

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration**

Maternal and Child Health Bureau
Division of Home Visiting and Early Childhood Systems

***Affordable Care Act -
Maternal, Infant and Early Childhood Home Visiting Program
Development Grants to States***

Announcement Type: New
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FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2012

Application Due Date: August 8, 2012

*Ensure your Grants.gov registration and passwords are current immediately!
Deadline extensions are not granted for lack of registration.
Registration may take up to one month to complete.*

**Release Date: July 9, 2012
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Modified on 7/12: Modification to footnote 1 in Section I.1. Purpose; modification to the budget period start date in Section V.3. Anticipated Announcement and Award Dates and Section VI.1. Award Notices.

Modified on 7/16: Modification to CCR information throughout the FOA. Modification to the policy requirements in Section VI.2. Administrative and National Policy Requirements.

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I. Funding Opportunity Description

1. Purpose

The purpose of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Competitive Grant program is to award Development Grants to States that currently have modest home visiting programs and want to build on existing efforts. Successful applicants will sufficiently demonstrate the capacity to expand or enhance their evidence-based home visiting programs.

The funding provided will build on the formula funding already provided to States and territories to support the quality implementation of home visiting programs. Additionally, this funding opportunity will continue the program's emphasis on rigorous research by grounding the proposed work in relevant empirical literature, and by including requirements to evaluate work proposed under this grant.

In Fiscal Year (FY) 2012, approximately \$12,000,000 will be available to support competitive Development Grants to eligible States and jurisdictions under the MIECHV program. \$125,000,000 will be awarded on a formula basis¹ to grantees funded under HRSA-11-187 for the MIECHV program. Successful applicants will be awarded FY 2012 competitive Development Grant funds, in addition to the FY2012 MIECHV formula based funds.

Priority for Serving High-Risk Populations and Programmatic Areas of Emphasis

As directed in the legislation², successful applicants will give priority to providing services to the following populations:

- a) Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under subsection (b)(1)(A).
- b) Low-income eligible families.
- c) Eligible families who are pregnant women who have not attained age 21.
- d) Eligible families that have a history of child abuse or neglect or have had interactions with child welfare services.
- e) Eligible families that have a history of substance abuse or need substance abuse treatment.
- f) Eligible families that have users of tobacco products in the home.
- g) Eligible families that are or have children with low student achievement.
- h) Eligible families with children with developmental delays or disabilities.
- i) Eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.”

In addition, the Health Resources and Service Administration (HRSA) and the Administration for Children and Families (ACF) have identified the following programmatic areas of emphasis.

¹ FY 2012 funds will be distributed to states as follows:

1. A base allocation of \$1,000,000 for each state;
2. An amount based on the number of children under age five in families at or below 100% of the Federal poverty line in the state as compared to the number of such children nationally.

² Section 511(d) (4).

Applicants may propose to address one or more of these areas in response to this funding opportunity announcement:

- **Emphasis 1:** Improvements in maternal, child, and family health
- **Emphasis 2:** Effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to the evidence-based model selected
- **Emphasis 3:** Development of statewide or multi-State home visiting programs
- **Emphasis 4:** Development of comprehensive early childhood systems that span the prenatal-through-age-eight continuum
- **Emphasis 5:** Outreach to high-risk and hard-to-engage populations
- **Emphasis 6:** Development of a family-centered approach to home visiting
- **Emphasis 7:** Outreach to families in rural or frontier areas
- **Emphasis 8:** The development of fiscal leveraging strategies to enhance program sustainability

For a more detailed description of each area of emphasis, please see Appendix A: MIECHV Programmatic Emphasis Areas.

2. Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (Affordable Care Act) (P.L. 111-148), legislation designed to make quality, affordable health care available to all Americans, reduce costs, improve health care quality, enhance disease prevention, and strengthen the health care workforce. Through a provision authorizing the creation of the MIECHV program³, the Affordable Care Act responds to the diverse needs of children and families in communities at risk and provides an unprecedented opportunity for collaboration and partnership at the Federal, State, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

This program is designed: (1) to strengthen and improve the programs and activities carried out under Title V; (2) to improve coordination of services for at-risk communities; and (3) to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. The legislation reserves the majority of funding for one or more evidence-based home visiting models. In addition, the legislation supports continued innovation by allowing for up to 25 percent of funding supporting promising approaches that do not yet qualify as evidence-based models.

