The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program Form 1 and Form 2 Frequently Asked Questions (FAQs) Updated 2024

This FAQ includes commonly asked questions about MIECHV Form 1 and Form 2. This is one of several technical assistance (TA) resources to support MIECHV awardees in adopting and implementing the performance measures. This document has been updated to reflect the most recent changes to MIECHV reporting requirements (see "FY 2024 Annual Performance Reporting Updates" section for more information).

FY 2024 Annual Performance Reporting Updates

In July 2021, OMB approved Form 1 updates that included edits to Table 15 (Home Visits) to disaggregate data by home visiting model. In September 2024, OMB approved renewal of the MIECHV Annual Performance Reports (Form 1 and Form 2, OMB NO. 0906-0017) with no changes.

Copies of updated Forms and updated Form 1 and 2 Toolkits are available on the MIECHV Data & Continuous Quality Improvement (CQI) website. Additional technical assistance resources are available on the MIECHV Awardee Learning Library (MALL) or by contacting your TARC TA Specialist.

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

General

1. **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 participant is pregnant at the time the participant enrolls in the home visiting program, they should be counted as pregnant, even if the participant completes their pregnancy within the same reporting period. If the participant continues enrollment after pregnancy into subsequent reporting periods, then the participant would be counted as a continuing caregiver.
   - If a participant is enrolled as a caregiver and becomes pregnant in the same reporting period with a sibling of the enrolled index child, the participant will continue to be counted as a newly enrolled caregiver since awardees will report their status at the time of enrollment.
   - If a participant is pregnant at the time the participant 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.
   - If a continuing participant is pregnant at the time of the annual update, the participant would be counted as a continuing pregnant participant. (5/6/16, updated 9/20/2024)

2. **What is HRSA's guidance for reporting households?**

   A: For the purposes of reporting to HRSA on performance reporting Forms 1, 2, and 4, a "MIECHV household" is defined as a household served during the reporting period by a trained home visitor implementing services with fidelity to the home visiting model and that is identified as a MIECHV household at enrollment. HRSA has identified two different methods to identify MIECHV households:

   - Home Visitor Personnel Cost Method: Households are designated as MIECHV at enrollment based on the designation of the home visitor they are assigned. Using this methodology, awardees designate all households as MIECHV that are served by home visitors for whom at least 25 percent of their personnel costs (salary/wages including benefits) are paid for with MIECHV funding.
   - Enrollment Slot Method: Households are designated as a MIECHV household based on the slot they are assigned to at enrollment. Using this methodology, awardees identify certain slots as MIECHV-funded and assign households to these slots at enrollment in accordance with the terms of the contractual agreement between the MIECHV awardee and the LIA regardless of the percentage of the slot funded by MIECHV.

   See the Form 1 toolkit available on the MIECHV Data & Continuous Quality Improvement (CQI)

website for additional guidance on household status changes (08/10/2022, updated 9/20/2024)

3. **There are some entries that may change over time (such as education or 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 awardees 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. **Can we use data captured for a continuing household in a prior reporting period for Form 1, rather than report the data as missing if the household completes/discharges from services prior to their annual update?**

   A: Yes, you should report the most recent data available. For households that completed/left services prior to an annual update, this may include data that was collected during the prior reporting period. (9/27/19)

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, newly enrolled participants are participants who sign up to participate in the home visiting program at any time during the reporting period and who were identified as being part of a MIECHV household.

   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 and who were identified as being part of a MIECHV household.

   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 on the MIECHV Data & Continuous Quality Improvement (CQI) website. (08/28/18)

7. **For Form 1, do we only include participants 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)

8. **What is the guidance for reporting on index children?**

   A: You are expected to report all enrollees, including all index children, on Form 1. Refer to model guidance for instructions on identifying index children. (08/28/18, updated 9/20/2024)

9. **How should we report participants who leave and re-enroll within the same reporting period? For example, a participant enrolls in January, leaves the program in March, re-enrolls in September and is still enrolled at the end of the reporting period.**

   A: There should be an unduplicated count of participants in each reporting period. A participant that is discharged and re-enrolls in the same reporting period would count once during that reporting period. In this case, the participant would not be counted as discharged during that reporting period. (10/19/17)

10. **How should we report participants who leave and re-enroll in a subsequent reporting period? For example, a person enrolled in January, left the program in March, and came back a year later.**

    A: Using this example, when the participant first enrolled, that participant would be considered a new enrollee in that fiscal year and discharged in the same year. If the same participant re-enrolled in the next reporting period, that participant would count as a continuing enrollee since the participant is continuing services already initiated. (10/19/17)

11. **Some participants may fall under different funding streams throughout the reporting year (i.e., enrolled under MIECHV funding at start of the fiscal year, then switched to non-MIECHV funding in the middle of the fiscal year). How does this affect Form 1 and Form 2 reporting?**

    A: Form 1 should include any participant/index children/household that had at least one home visit during the reporting year as a MIECHV household. For Form 2, HRSA recommends using the approach of, "once a MIECHV household, always a MIECHV household". To the extent possible, you should attempt to collect and report Form 2 data on households throughout their tenure in the program. Appendix A of the Form 1 Toolkit and Appendix D of the Form 2 Toolkit available on the MIECHV Data & Continuous Quality Improvement (CQI) website provide additional guidance on how to handle household status changes. (9/20/2024)

12. **What if the primary caregiver of the index child changes within a reporting period? Or if the primary caregiver changes from one reporting period to the next?**

    A: In general, you should develop policies to document how changes in primary caregivers are handled. You should consider the capabilities of your data collection and/or reporting system(s) and the impacts on Form 1 and Form 2. Consider documenting the policy in your Performance Measurement Plan (PMP). (9/20/2024)

13. **If we choose to switch from one validated tool to another validated tool, how will this impact the participant count for the numerator and denominator?**

    A: Switching validated tools should not impact participant counts for screening or referral measures. Use information provided in the Form 1 Toolkit (available on the MIECHV Data & Continuous Quality Improvement (CQI) website) to identify and include participants appropriately. When switching tools, consider how timing of the transition will impact Form 2 reporting and ensure the PMP is updated to account for the new tool. (10/19/17, updated 9/20/2024)

14. **Are participants required to sign informed consent for data collection and reporting in order to receive MIECHV services?**

    A: There is no program requirement that providing informed consent for collection and reporting is required in order to receive MIECHV services. However, before any MIECHV data can be collected, households must provide informed consent to share their data. You should make a good faith effort to attain informed consent for every participant. (08/10/2022)

15. **Are we required to include an unknown option in our data collection systems?**

