 days, or c) were referred to other community services who received services within 30 days). (5/6/16)

141. Some grantees are screening at more than just the AAP-recommended time points. Should all positive screenings be included in this measure, or just those from the AAP-recommended intervals?

A: Yes; all positive screenings can be included for this measure, even if they were not within the AAP-recommended intervals as noted in Measure 12. (9/27/16)

142. How should grantees address a child who receives a referral mid-September, but is not assessed for whether the referral was linked until the end of October? Should this child be included in the denominator in both reporting periods?

A: Yes; the child would be included in the denominator for both reporting periods and until a condition of the numerator is met. (9/27/16)

143. Can grantees limit the index children in the denominator to those that were in the program for at least 45 days from the date of the referral?

A: No; grantees must include all participants that meet the eligibility criteria defined by the measure definition. (9/27/16)

Intimate Partner Violence Referrals

144. Does receipt of IPV referral information need to occur within the reporting period in order to be counted?

A: The receipt of IPV referral information will be counted in the numerator in the reporting period in which it occurs. The screening must occur within 6 months of enrollment. There is no specific time frame for when the referral should occur, and it could occur in a different reporting period than the screening. Primary caregivers will be eligible to be included in the denominator once a positive screening occurs and will be included in the denominator of each annual report until the conditions in the numerator have been met. This means that a primary caregiver may be included in more than one annual report. (5/6/16)

145. How is “received referral information” defined for this measure?

A: Received referral information means that the primary caregiver was provided information about IPV community resources by the home visitor. (5/6/16)

146. With regards to the denominator, can we exclude those who have already received a referral or are receiving services prior to home visiting?

A: Programs are expected to screen all primary caregivers for IPV within 6 months of enrollment. If a primary caregiver screens positive for IPV after enrollment, the program is expected to provide referral information regardless of whether or not the primary caregiver previously received a referral for services prior to enrolling in the home visiting program. (5/6/16)