HRSA and ACF believe that home visiting should be viewed as one of several service strategies embedded in a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development, strong parent-child relationships,

³ See <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>, pages 334-343.

and promotes responsible parenting among mothers and fathers. Together, we envision high-quality, evidence-based home visiting programs as part of an early childhood system for promoting health and well-being for pregnant women, children through age eight, and their families. This system would include a range of other programs such as child care, Head Start, pre-kindergarten, special education and early intervention, and early elementary education. Recognizing that the goal of an effective, comprehensive early childhood system that supports the lifelong health and well-being of children, parents, and caregivers is broader than the scope of any one agency, HRSA and ACF are working in close collaboration with each other and with other Federal agencies and look forward to partnering with States and other stakeholders to foster high-quality, well-coordinated home visiting programs for families in at-risk communities. HRSA and ACF realize that coordination of services with other agencies has been an essential characteristic of State and local programs for many years and will continue to encourage, support, and promote the continuation of these collaborative activities, as close collaboration at all levels will be essential to effective, comprehensive home visiting and early childhood systems.

HRSA and ACF believe further that this law provides an unprecedented opportunity for Federal, State, and local agencies, through their collaborative efforts, to effect changes that will improve the health and well-being of vulnerable populations by addressing child development within the framework of life course development and a socio-ecological perspective. Life course development points to broad social, economic, and environmental factors as contributors to poor and favorable health and development outcomes for children, as well as to persistent inequalities in the health and well-being of children and families. The socio-ecological framework emphasizes that children develop within families, families exist within a community, and the community is surrounded by the larger society. These systems interact with and influence each other to either decrease or increase risk factors or protective factors that affect a range of health and social outcomes.

Criteria for Evidence-Based Models

On July 23, 2010, a Federal Register Notice was published requesting comment on proposed evidence criteria for home visiting models.⁴ Approximately 140 letters providing comments were received and considered in developing the final criteria to identify evidence-based home visiting models for the purposes of the MIECHV program.

Taking into account the legislative requirements, the original criteria contained in the Federal Register Notice, and the comments received, HHS will consider a model eligible for evidence-based funding for the purposes of the Affordable Care Act MIECHV program if it meets either of the following minimum criteria:⁵

⁴ Department of Health and Human Services, Health Resources and Services Administration, Administration for Children and Families, Maternal, Infant, and Early Childhood Home Visiting Program; Request for Public Comment, 75 Federal Register 141 (23 July 2010), pp. 43172-43177.

⁵ For the purposes of the MIECHV, home visiting models have been defined as programs or initiatives in which home visiting is a primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children birth to kindergarten entry, targeting participant outcomes which may include improved maternal and child health; prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; improvements in the coordination and referrals for other community resources and supports; or improvements in parenting skills related to child development.

- At least one high-quality or moderate-quality impact study of the model has found favorable, statistically significant impacts in two or more of the eight outcome domains described below, or
- At least two high-quality or moderate-quality impact studies of the model using non-overlapping analytic different samples with one or more favorable, statistically significant impacts in the same domain.

For the purposes of the criteria, different samples are defined as non-overlapping participants in the analytic sample. To meet either criterion, the impacts must be found for the full sample or, if found for subgroups but not for the full sample, impacts must be replicated in the same domain in two or more studies using different samples. Isolated positive findings, and effects found only for a subgroup but not the full sample in a study, raise concerns about false positives that may be artifacts of multiple statistical tests rather than reflecting true results. The requirements for replication of positive findings across samples or for findings in two or more outcome domains are meant to guard against this problem. HHS recognizes the importance of subgroup findings for determining effects on subgroups of the population of interest, including specific racial or ethnic groups, and the Home Visiting Evidence of Effectiveness (HomVEE) website includes information on subgroup findings, whether replicated or not (<http://homvee.acf.hhs.gov/Default.aspx>).

Additionally, if the model has met the above criteria based on findings from randomized control trial(s) only, then one or more impacts in an outcome domain must be sustained for at least one year after program enrollment, and one or more impacts in an outcome domain must be reported in a peer-reviewed journal (consistent with section 511(d)(3)(A)(i)(I)). Information regarding duration of impacts and publication venue will be available for all studies on the HomVEE website.