    A: You should ensure that there are procedures in place to account for and report cases where demographic information is unknown or not collected. If there are cases where information is unknown, then that count should be reported under the respective Unknown/Did Not Report column. (08/10/2022)

16. **Are there changes to reporting given the requirement to have at least one in-person visit per year with households that received virtual visits?**

    A: There are no changes in reporting. To meet the requirement of every household receiving at least one in-person visit per year, you may wish to track the first in-person visit each household receives during a given 12-month enrollment period. This visit will count toward the aggregate number of in-person visits that you report Form 1. You are not required to report household-level in-person visit data to HRSA. (9/20/2024)

17. **Where would participants and households enrolled in universal intake and referral services be reported?**

    A: Universal intake and referral services are not considered targeted, intensive home visiting. Universal intake and referral services should only be budgeted as an infrastructure cost, not MIECHV service delivery. Participants and households served under universal intake and referral services should only appear in Table 3 of Form 1 (Unduplicated Count of Participants and Households Served by State Home Visiting Programs (non-MIECHV)) and should not be reported elsewhere on Form 1 or Form 2 as they do not qualify as a "MIECHV household" for reporting purposes. (9/20/2024)

18. **Will awardees be required to submit separate annual performance reports (Forms 1 and 2) for**

MIECHV participants supported through matching funds?

A: No, data across all active grants (X10 base and matching funds) must be consolidated into one Annual Performance Report submission, due in October of each year. Families served using federal matching funds must be included in your Annual Performance Report (Forms 1 and 2). Annual performance reporting for matching funds should be consolidated with annual performance reporting for MIECHV base funds for the corresponding fiscal year. (9/20/2024)

19. **For awardees using the home visitor personnel cost method, how should households be reported for cases where home visitors are supported through both base and matching funds?**

A: Under the home visitor personnel cost method, families are designated as MIECHV families at enrollment based on the designation of the home visitor they are assigned. Under this methodology, recipients designate all families as MIECHV families that are served by home visitors for whom at least 25% of their personnel cost (salary/wages including benefits) are paid for with MIECHV funding. "MIECHV funding" includes both federal base and matching funds, meaning all families for a home visitor for whom at least 25% of their FTE is MIECHV funding, regardless of whether that is base funds, matching funds, or a combination of both, would qualify as a MIECHV family. (9/20/2024)

20. **How does a household status change if the funding source changes from base to matching funds for reporting purposes?**

A: A household is considered as a "MIECHV household" (a family served during the reporting period by a trained home visitor implementing services with fidelity to the model and that is identified as a MIECHV household at enrollment) regardless of whether the funding source is from federal base or matching funds. Please refer to Appendix A of the Form 1 Toolkit or Appendix D of the Form 2 Toolkit (available on the MIECHV Data & Continuous Quality Improvement (CQI) website) for additional guidance around household status changes. (9/20/2024)

Participant Demographics

21. **How should we report one index child with two caregivers living in different homes for Table 1 (Unduplicated Count of New and Continuing Program Participants Served by MIECHV) and Table 2 (Unduplicated Count of Households Served by MIECHV)?**

A: For the total number of participants reported in Form 1 Table 1, all caregivers enrolled in the program per model guidelines should be reported. For the total number of households reported in Form 1 Table 2, use the definition of a household provided by HRSA, which is based on the adult caregiver, not the index child, so each separate caregiver who maintains their own household as distinct from the other caregiver's household should be reported. This would remain true for divorced parents both enrolled in the program and receiving home visiting services with one index child receiving services. The number of households must be equal to or

less than the number of participants, so for the above example, you should report two adult participants, one index child, and two households. (10/19/17)

22. **How do we report a participant who is pregnant and non-binary in Table 1 (Unduplicated Count of New and Continuing Program Participants Served by MIECHV)?**

    A: A participant who meets the definition for pregnant participant should be included in that category. Once they are no longer considered a pregnant participant, they can be included in the appropriate caregiver category by gender. The category "pregnant women" was changed to "pregnant participant" to be inclusive of all genders and non-binary pregnant participants. (08/10/2022)

23. **For Table 1 (Unduplicated Count of New and Continuing Program Participants Served by MIECHV), "Unknown/Did Not Report Gender" category, would this include cases where the home visitor did not know the participant gender as well as situations where the household chose not to disclose their gender?**

    A: Yes, you should use the "Unknown/Did Not Report Gender" categories any time the gender of the participant is not known, including if the participant chose not to disclose gender. (08/10/2022)

24. **For Table 1 (Unduplicated Count of New and Continuing Program Participants Served by MIECHV): How should transgender participants be reported?**

    A: Information on gender should reflect participant gender identity following the gender category definitions available in Form 1 Key Terms. For example, if a transgender caregiver identifies as female then she should be reported under the "Female-Caregiver" category. The reporting categories currently do not further disaggregate by gender identity in relation to sex assigned at birth. You may use the comments section in Table 1 to capture and report additional information related to participants' gender identity. (08/10/2022, updated 9/20/2024)

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

    A: Yes. (5/6/16)

26. **For Table 3 (Unduplicated Count of Participants and Households Served by State Home Visiting Programs non-MIECHV): 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 MIECHV. MIECHV awardees 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 MIECHV. (5/6/16)

27. **For Table 3 (Unduplicated Count of Participants and Households Served by State Home Visiting Programs non-MIECHV): 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)

28. **For Table 3 (Unduplicated Count of Participants and Households Served by State Home Visiting Programs non-MIECHV): 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 programs who are not designated as a MIECHV household following HRSA guidance, but who are 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. (5/19/16)

29. **For Table 3 (Unduplicated Count of Participants and Households Served by State Home Visiting Programs non-MIECHV): should we include only cases that remained open at the end of the reporting period, or do we 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)

30. **For Table 3 (Unduplicated Count of Participants and Households Served by State Home Visiting Programs non-MIECHV): Pregnant participants and 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, you should use HRSA definitions for participant type to report in Table 3. In cases where definitions vary across MIECHV and non-MIECHV funded programs, you should use your best judgment to categorize participants and explain any variation in reporting definitions in the "Notes" section of Form 1. (9/27/16)

31. **For Table 7 (Participants by Race): Some data collection systems may collect an additional "Other Race" category, which is not included as race category option in Form 1 Table 7. How should we report individuals who select the "Other Race" category?**

    A: Participants who do not identify with any the reporting categories available in Form 1 should be reported in the Unknown/Did Not Report Category. You may use the comments section

to capture and report additional information on race reporting. (08/10/2022)

32. **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)