The relevant outcome domains are:

- 1) Maternal health
- 2) Child health
- 3) Child development and school readiness, including improvements in cognitive, language, social-emotional, or physical development
- 4) Prevention of child injuries and maltreatment
- 5) Parenting skills
- 6) Reductions in crime or domestic violence
- 7) Improvements in family economic self-sufficiency
- 8) Improvements in the coordination and referrals for other community resources and supports

HRSA and ACF acknowledge that there is not a one-size-fits-all home visiting program for any individual applicant. Therefore, applicants are encouraged to consider more than one model to adopt for their home visiting needs. For additional information, please see the HomVEE Executive Summary: <http://homvee.acf.hhs.gov/document.aspx?rid=5&sid=20&mid=2>.

[Supporting Infrastructure for Quality Implementation of Evidence-based and Evidence-Informed Home Visiting Programs](#)

A growing body of research points to the importance of implementation and infrastructure as necessary factors to support evidence-based programs.^{6,7,8,9} In a meta-analysis of treatment impacts across a range of social service interventions, Wilson and Lipsey (2000) found implementation quality was one of the strongest predictors of achieved effect size of the programs.⁷

The implementation science field has identified, and continues to identify, implementation factors related to whether expected outcomes are obtained and the strength of those impacts. Research has begun to highlight the role of the multiple levels of the infrastructure and system to support implementation of evidence-based programs. For example, Wandersman and colleagues (2008) proposed the Interactive Systems Framework to elucidate the role of communities in selecting and implementing evidence-based programs and to draw attention to the multi-layered implementation system necessary to support evidence-based programs.¹⁰ The model highlights the necessity of building capacity at all levels of the infrastructure, including service provision and the technical assistance network. Durlak and Dupre (2008) analyzed over 500 empirical studies and identified over 23 different contextual factors related to quality of implementation, including: communities, providers, organizational capacity, and training or technical assistance.¹¹

In the largest synthesis of research on implementation to date, Fixsen and colleagues (2005) conclude that quality implementation occurs in a complex ecological framework that includes several aspects: professional development (including initial training, ongoing technical assistance, and fidelity monitoring), staff selection, administrative supports, and systems interventions.¹² Three key aspects of implementation that are currently receiving the most attention in the research field are fidelity, community context, and professional development.

Fidelity. A program must be implemented with an acceptable level of fidelity in order to achieve expected outcomes.¹³ Dane and Schneider (1998) examined the extent to which evidence-based programs were implemented as intended and found only approximately 10% of studies even documented adherence; for those that did, lower adherence was related to smaller effects.¹⁴ Hamre and colleagues (2010) found basic adherence was necessary but not sufficient to obtaining child outcomes and instead *quality* of delivery

⁶ Durlak, J. A., & Dupre, E.P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and factors affecting implementation. *American Journal of Community Psychology, 41*, 327-350.

⁷ Fixsen, D. L., Naoom, S., F., Blasé, K. A., Friedman, R. M., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

⁸ Rubin, D. M., O'Reilly, A. L. R., Luan, X., Dai, D., Localio, R., & Christian, C. W. (2010). Variation in pregnancy outcomes following statewide implementation of a prenatal home visitation program. *Archives of Pediatric and Adolescent Medicine*. Downloaded on 11/2/10 from: www.archpediatrics.com.

⁹ Wilson, D. B., & Lipsey, M. W. (2001). The role of method in treatment effectiveness research: Evidence from a meta-analysis. *Psychological Methods, 6*(4), 413-429.

¹⁰ Wandersman, A., Duffy, J., Flaspohler, P., Nooan, R., Lubell, K., Stillman, L., Blachman, M., Dunville, R., & Saul, J. (2008). Bridging the gap between prevention research and practice: The interactive systems framework for dissemination and implementation. *American Journal of Community Psychology, 41*, 171-181.

¹¹ *Ibid.* 4.

¹² *Ibid.* 5.

¹³ *Ibid.*

¹⁴ Dane, A.V., & Schneider, B. H. (1998). Program integrity in primary and secondary prevention: Are implementation effects out of control? *Clinical Psychology Review, 18*, 23-45.

was the variable most strongly related to outcomes.¹⁵ In order to obtain quality in fidelity, multiple aspects of implementation must be addressed, including such things as recruiting and retaining the clients best suited for the program, establishing a management information system to track data related to fidelity and services, providing ongoing training and professional development for staff, and establishing an integrated resource and referral network to support client needs.