33. **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: A participant should only be included in one category in each reporting year. However, the category in which a participant is counted may change over the course of their participation in home visiting. You should report on the most recent data collected (i.e., at enrollment or the annual update). A participant should be categorized according to the highest level of educational attainment at the time of data collection (5/19/16, updated 9/20/2024)

34. **For Table 11 (Adults Participants by Housing Status): Can you clarify the definitions for each category?**

    A: Table 11 is a tiered table. You must first determine whether each adult participant is homeless, according to the definition provided in the Key Terms for Form 1. You must then assess the current housing status of each adult participant. Definitions for all the categories are provided in the Key Terms. You should categorize participants according to the category that most closely matches the participant's housing status. (5/6/16)

35. **For Table 11 (Adults Participants by Housing Status): How should clients who rent or own homes in a trailer park be categorized?**

    A: First, determine if the participant would be categorized as homeless or not homeless. Subtitle VII-B of the McKinney-Vento Homeless Assistance Act designates individuals as homeless if they are living in a trailer park due to a lack of a fixed, regular, and adequate nighttime residence, including if they are "living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations" (See the full definition here: https://nche.ed.gov/mckinney-vento-definition/). Once a participant is identified as either homeless or not homeless, identify which subcategory best represents their housing situation, based on the definitions for each housing category in the Form 1 Toolkit available on the MIECHV Data & Continuous Quality Improvement (CQI) website. (9/27/16, updated 9/20/2024)

36. **The Form 1 Toolkit suggests a link between Table 13 (Household Income in Relation to Federal Poverty Guidelines) and Table 14 (Priority Population Characteristics for Each Household). It indicates that priority population of "Low-income households" on Table 14 should equal those under 100% Federal Poverty Level (FPL) on Table 13. Is there a MIECHV requirement for households' incomes to be 100% FPL?**

A: There is no MIECHV eligibility requirement on household income. For the purposes of MIECHV reporting on priority populations (Table 14), "low income" is defined an individual or household with an income determined to be below the poverty guidelines updated periodically in the Federal Register by HHS in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981 [Title V, Sec. 501(b)(2)]. To further operationalize this definition in Table 14, MIECHV sets the FPL threshold to be 100% or below. Thus, as stated in the Form 1 Toolkit (available on the MIECHV Data & Continuous Quality Improvement (CQI) website), the combined number of households reported in the first two categories of Table 13 (50% and under, 51-100%) should be the same number as those reported as being a low-income household in Table 14. HRSA acknowledges the data sources may differ for Tables 13 and 14. If the two categories do not align, consider adding a comment the Form 1 Report to explain the differences that may occur. (9/20/2024)

37. **For Table 13 (Household Income in Relation to Federal Poverty Guidelines): How should the number of household members be determined?**

A: All Form 1 data should be collected at the time of enrollment and updated annually thereafter. Home visitors should work directly with households to identify who they consider as contributing to the household's income and include those people's income. You should develop programmatic guidance to support home visitors in identifying household income. Such guidance may be informed by model guidelines, and/or may be developed in alignment with other policies in your state/jurisdiction (such as Medicaid, WIC). Such guidance should be consistently applied across reporting periods. (9/20/2024)

38. **For Table 14 (Priority Population Characteristics for Each Household): How do we account for duplication if households meet multiple priority populations?**

A: HRSA recognizes that the priority population categories are not mutually exclusive, meaning that households can be included in multiple priority population categories. However, every household should be counted in each priority population category, either yes, no, or unknown/did not report. (5/6/16, updated 9/20/2024)

39. **For Table 14 (Priority Population Characteristics for Each Household): Should we to report individual or household income?**

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

40. **For Table 14 (Priority Population Characteristics for Each Household): Will the reported information be limited to only newly enrolled households?**

A: No, all households should be included in Table 14. Households should be assessed at program enrollment and annually thereafter. (5/6/16, updated 9/20/2024)

41. **For Table 14 (Priority Population Characteristics for Each Household): How is "history of**

substance abuse" determined?

A: As this data is self-reported, you should develop guidance on how to collect these data, including developing definitions for substance abuse. (9/20/2024)

42. **For Table (Home Visits): How will in-person visits not in the home be captured?**

A: As included in the Definitions for Form 1: a home visit "refers to the definition of a completed home visit enacted by the various evidence-based models approved for implementation through the MIECHV Program or a Promising Approach. Please refer to model-specific guidance for specific definitions. Virtual Home Visit means a home visit, as described in an applicable service delivery model, that is conducted solely by use of electronic information and telecommunications technologies. Please refer to model-specific guidance for specific definitions. (8/10/22)

43. **For Table 16 (Family Engagement by Household): Which households would be included under the category "enrolled but not currently receiving services/Other"?**

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

44. **For Table 16 (Family Engagement by Household): Do we need to use all reporting categories? For example, if a case is required to be kept open by the model, can an awardee report a household as "currently receiving services" rather than "enrolled but not currently receiving services"?**

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

45. **For Table 17 (Unduplicated Count of Households by Evidence-Based Home Visiting Model or Promising Approach): How is HRSA defining a "program that qualifies as a promising approach"? Will this be restricted to only non-evidence-based models that have already been submitted to HomVEE for review? Is it any non-evidence-based 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." Table 17 only includes evidence-based home visiting models or promising approaches. (5/6/16, updated 9/20/2024)

Insurance and Clinical Indicators

46. **For Table 18 (Participants by Type of Health Insurance Coverage): Our Medicaid allows for retroactive insurance coverage. How should we take this into account for Table 18?**

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

47. **For Table 19 (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: You should report the *usual* source of care for the index child at enrollment and annually thereafter. This table is not intended to document all sources of medical care during the reporting, just the usual source as reported at enrollment or the annual update. (5/6/16, updated 9/20/2024)

48. **For Table 19 (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 illness and does not necessarily describe a particular setting of care. Urgent care may be provided in many of the categories outlined in Table 19. You should attempt to determine which category provided in Table 19 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)

49. **For Table 20 (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: Only index children greater than or equal to 12 months of age should be included in this table. (08/28/18)

50. **For Table 20 (Index Children by Usual Source of Dental Care): Can awardees use the pediatrician as the dental home, or should these children 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)

51. **For Table 20 (Index Children by Usual Source of Dental Care): If a household 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)

FORM 2: Performance Indicators and Systems Outcomes

General

52. **If a household is enrolled in services but has been disengaged for the entire reporting period (no home visit is completed in the reporting period), should that household be 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 could complete the referral in a subsequent reporting period and may be included, even if a home visit was not completed during the subsequent reporting period. (9/27/16) (Updated 7/7/20)