Community context. At a recent meeting on scaling-up of evidence-based practices, there was consensus among the research, practice and policy attendees on the critical nature of community systems to support implementation (Emphasizing Evidence Based Programs for Children and Youth Forum, April 27-28, 2011). In one example, Rubin and colleagues (2010) reported that the effects of the Nurse Family Partnership were found only after three years of implementation and were moderated by community context.¹⁶ Rubin notes that the delayed achievement of the impacts was consistent with the research around implementation in community-based settings. In addition, Rubin and colleagues (2010) found stronger impacts for rural versus urban sites.⁶ The researchers noted that aspects of the community may explain these differences; for example, the tendency to facilitate referrals through word of mouth, or the lack of other community resources in the rural communities.

Professional development. The Fixsen and colleagues (2005) review identified professional development, including coaching and ongoing support, to be critical to implementation.¹⁷ Evidence indicates that although initial training is critical, ongoing professional development is also important for implementation. For example, Aarons and colleagues (2009a, 2009b) found home visitors who were given fidelity monitoring along with supervision and consultation had lower levels of emotional exhaustion and burnout, two variables found to negatively impact fidelity.^{18,19} In addition, the home visitors with supervision and consultation were more likely to remain employed by the program, therefore reducing costs and time of hiring and retraining staff.

Infrastructure to support implementation is critical to the success of an evidence-based home visiting program (including promising approaches) in achieving the intended impacts. Though the field is growing, rigorous research in real-world settings at scale is necessary to better identify key elements of infrastructure related to the achievement of the desired effects in evidence-based programs and promising approaches.

Researchers regularly state that the available information in many of the efficacy trials currently is lacking in depth and breadth around implementation of the programs. In their detailed synthesis of the literature, Fixsen and colleagues (2005) noted that the proportion of research

¹⁵ Hamre, B.K., Justice, L. M., Pianta, R. C., Kilday, C., Sweeney, B. Downer, J. T., & Leach, A., (2010). Implementation fidelity of MyTeachingPartner literacy and language activities: Association with preschoolers' language and literacy growth. *Early Childhood Research Quarterly*, 25, 329-347.

¹⁶ *Ibid.* 6.

¹⁷ *Ibid.* 5.

¹⁸ Aarons, G. A., Fettes, D. L., Flores, L. E., & Sommerfeld, D. H. (2009a). Evidence-based practice implementation and staff emotional exhaustion in children's services. *Behavior Research and Therapy*. Downloaded online on 9/3/09 from www.elsevier.com/locate/brat

¹⁹ Aarons, G.A., Sommerfeld, D. H., Hect, D. B., Silvosky, J. F., & Chaffin, M., J. (2009b). The impact of evidence-based practice implementation and fidelity monitoring on staff turnover: Evidence for a protective effect. *Journal of Consulting and Clinical Psychology*, 77 (2), 270-280.

studies on implementation that utilized rigorous designs was small.²⁰ An important component of the purpose of the activities to be supported under this grant program is to support quality implementation and the building of infrastructure necessary for quality implementation of evidence-based practices and to rigorously evaluate those supports, with the ultimate goal of building knowledge about the necessary factors to support the capacity of evidence-based programs to achieve their intended outcomes, as well as to build solid foundations to support evidence-based home visiting services to families in at-risk communities.

Please note: Enhancements of evidence-based home visiting models with one or more of the aforementioned emphasis areas may constitute an *adaptation* to the model. For the purposes of the MIECHV program, an acceptable adaptation of an evidence-based model includes changes to the model that have not been tested with rigorous impact research but are determined by the model developer *not to alter the core components related to program impacts*.

Changes to an evidence-based model that alter the components related to program outcomes could undermine the program's effectiveness. Such changes (otherwise known as "drift") will not be allowed under the funding allocated for evidence-based models. Adaptations that alter the core components related to program impacts may be funded with funds available for promising approaches if the State wishes to implement the program as a promising approach instead of as an acceptable adaptation of an evidence-based model. Per the authorizing legislation, at least 75 percent of the total grant funds (i.e., formula and competitive funds combined) must be used for evidence-based home visiting models. The State may propose to expend up to 25 percent of the total grant funds to support a model that qualifies as a promising approach.²¹

II. Award Information

1. Type of Award

Funding will be provided in the form of a grant.

2. Summary of Funding

This program will provide funding to applicants who successfully demonstrate the existence of modest home visiting programs, and the desire and capacity to build on existing home visiting efforts.

Approximately \$12 million of the competitive FY 2012 funding will be awarded for four (4) to eight (8) Development Grants. The total grant award may range between \$1 million to \$3 million annually. Applicants may apply for a ceiling amount of up to \$3 million per year. The project period is two (2) years. Funding beyond the first year is dependent on the availability of appropriated funds for the MIECHV program in subsequent fiscal years, grantee satisfactory

²⁰ *Ibid.* 5.

²¹ This 25% limit on expenditures pertains to the total funds awarded to the grantee for the fiscal year, i.e., the amount equal to state's formula grant plus the amount of the competitive grant award, if the state's application is successful. The formula allocation for each state is provided in Appendix B of this funding opportunity announcement.

performance, and a decision that continued funding is in the best interest of the Federal Government.

Per Section 511 [42 U.S.C. 711] (j)(3) of the Social Security Act, as amended by the Affordable Care Act, funds made available to an eligible entity under this section for a fiscal year shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award.

III. Eligibility Information

1. Eligible Applicants

Eligible applicants for this competitive grant opportunity include the following eligible entities listed in Section 511(k)(1)(A): States (including the District of Columbia), Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and America Samoa. The Governor has the responsibility and authority to designate which entity or group of entities will apply for and administer MIECHV funds on behalf of the State. Indian Tribes, Tribal Organizations, or Urban Indian Organizations are ineligible for this competition.

States that received either a FY 2011 Competitive Expansion Grant or Development Grant (under announcement number HRSA-11-179) are not eligible to apply.

2. Cost Sharing/Matching

There are no cost sharing/matching requirements for the MIECHV Competitive Grant program.

3. Other

Maintenance of Effort/Non-Supplantation

Funds provided to an eligible entity receiving a grant shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives. The grantee must agree to maintain non-federal funding (State General Funds) for grant activities at a level which is not less than expenditures for such activities as of the most recently completed fiscal year (Attachment 9).

For purposes of maintenance of effort/non-supplantation in this funding opportunity announcement, home visiting is defined as an evidence-based program, implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting), and is offered on a voluntary basis to pregnant women or children birth to age five targeting the participant outcomes in the legislation which include improved maternal and child health, prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits, improvement in school readiness and achievement, reduction in crime or domestic violence, improvements in family economic self-sufficiency, and improvements in the coordination and referrals for other community resources and supports.

Ceiling Award Amount

Applications that exceed the ceiling amount will be considered non-responsive and will not be considered for funding under this announcement.

Deadlines

Any application that fails to satisfy the deadline requirements referenced in Section IV.3 will be considered non-responsive and will not be considered for funding under this announcement.

IV. Application and Submission Information

1. Address to Request Application Package

Application Materials and Required Electronic Submission Information

HRSA *requires* applicants for this funding opportunity announcement to apply electronically through Grants.gov. This robust registration and application process protects applicants against fraud and ensures that only authorized representatives from an organization can submit an application. Applicants are responsible for maintaining these registrations, which should be completed well in advance of submitting your application. All applicants *must* submit in this manner unless they obtain a written exemption from this requirement in advance by the Director of HRSA's Division of Grants Policy. Applicants must request an exemption in writing from DGPWaivers@hrsa.gov, and provide details as to why they are technologically unable to submit electronically through the Grants.gov portal. Your email must include the HRSA announcement number for which you are seeking relief, the organization's DUNS number, the name, address, and telephone number of the organization and the name and telephone number of the Project Director as well as the Grants.gov Tracking Number (GRANTXXXX) assigned to your submission along with a copy of the "Rejected with Errors" notification you received from Grants.gov. **HRSA and its Digital Services Operation (DSO) will only accept paper applications from applicants that received prior written approval.** However, the application must still be submitted by the deadline. Suggestion: submit application to Grants.gov at least two days before the deadline to allow for any unforeseen circumstances.