53. **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. If missing data is included in the numerator or denominator it can affect the accuracy of the data and could misrepresent program performance. You should consult with TA Specialists on how to account for missing data. If data are considered missing, they should not be included in the numerator or denominator unless exceptions are made in the missing data guidance. See the guidance document pertaining to when data are considered missing on a measure-by measure basis available at the MIECHV Data & Continuous Quality Improvement (CQI) website. (5/6/16, updated 9/20/2024)

54. **For well-child visits, if a home visit does not take place after well-child data should be collected, awardees are instructed to use the previous expected well-child visit data point rather than have missing data. What other measures does this apply to?**

    A: This does not apply to other measures. See the guidance on identifying missing data for more information about when data are considered missing on a measure-by-measure basis on the MIECHV Data & Continuous Quality Improvement (CQI) website. (10/19/17, updated 9/20/2024)

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

    A: For the purposes of reporting to HRSA on performance reporting Forms 1, 2, and 4, a "MIECHV household" is defined as a household served during the reporting period by a trained home visitor implementing services with fidelity to the model and that is identified as a MIECHV household at enrollment. HRSA has identified two different methods to identify MIECHV households:

- Home Visitor Personnel Cost Method: Households are designated as MIECHV at enrollment based on the designation of the home visitor they are assigned. Using this methodology, recipients designate all households as MIECHV that are served by home visitors for whom at least 25 percent of their personnel costs (salary/wages including benefits) are paid for with MIECHV funding.
- Enrollment Slot Method: Households are designated as MIECHV households based on the slot they are assigned at enrollment. Using this methodology, recipients identify certain slots as MIECHV-funded and assign households to these slots at enrollment in accordance with the terms of the contractual agreement between the MIECHV awardee and the LIA regardless of the percentage of the slot funded by MIECHV. (5/16/16, Updated 9/20/2024)

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

A: Awardees should collect and report on all MIECHV required data for each relevant participant and household. Review the model developer crosswalk on the MIECHV Data & Continuous Quality Improvement (CQI) website for more information. If you have additional questions, HRSA recommends reaching out to model representatives to determine how their required data collection aligns with MIECHV and develop supplemental data collection protocols as needed. (5/6/16, updated 9/20/2024)

57. **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 tool 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.

You should follow the administration and training protocols of the tool you select to ensure it is being used appropriately. Some measurement tools have specific training requirements that need to be met before staff can administer the tool. You 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)

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

A: HRSA does not endorse specific tools but requires that awardees use validated tools to assess caregiver-child interaction and to screen households for postpartum depression, intimate partner violence, and child developmental delays. Validated screening tools are also required for Optional Measure 1: Substance Use Screening. You have the discretion to select validated tools that are appropriate and in accordance with model guidelines. Your Performance

Measurement Plan (PMP) should include the tools used for each measure. To support awardees in identifying validated tools, examples of validated tools are included in the Form 2 toolkit available on the MIECHV Data & Continuous Quality Improvement (CQI) website. These examples do not constitute an endorsement of the instrument by the authors, the publishers, or HHS. (5/6/16, Updated 9/20/2024)

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

A: All Form 2 measures should use self-report 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 you would prefer to use data from another reliable source, like birth certificate data. (5/6/16)

60. **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, you *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 you to monitor which home visits will fall closest to the end of the reporting period for each household to ensure data collection is complete for each household.

For some measures, the timing of data collection is specified in the numerator and denominator definition of the measure. You should follow the criteria specified in these measures. Additional information may be found in the Form 2 Toolkit available on the MIECHV Data & Continuous Quality Improvement (CQI) website. (5/6/16)

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

A: You will need to collect all data elements 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 you 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, (3) date of referral and (4) date of enrollment (to determine if the caregiver has been enrolled for 3 months). For additional support in identifying the needed data elements, please see the Form 2 Toolkit available on the MIECHV Data & Continuous Quality Improvement (CQI) website or check with your TA specialist. (5/6/16, updated 9/20/2024)

62. **If we have a household with two primary caregivers, should we include one or both primary caregivers?**

A: For Form 2 reporting, only one primary caregiver should be reported per household. For home visiting models that allow programs to enroll more than one adult participant, only one adult

participant per household 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, updated 9/20/2024)

63. **If all index children are assessed in Form 2, does that mean all primary caregivers are also assessed in Form 2?**

A: Only one primary caregiver should be assessed for Form 2, even if multiple primary caregivers are enrolled per model guidance. (10/19/17)

64. **What is the guidance for reporting on index children?**

A: You must report all index children enrolled in the program, including subsequent pregnancies after enrollment, on Form 2. You should indicate in your Performance Measurement Plans how you will report index children on Form 2. (10/19/17)

65. **If a caregiver is pregnant at enrollment, but also has a child who is the designated target child, is the enrollee counted as a female caregiver or a pregnant participant?**

A: The participant would be counted as pregnant. The definition of a pregnant enrollee does not specify that the pregnancy will result in the child being enrolled. (10/19/17)

66. **Does the denominator only include children or households 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 would not be included in the denominator. Note that a participant can be considered enrolled and receiving services without having a home visit. For example, a primary caregiver who received a referral for depression services in a prior reporting period could complete the referral in a subsequent reporting period and may be included, even if a home visit was not completed during the subsequent reporting period. (5/6/16) (Updated 7/7/20)

67. **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 awardees?**

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)

68. **Are households 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 household, whereas households are assessed in multiple reporting periods for other measures, depending on the measure criteria. See the Form 2 Toolkit available on the MIECHV Data & Continuous Quality Improvement (CQI) website for more information. (5/6/16)

69. **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 disenrolled 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 that the household will not return to services). (5/6/16) (updated 9/27/16)

70. **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 awardees who receive funding under the Tribal Home Visiting Program, administered by ACF. (5/6/16)

71. **For screening measures, how to we count individuals who don't consent to screening?**

A: If a participant does not consent to screening, include them in the denominator as appropriate, based on inclusion criteria, but not in the numerator. If possible, please include the number of these cases in the comments. (9/20/2024)

Measure 1: Preterm Birth

72. **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)

73. **Will this measure include primary caregivers 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). You 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, you 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)

74. **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) [1]. (5/6/16) (updated 5/19/16)

75. **If a pregnant participant enrolled at 36 weeks and gives birth within the 36th week, would the participant still be considered in the numerator and denominator?**

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

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

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

77. **Are there any exceptions or exclusions for preterm birth with regards to those 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. Consider adding additional details in the comments about multiples. (5/6/16) (updated 9/20/2024)

Measure 2: Breastfeeding

78. **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)