IMPORTANT NOTICE: CCR to be moved to SAM **Effective July 30, 2012**

CCR will transition to SAM at the end of July. CCR must stop accepting new data in order to successfully migrate the existing data into SAM. CCR's last business day is Tuesday, July 24, 2012. It will no longer accept new registrations or updates to current registrations after that time. The CCR Search capability will remain active through the transition to allow users to search for an entity's current registration status. SAM will be online for use Monday morning, July 30, 2012.

CCR will stop accepting data at 11:59 pm on Tuesday, July 24, 2012. **No new registrations can be submitted after that time. No updates to existing registrations can be submitted after that time.** Any registrations in process will be on hold until SAM goes live the morning of July 30, 2012. If users are in the middle of a registration, the data that has been submitted will be migrated to SAM.

If a record was scheduled to expire between July 16, 2012 and October 15, 2012, CCR is extending the expiration date by 90 days. The registrant will receive an e-mail notification from

CCR when it extends the expiration date. The registrant will then receive standard e-mail reminders to update their record based on this new expiration date. Those future e-mail notifications will come from SAM.

SAM will reduce the burden on those seeking to do business with the government. Vendors will be able to log into one system to manage their entity information in one record, with one expiration date, through one streamlined business process. Federal agencies will be able to look in one place for entity pre-award information. Everyone will have fewer passwords to remember and see the benefits of data reuse as information is entered into SAM once and reused throughout the system.

Active CCR registration is a pre-requisite to the successful submission of grant applications!

Grants.gov strongly suggests visiting CCR prior to this change and checking the account status. Some things to consider are:

- When does the account expire?
- Does the organization need to complete the annual renewal of registration?
- Who is the eBiz POC? Is this person still with the organization?
- Does anything need to be updated?

To learn more about the switch from CCR to SAM, more information is available at <https://www.bpn.gov/ccr/NewsDetail.aspx?id=2012&type=N>. To learn more about SAM, please visit <https://www.sam.gov>.

Note: CCR or SAM information must be updated at least every 12 months to remain active (for both grantees and sub-recipients). As of August 9, 2011, Grants.gov began rejecting submissions from applicants with expired CCR registrations. Although active CCR registration at time of submission is not a new requirement, this systematic enforcement will likely catch some applicants off guard. According to the CCR Website it can take 24 hours or more for updates to take effect; or SAM Quick Guide for Grantees (https://www.sam.gov/sam/transcript/SAM_Quick_Guide_Grants_Registrations-v1.6.pdf), an entity's registration will become active after 3-5 days. Therefore, ***check for active registration well before your grant deadline.***

An applicant can view their CCR Registration Status by visiting <http://www.bpn.gov/CCRSearch/Search.aspx> and searching by their organization's DUNS. The [CCR Website](#) provides user guides, renewal screen shots, FAQs and other resources you may find helpful.

Applicants that fail to allow ample time to complete registration with CCR (prior to July 25, 2012) / SAM (starting July 30, 2012) or Grants.gov will not be eligible for a deadline extension or waiver of the electronic submission requirement.

All applicants are responsible for reading the instructions included in HRSA's *Electronic Submission User Guide*, available online at <http://www.hrsa.gov/grants/apply/userguide.pdf>. This Guide includes detailed application and submission instructions for both Grants.gov and HRSA's Electronic Handbooks. Pay particular attention to Sections 2 and 5 that provide detailed information on the competitive application and submission process.

Applicants are also responsible for reading the Grants.gov Applicant User Guide, available online at <http://www.grants.gov/assets/ApplicantUserGuide.pdf>. This Guide includes detailed information about using the Grants.gov system and contains helpful hints for successful submission.

Applicants must submit proposals according to the instructions in the Guide and in this funding opportunity announcement in conjunction with Application Form SF-424. The forms contain additional general information and instructions for applications, proposal narratives, and budgets. The forms and instructions may be obtained by:

- 1) Downloading from <http://www.grants.gov>, or
- 2) Contacting the HRSA Digital Services Operation (DSO) at: HRSADSO@hrsa.gov

Each funding opportunity contains a unique set of forms and only the specific forms package posted with an opportunity will be accepted for that opportunity. Specific instructions for preparing portions of the application that must accompany Application Form SF-424 appear in the “Application Format Requirements” section below.

2. Content and Form of Application Submission

Application Format Requirements

The total size of all uploaded files may not exceed the equivalent of 80 pages when printed by HRSA. The total file size may not exceed 10 MB. The 80-page limit includes the abstract, project and budget narratives, attachments, and letters of commitment and support. Standard forms are NOT included in the page limit. **We strongly urge you to print your application to ensure it does not exceed the 80-page limit. Do not reduce the size of the fonts or margins to save space. See the formatting instructions in Section 5 of the Electronic Submission User Guide referenced above.**

Applications must be complete, within the 80-page limit, within the 10 MB limit, and submitted prior to the deadline to be considered under this announcement.

Application Format

Applications for funding must consist of the following documents in the following order:

SF-424 Non-Construction – Table of Contents

- 🔔 It is mandatory to follow the instructions provided in this section to ensure that your application can be printed efficiently and consistently for review.
- 🔔 Failure to follow the instructions may make your application non-responsive. Non-responsive applications will not be considered under this funding opportunity announcement.
- 🔔 For electronic submissions, applicants only have to number the electronic attachment pages sequentially, resetting the numbering for each attachment, i.e., start at page 1 for each attachment. Do not attempt to number standard OMB approved form pages.
- 🔔 For electronic submissions, no Table of Contents is required for the entire application. HRSA will construct an electronic table of contents in the order specified.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Application for Federal Assistance (SF-424)	Form	Pages 1, 2 & 3 of the SF-424 face page.	Not counted in the page limit
Project Summary/Abstract	Attachment	Can be uploaded on page 2 of SF-424 - Box 15	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.
Additional Congressional District	Attachment	Can be uploaded on page 3 of SF-424 - Box 16	As applicable to HRSA; not counted in the page limit.
Project Narrative Attachment Form	Form	Supports the upload of Project Narrative document	Not counted in the page limit.
Project Narrative	Attachment	Can be uploaded in Project Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions. Provide table of contents specific to this document only as the first page.
SF-424A Budget Information - Non-Construction Programs	Form	Pages 1–2 to support structured budget for the request of Non-construction related funds.	Not counted in the page limit.
Budget Narrative Attachment Form	Form	Supports the upload of Project Narrative document.	Not counted in the page limit.
Budget Narrative	Attachment	Can be uploaded in Budget Narrative Attachment form.	Required attachment. Counted in the page limit. Refer to the funding opportunity announcement for detailed instructions.
SF-424B Assurances - Non-Construction Programs	Form	Supports assurances for non-construction programs.	Not counted in the page limit.
Project/Performance Site Location(s)	Form	Supports primary and 29 additional sites in structured form.	Not counted in the page limit.
Additional Performance Site Location(s)	Attachment	Can be uploaded in the SF-424 Performance Site Location(s) form. Single document with	Not counted in the page limit.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
		all additional site location(s)	
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Not counted in the page limit.
Grants.gov Lobbying Form	Form	Complete this form online per the instructions embedded in the form.	Not counted in the page limit
Other Attachments Form	Form	Supports up to 15 numbered attachments. This form only contains the attachment list.	Not counted in the page limit.
Attachment 1-15	Attachment	Can be uploaded in Other Attachments form 1-15.	Refer to the attachment table provided below for specific sequence. Counted in the page limit.

-  To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.
-  Additional supporting documents, if applicable, can be provided using the available rows. Do not use the rows assigned to a specific purpose in the program funding opportunity announcement.
-  Merge similar documents into a single document. Where several documents are expected in the attachment, ensure that you place a table of contents cover page specific to the attachment. The Table of Contents page will not be counted in the page limit.
-  Limit the file attachment name to under 50 characters. Do not use any special characters (e.g., %, /, #) or spacing in the file name or word separation. (The exception is the underscore (_) character.) Your attachment will be rejected by Grants.gov if you use special characters or attachment names greater than 50 characters.

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Tables, Charts, etc.
Attachment 2	Job Descriptions for Key Personnel
Attachment 3	Biographical Sketches of Key Personnel
Attachment 4	Letters of Agreement or Description(s) of Proposed/Existing Contracts
Attachment 5	Project Organizational Chart
Attachment 6	Timeline
Attachment 7	Model Developer Approval Letter(s)
Attachment 8	Logic Model
Attachment 9	Maintenance of Effort Chart
Attachments 10–15	Other Relevant Documents not specified elsewhere in the Table of Contents

Application Format

i. Application Face Page

Complete Application Form SF-424 provided with the application package. Prepare according to instructions provided in the form itself. Important note: enter the name of the **Project Director** in 8. f. "Name and contact information of person to be contacted on matters involving this application." If, for any reason, the Project Director will be out of the office, please ensure their email Out of Office Assistant is set so HRSA will be aware if any issues arise with the application and a timely response is required. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is 93.505.