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

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

A: No; the infant must be receiving breastmilk in any amount at 6 months of age to be included in the numerator for this measure. (5/6/16, updated 9/20/2024)

80. **Does feeding a child pumped breastmilk count as breastfeeding?**

A: Yes. The goal is to increase the proportion of infants breastfed at 6 months, regardless of whether the breastmilk is fed directly to the infant or from a bottle. The definition of breastfeeding does include the feeding of pumped or expressed breast milk. These are acceptable methods for inclusion in this measure, assuming all other criteria are met. (10/19/17, updated 9/20/2024)

81. **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, the birth parent 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)

82. **Is it possible to exclude from the denominator infants who are not living with their biological mother and thus cannot be breastfed?**

A: If the mother who enrolled prenatally remains enrolled in the program as the primary caregiver, even if the infant is not residing with the mother, they would be included in the denominator. If the prenatally enrolled mother exits the program, and a new caregiver is enrolled as the primary caregiver, they were not enrolled prenatally and therefore would be excluded from the measure. (9/20/2024)

83. **How do we address birth parents who could not continue breastfeeding at 6 months postpartum due to medical complications or difficulties?**

A: Birth parents who are not recommended to breastfeed due to certain medical conditions should be excluded from this measure. Medical exclusion criteria can be found at Contraindications to Breastfeeding | Breastfeeding special circumstances | CDC. (5/6/16)

84. **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. Households that meet this criterion during the reporting period should be included in this measure. You should outline how to account for the six-month data collection timeframe in your PMP. (5/6/16, updated 9/20/2024)

85. **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 whose birth parents were enrolled prenatally and were enrolled for at least 6 months. Infants should not be reported in multiple reporting periods. (5/6/16) (Updated 10/19/17)

Measure 3: Depression Screening

86. **What if we are currently only screening pregnant (or postpartum) participants? Do we need to expand our data collection to include all primary caregivers?**

A: Yes; you must screen all primary caregivers for depression. For programs that currently screen a narrower target population (e.g., participants who are pregnant or postpartum), 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 household. (5/6/16)

87. **Do we need to screen primary caregivers who are already receiving treatment for depression?**

A: Yes; you must screen all primary caregivers for depression regardless of whether they are receiving mental health services when they enroll in home visiting. (NOTE: This does not impact the previous decision that primary caregivers who are already receiving recommended services for depression do not need to be referred again after a positive screen for depression after enrollment in home visiting services). (10/19/17)

88. **Is there any flexibility to screen a pregnant participant 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, participants 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)

Measure 4: Well-Child Visits

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

A: Data regarding well-child visits may be collected after each scheduled well-child visit or retrospectively at the end of the reporting period. This will require you to monitor which home visit will fall closest to the end of the reporting period for each household to ensure data

collection is complete. (5/6/16)

90. **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, you should use the American Academy of Pediatrics (AAP)-informed intervals which are based on the AAP schedule (https://downloads.aap.org/AAP/PDF/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. This measure should only count those well-child visits that took place after enrollment in home visiting. (5/6/16) (Updated 10/19/17)

91. **What if a child was up to date on well-child visits as of their last home visit, but the household dropped out? Does it count if the child was 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 that child had his/her 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)

92. **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. You should use the following intervals, which are based on the AAP schedule (https://downloads.aap.org/AAP/PDF/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 years. 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)

93. **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)

94. **If a child has a well-child visit that occurs outside of the AAP-informed intervals cited in the FAQs be included in the numerator when the visit is conducted according to AAP guidelines for the purpose of "catching up" on a missed visit?**

A: No, this measure is intended to capture whether the child received their last recommended visit based on the AAP schedule. (9/27/19)

95. **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 awardee has for the child is their 4-month visit, how should the awardee report this?**

A: In this situation, you would report the well-child information as missing. You should report 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)

96. **What if the home visit occurred after an expected well-child visit, but the home visitor did not collect the data? Should the participant be excluded from the denominator (treated as missing data)? Or should the program use an earlier data point?**

A: If the home visit occurred, but the home visitor did not collect the data, then the data would be considered missing as they had the opportunity to collect it and did not. (10/19/17)

97. **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 during the reporting period should be included in the denominator. (5/6/16) (updated 9/20/2024)

98. **For the AAP schedule, should we follow the new AAP schedule released in July 2022?**

A: The updates to Bright Futures guidelines released in July 2022 do not include changes to the well-child visit schedule. A summary of the changes can be found here: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf (08/10/2022)

Measure 5: Postpartum Care

99. **How is a postpartum care visit defined and do these visits have to occur with specific types of health care providers?**

A: A postpartum visit is a visit between the participant and their health care provider to assess the birth parent's current physical health, including the status of pregnancy-related conditions such

as gestational diabetes, to screen for postpartum depression, to provide counseling on infant care and family planning, and to provide screening and referrals for the management of chronic conditions. Additionally, a provider may use this opportunity to conduct a breast exam and discuss breastfeeding. While there is no restriction on the types of health care providers that are seen in a postpartum visit, the purpose of the visit has to be for one of the reasons outlined above. (10/19/17)

100. **Do virtual telehealth visits count as a postpartum visit?**

A: Yes, virtual telehealth visits can be included as postpartum visits, as long as the visit fits the definition of a postpartum visit (e.g. a visit with a healthcare provider to discuss current physical health, including the status of pregnancy-related conditions like gestational diabetes, screen for postpartum depression, provide counseling on infant care and family planning as well as screening and referrals for the management of chronic conditions). (9/20/2024)

101. **If a participant meets the eligibility criteria for this measure but has their postpartum visit prior to enrollment, will the participant be included in the denominator?**

A: Participants 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)

Measure 6: Tobacco Cessation Referrals

102. **What does "at enrollment" mean when a household 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)

103. **The performance measure definition refers to "primary caregivers." We currently only screen pregnant (or postpartum) participants for tobacco use. Do we need to expand data collection to include all primary caregivers?**

A: You should report tobacco or cigarette use for the primary caregiver only (only one primary caregiver per household). If you currently limit data collection to a sub-population of primary caregivers, then data collection should be expanded so that primary caregivers are assessed for this measure. (5/6/16)

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

A: This measure is assessed once per eligible family, using data collected at intake and at 3 months following enrollment. (5/6/16, updated 9/20/2024)

105. **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)

106. **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)

107. **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 completed during program services. If a primary caregiver reports tobacco use at the time of enrollment, that caregiver should be counted in the denominator once s/he has 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. However, if the primary caregiver is already receiving tobacco cessation services at the time of program enrollment, that caregiver should be excluded from both the numerator and denominator. (5/6/16) (updated 10/19/17)

108. **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). You 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)

Measure 7: Safe Sleep

109. **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)

110. **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)

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

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)

112. **How should we report on safe sleep when an infant turns over to their stomach or stands up when put to bed?**

A: To be counted in this measure, the primary caregiver must report that the infant is always placed to sleep on their back, without bed sharing or soft bedding. For older infants, if a caregiver puts the infant to sleep on their back and the infant rolls over or stands up on their own, this is developmentally appropriate and would still constitute a safe sleep practice. (9/27/19)

113. **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) they always place the index child to sleep on their back and 2) if they always place 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. Note, this measure applies to when the caregiver intentionally places the infant to sleep, not times where the child incidentally falls asleep. For example, unplanned incidences where the child falls asleep while traveling secured in a stroller or car seat should not be considered by the caregiver when answering this question. (5/6/16, updated 9/20/2024)

114. **Does swaddling count as soft bedding?**

A: If swaddling is performed according to AAP guidelines, it does not count as soft bedding. Note that for measure inclusion, swaddled infants must still be placed on their back, without bedsharing or soft bedding. More information about AAP guidelines on swaddling can be found at: https://publications.aap.org/pediatrics/article/150/1/e2022057991/188305/Evidence-Base-for-2022-Updated-Recommendations-for. (08/10/2022, updated 9/20/2024)

115. **Do children who are still in the hospital following delivery count as missing or excluded for this measure?**

A: In this case, the program may not have enough information to determine if they should be included in the numerator and would therefore be counted as missing. (9/20/2024)

Measure 8: Child Injury

116. **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 the participant was 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)

117. **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)

118. **Some hospitals have urgent care departments where they refer individuals before triaging to emergency department if necessary. Should awardees 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)

Measure 9: Child Maltreatment

119. **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)

120. **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 the cases were opened; they will not be reported in subsequent years, regardless of the status of the case. (5/6/16)

121. **If an investigated case of child maltreatment occurs after the household exited home visiting services but before the end of the reporting period, should it be included in this measure?**

A: No, this measure captures investigated cases of child maltreatment that occurred while the child was enrolled in home visiting. (7/7/20)

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

A: Yes; the denominator should include children or households 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)

123. **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. If no consent to share data with child welfare systems has been obtained, those index children should be counted as missing, and not included in the numerator or denominator. Note that this differs for screening measures (Measure 3, 10, 12, 14), where if a participant does not consent to screening they are included in the denominator, based on inclusion criteria, but not in the numerator. (5/6/16, updated 9/20/2024)

124. **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 households who are enrolled during the reporting period. (5/6/16)

125. **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)

126. **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: HRSA recognizes that this is a multi-step process: a referral for suspected maltreatment is made, that referral is either screened in or out, an investigation is conducted on screened-in reports, and finally a disposition is made. HRSA realizes you may 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 and further received an investigation. (A screened-in report is one that is accepted for investigation based on your screen-in criteria.) If you use the term "assessment" interchangeably with the term "investigation", then those cases would be applicable for the purposes of this measure. However, some states and localities operate alternative response systems whereby some screened-in reports are assessed for services as an alternative path to receiving a full investigation. Within these systems the term "assessment" is often used to distinguish from a formal investigation. In these instances, only screened-in reports that receive a formal investigation should be reported for this measure. The alternative response assessments would not be counted. (5/19/16) (Updated 10/19/17)

127. **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)

Measure 10: Parent-Child Interaction

128. **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: You have discretion to select your own caregiver-child interaction observation tool as long as you use a validated tool, adhere to the training and administration requirements of the tool, and continue to adhere to model guidelines. You should report on all primary caregivers with index children that are within the validated target age range(s) of the tool(s) that are being used. All primary caregivers with children within the target age range of the tool should be reported and reassessed annually. (5/6/16) (10/19/17) (Updated 11/22/17)

129. **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; you do not need to use the same observational tool and target age range across all LIAs. You 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)

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

A: Yes, the denominator includes each primary caregiver enrolled in the program (not each parent-child dyad). There may only be one primary caregiver per household, regardless of the number of caregivers enrolled. (5/6/16) (Updated 11/22/17)

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

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

132. **Can awardees 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)

133. **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; you should make the determination about when the tool is implemented within the defined target age range and the validated ages for the instrument. You should administer the tool when the child reaches the target age. The target age is determined by the awardee and must be consistent with the tool administration protocol. (9/27/16)

134. **What is the unit of measurement for this measure?**

A: The unit of measurement for Performance Measure 10 is a primary caregiver with an index child(ren) within the target age range of the validated tool selected. (08/28/18)

135. **Is the Healthy Families Parenting Inventory (HFPI) an approved parent-child interaction observation tool for Measure 10?**

A: No, Healthy Families Parenting Inventory is not an approved tool for observing caregiver-child interaction. (08/28/18)

Measure 11: Early Language and Literacy

136. **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)

137. **When and how often should these data be collected?**

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

138. **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)

139. **If households are enrolled through two reporting periods, will they be counted multiple times?**

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

140. **In many families, a combination of individuals (e.g., parent, grandparent) 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)

Measure 12: Developmental Screening

141. **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)

142. **Do we need to screen index children who have previously screened positive or been identified as having developmental delays?**

A: You should screen index children for developmental delays at each AAP-recommended age interval. However, a child who screened positive for developmental delays during a screening

conducted in a previous reporting period or during a screening conducted prior to enrolling in home visiting, may be excluded from additional screenings. These children are excluded from the denominator and are not counted as missing. Children that were not screened within the AAP-recommended age intervals and have not been previously identified as having a developmental delay are included in the denominator but not the numerator. (NOTE: This does not impact the previous determination that children screening positive for developmental delays who are already receiving services must be referred to appropriate services as outlined in the numerator of the developmental screening referral measure) (10/19/17)

143. **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. You may choose to screen at additional ages but are expected to report on screenings at these specified ages. For households whose index children are being assessed at multiple ages within a reporting period, you 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)

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

A: You 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. You should ensure index children are screened at the AAP-recommended ages within the administration window of the selected tool. For example, a tool may allow the 9-month screener to be administered between the window of 8 months 0 days and 9 months 30 days. In this instance, screening a child between 8 months, 0 days and 9 months, 30 days of age is acceptable and can count in the numerator for this measure. (5/6/16, updated 9/20/2024)

145. **Can the 10-month ASQ be used for Measure 12?**

A: The 10-month ASQ, which is validated to be used between 9 months, 0 days and 10 months, 30 days of age, can count towards Measure 12 if used between 9 months, 0 days and 9 months 30 days of age. (9/20/2024)

146. **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: You may choose to screen at additional ages but you are expected to report on screenings at the AAP-recommended ages. If you 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)

147. **How should awardees 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)

148. **How should awardees 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: You should follow the implementation instructions for the screening tool you have chosen to administer. Many developmental screening tools provide guidance on adjusting for premature birth. (9/27/16)

149. **Can ASQ:SE-2 be used as a standalone screener for Measure 12?**

A: No, ASQ: SE 2 cannot be used as a standalone screener (08/10/2022)

Measure 13: Behavioral Concerns Inquiries

150. **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)

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

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)

152. **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)

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

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

Measure 14: Intimate Partner Violence Screening

154. **Is the screening required once per reporting period, or once during the household'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)

155. **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 current relationship status. The CDC definition of IPV includes any current and former partners (About Intimate Partner Violence | Intimate Partner Violence Prevention | CDC). (5/6/16, updated 9/20/2024)

156. **When the primary caregiver is male, but the IPV screener has been validated for women only, does HRSA expect that awardees find a way to screen men if the tools they want to choose are not valid for men? Or does HRSA expect awardees to limit selection of tools only to those that apply to both men and women?**

A: You are expected to use validated tools. Therefore, you should have validated tools available to measure IPV among the primary caregivers enrolled in the program, regardless of their gender. (10/19/17)

157. **Is there any guidance on if a person with a developmental delay can complete the IPV screen?**

A: We recommend consulting the tool developer regarding appropriateness/relevancy to conduct the IPV screening in this scenario. (9/20/2024)

Measure 15: Primary Caregiver Education

158. **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)

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

A: You 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)

160. **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)

161. **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)

162. **How do we address a caregiver who obtained their degree in a previous reporting period (2016-17), but was not captured until the following reporting period (17-2018)? 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 17-2018 reporting period rather than in the 2016-17 reporting period when the degree was obtained. (5/19/16)

163. **How long should a caregiver be retained in the denominator? A caregiver can be included in the denominator for several years, but once s/he is included in the numerator (for any of the three criteria provided), does s/he go back into the denominator the following year until the**

completion criterion is met?

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 s/he is 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 at least one of the conditions in the numerator has been met. Once one or more conditions in the numerator is met, the primary caregiver will not be assessed in subsequent reporting periods and will not be included in the denominator. (10/19/17)

164. **If a primary caregiver does not have a high school degree or equivalent at enrollment and enrolls in high school after enrollment into home visiting, but then drops out (within the same reporting period), do they count in the numerator as having enrolled in high school?**

A: Yes; since the primary caregiver met one of the conditions in the numerator during the reporting period (i.e., enrolled in high school), then s/he will be counted in the numerator, even though s/he subsequently dropped out of high school in the same reporting period. (10/19/17)

165. **Can households enrolled in English as a Second Language (ESL) classes count toward the numerator?**

A: Enrollment in ESL classes would not count as enrollment in middle school, high school, or equivalents when not taken as degree-seeking classes and/or if taken outside of the high school curriculum. (9/20/2024)

166. **How should awardees 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 be included in the denominator for this measure because s/he did not have a high school degree at enrollment. This participant will also be included in the numerator as s/he is enrolled in school on a trajectory to earn a high school diploma. (9/27/16) (Updated 10/19/17)

Measure 16: Continuity of Insurance Coverage

167. **How is HRSA recommending states measure continuous enrollment?**

A: Continuous enrollment in health insurance for 6 consecutive months (on or after 6 months post enrollment) 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. The latter

approach allows for programs to support households in obtaining eligible coverage earlier during their enrollment in the program. (5/6/16)

168. **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 does not need to be within the same reporting period and can overlap with another reporting period. (08/28/18)

169. **Should households continue to be included in the numerator and/or denominator in subsequent reporting periods?**

A: Participants should continue to be reported in any subsequent reporting period for which they meet the inclusion criteria for that specific measure. This may vary across measures. Refer to the Form 2 Toolkit (available on the MIECHV Data & Continuous Quality Improvement (CQI) website) for more details on when to include participants in a measure in subsequent reporting periods. (10/19/17)

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

A: Any primary caregiver that is enrolled for at least 6 consecutive months, regardless of the length of time enrolled during the reporting period, should be included in the denominator. (08/28/18)

171. **Do any of the six months of consecutive health insurance need to be within the reporting period?**

A: Yes, effective with the FY 2022 reporting update the measure specification has been updated to be timebound to the most recent data collection timepoint. The data collection timepoint must occur within the reporting period, thus at least part of the 6 months must occur during the reporting period. (08/28/18, updated 08/10/2022)

172. **Should eligible participants be counted in multiple reporting periods?**

A: Participants may be counted in multiple reporting periods for this measure. To be included in the denominator, a participant must be enrolled in home visiting for at least six consecutive months. Of those in the denominator, the participant must have had health insurance for six consecutive months since enrollment. Therefore, it is possible for participants to be included in multiple reporting periods. (08/28/18)

173. **If a participant is enrolled for over a year in the program, and only one month in the reporting period, is the participant counted in the denominator?**

A: Yes, since this participant was enrolled for at least six months, and a portion of the six months occurred during the reporting period, this participant should be included in the denominator.

(08/28/18)

174. **For example, say household A and household B were asked the health insurance question in August. Household A had health insurance from February to August. Household B had health insurance from January to July. With this change, does this mean that only household A would be in the numerator or could household B be in the numerator of the measure as well?**

A: In this example, Household A would be included in both the numerator and denominator for the measure. Household B would count in the denominator, but not in the numerator, since the household did not have health insurance in August, when data collection occurred. (08/10/2022)

175. **Anyone who is not enrolled for at least six months would be excluded from the measure?**

A: Correct. Denominator definition is "number of primary caregivers enrolled in home visiting for at least six months". (08/10/2022)

176. **Can the six months of health insurance coverage be before the participant was enrolled in home visiting? For example, participant enroll and exits at months post-enrollment, data were collected at 5 months post enrollment, and they had 1 month of coverage before entering home visiting program.**

A: No, the six months of continuous health insurance must occur during enrollment. The data collection timepoint should be measured on or after 6 months post enrollment. (08/10/2022)

177. **Is the most recent consecutive 6 months going to be April to September and previous six months prior to exit for those exiting program during the reporting period?**

A: No, the most recent consecutive 6 months is time bound to the most recent data collection time point, which refers to the time point closest to the end of the reporting period according to the data collection schedule(s) identified in you Performance Measurement Plan (PMP). For households exiting the program during the reporting period, this also refers to the time point closest to the end of the reporting period prior to exiting the program. (08/10/2022)

178. **If a household was enrolled for 6 months, but exited the program 2 days into the new reporting period, would this household be excluded?**

A: This depends on the data collection time point designated in your Performance Measurement Plan. If the primary caregiver meets all requirements for the denominator, but they did not reach the data collection time point, they would count as missing. (9/20/2024)

179. **Do the 6 consecutive months have to be within the reporting year?**

A: Any primary caregiver that is enrolled for at least 6 consecutive months, regardless of the length of time enrolled during the reporting period, should be included in the denominator. (08/10/2022)

Measure 17: Completed Depression Referrals

180. **What is included for "recommended services for depression"?**

A: Recommended services for depression should be defined by home visiting models or awardee 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)

181. **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)

182. **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)

183. **How should we report primary caregivers who have not received a referral?**

A: If no referral is provided or if the primary caregiver does not receive a referral because they are already receiving services for depressive symptoms, the primary caregiver is not included in the numerator or denominator and is not counted as missing. If information on referral is missing, then the primary caregiver is counted as missing. (08/10/2022)

184. **What do we do if a primary caregiver screens positive for depressive symptoms and then a subsequent screening does not indicate depressive symptoms? Can the primary caregiver be counted in the numerator?**

A: A primary caregiver that screens positive for depressive symptoms is included in the denominator until they receive one or more service contacts. However, if a primary caregiver subsequently screens negative for depressive symptoms after initially screening positive, you ***may*** remove them from the denominator. In these instances, they would never count in the numerator, but instead be removed from the denominator without ever being counted in the numerator. (Please note: this guidance differs from guidance in Measure 18, as the index child is not removed from the denominator as a result of a subsequent negative screen) (10/19/17, updated 9/20/2024)

185. **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)

186. **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)

187. **If a participant calls the new Maternal Mental Health Hotline, is that considered a service for Measure 17?**

A: No, calling the Maternal Health Hotline is not considered a completed depression referral for Measure 17. The National Maternal Mental Health Hotline provides free confidential support, resources, and referrals to pregnant and postpartum individuals facing mental health challenges and their loved ones, which may or may not result in caller receiving services for depression that meet HRSA guidance (i.e. specific techniques and intervention models delivered in the context of client characteristics, culture, and preferences that have shown to have positive effects through rigorous evaluations and have demonstrated to achieve positive outcomes for the client). If disclosed by the participant to the home visitor, you may be able to track completion of referral services recommended by the hotline and determine inclusion in accordance with HRSA guidance (08/10/2022)

Measure 18: Completed Developmental Referrals

188. **Is this "ever" received services? Or within a certain time frame?**

A: You 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)

189. **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)

190. **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)

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

A: If an index child screens positive for developmental delays, that child must be included in this measure, regardless if s/he is 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 developmental delay services and is later rescreened at one of the AAP recommended ages, s/he 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).

If an index child is already enrolled in developmental delay services and is **not** rescreened at one of the AAP recommended ages, that child ***may*** be excluded from the denominator if s/he was not rescreened or provided a referral while enrolled in the program. (5/6/16) (updated 10/19/17)

192. **If a client refuses a referral to additional developmental services after a positive screen should they be included in denominator or counted as missing?**

A: If a client refuses a referral for additional developmental services, they are included in the denominator and not considered missing data. You may use the comments section to report additional information participants that refuse services. (7/7/20, updated 9/20/2024)

193. **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)

194. **Some awardees 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)

195. **How should awardees 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)

196. **Can awardees 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; you must include all participants that meet the eligibility criteria defined by the measure definition. (9/27/16)

197. **If an index children screens positive at a visit then screens negative at a later visit, are they removed from the denominator and not included at all?**

A: Once an index child with a positive screen is counted in the denominator, they should continue to be counted until the numerator criteria is met. In other words, if they are counted at the 9-month screening because of a positive result, then did not have a positive result at the 18-month screening, the index child would still be counted in the denominator due to the 9-month screening. This differs from Measure 17, which allows for the removal of the primary caregiver from the denominator if they screen negative after initially screening positive. (9/20/2024)

Measure 19: Intimate Partner Violence Referrals

198. **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)

199. **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)

200. **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. Primary caregivers should be included in the denominator even if already receiving services at enrollment. (5/6/16) (updated 10/19/17)

201. **Can we include caregivers in this measure who disclose intimate partner violence to a home visitor outside of when a screening occurred?**

A: No, this measure should only include caregivers who screened positive for IPV using a validated tool within the first 6 months of enrollment. (7/7/20)

Optional Measures 1 and 2: General

202. **Will the optional substance use screening and referral measures eventually be required?**

A: At this time, HRSA has not made any determinations on whether these will be required in the future and intends to evaluate feedback from both the optional reporting measures to inform any future updates to data collection activities related to substance use screening and referrals. (08/10/2022)

203. **Are awardees able to opt in to reporting for certain reporting years and not for others? For example, can an awardee opt out for FY 2022 reporting but opt in to FY 2023, or vice versa?**

A: Both screening and referral measures are optional and you have the flexibility to opt in or out of reporting across fiscal years. Please note that data reported should reflect information collected during the reporting period of that fiscal year, any data elements that are unrecorded or missing at any point of the reporting period should be reported in accordance with the missing data guidance. (08/10/2022)

204. **How does HRSA define unhealthy alcohol use and drug use?**

A: As outlined in the Form 2 Definitions section, definitions of unhealthy alcohol and drug use should align with your validated substance use screening tool's definition. (08/10/2022)

205. **Are awardees able to report just one, and not both of the optional measures?**

A: Yes, you may choose to report just one of the two optional measures. For example, you can report the optional substance use screening measure and not the optional substance use referral measure. Please note that the measures are intended to be a paired set and participants included in the denominator of the referral need to have met the criteria for inclusion in the screening measure. Therefore, if you opts into reporting the optional referral it is highly encouraged that the optional screening measure is also reported to aid in the review of data and technical assistance. (08/10/2022)

Optional Measure 1: Substance Use Screening

206. **Does HRSA have a list of approved tools for the new substance use screening measure?**

A: Information on the substance use screening and referral measures can be found in the Form 2 Toolkit available on the MIECHV Data & Continuous Quality Improvement (CQI) website. This list does not include all possible screening tools. If there is a tool you are interested in using that is not on the list, please reach out to your Data & CQI TA Specialist or HRSA Project Officer to discuss the validity of the tool. (08/10/2022)

Optional Measure 2: Substance Use Referrals

207. **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 substance use 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 Optional Measure 1 since the depression screening can take place in a previous reporting period from the receipt of services. (08/10/2022)