DUNS Number

All applicant organizations (and subrecipients of HRSA award funds) are required to have a Data Universal Numbering System (DUNS) number in order to apply for a grant or cooperative agreement from the Federal Government. The DUNS number is a unique nine-character identification number provided by the commercial company, Dun and Bradstreet. There is no charge to obtain a DUNS number. Information about obtaining a DUNS number can be found at <http://fedgov.dnb.com/webform> or call 1-866-705-5711. Please include the DUNS number in item 8c on the application face page. Applications **will not** be reviewed without a DUNS number. Note: A missing or incorrect DUNS number is the number one reason for applications being "Rejected for Errors" by Grants.gov. HRSA will not extend the deadline for applications with a missing or incorrect DUNS number. Applicants should take care in entering the DUNS number in the application.

Additionally, the applicant organization (and any subrecipient of HRSA award funds) is required to register annually with the Central Contractor Registration (CCR) (soon to be SAM) in order to do electronic business with the Federal Government. CCR (or SAM) registration must be maintained with current, accurate information at all times during which an entity has an active award or an application or plan under consideration by HRSA. It is extremely important to verify that your CCR (or SAM) registration is active and your Marketing Partner ID Number (MPIN) is current. Information about registering with the CCR can be found at <http://www.ccr.gov>. Please see Section IV of this funding opportunity announcement for **IMPORTANT NOTICE: CCR to be moved to SAM starting July 30, 2012.**

ii. Table of Contents

The application should be presented in the order of the Table of Contents provided earlier. Again, for electronic applications no table of contents is necessary as it will be generated by the system. (Note: the Table of Contents will not be counted in the page limit.)

iii. Budget

Complete Application Form SF-424A Budget Information – Non-Construction Programs provided with the application package.

Please complete Sections A, B, E, and F, and then provide a line item budget for each year of the project period. In Section A, use rows 1 - 2 to provide the budget amounts for the two years of the Development Grant. Please enter the amounts in the "New or Revised Budget" column- not the "Estimated Unobligated Funds" column. In Section B, Object Class Categories of the SF-424A, provide the object class category breakdown for the annual

amounts specified in Section A. In Section B, use column (1) to provide category amounts for Year 1 and use column (2) for Year 2.

iv. Budget Justification

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. However, the applicant **must** submit one-year budgets for each of the subsequent budget periods within the requested project period at the time of application. Therefore, applicants must submit budgets for Year 1 and Year 2.

Line item information must be provided to explain the costs entered in the SF-424A budget form. Be very careful about showing how each item in the “other” category is justified. For subsequent budget years, the justification narrative should highlight the changes from Year 1 or clearly indicate that there are no substantive budget changes during the project period. The budget justification **MUST** be concise. Do **NOT** use the justification to expand the project narrative.

Budget for Multi-Year Award

This announcement is inviting applications for project periods up to two years. Although the Development Grant project period is for two years, awards will be for a one-year budget period.

Submission and HRSA approval of your Progress Report(s) and any other required submission or reports is the basis for the budget period renewal and release of subsequent year funds. Funding beyond the one-year budget period but within the two-year project period is subject to availability of funds, satisfactory progress of the awardee, and a determination that continued funding would be in the best interest of the Federal Government.

Administrative cap applicable to state government entity applicants/grantees:

No more than 10 percent of the award amount may be spent on administrative expenditures. The requirements of the Social Security Act, §504(d) (relating to a limitation on administrative expenditures) apply to this award. Of the amounts paid to a state under §503 from an allotment for a fiscal year under §502(c), not more than 10 percent may be used for administering the funds paid under such section.

Per Section 511 [42 U.S.C. 711] (i)(2)(C) of the Social Security Act, MIECHV grants need to be administered “in the same manner” as the MCH Block Grant. The administration of the MCH Block Grant is governed by 45 CFR Part 96 which states that “a State shall obligate and expend block grant funds in accordance with the laws and procedures applicable to the obligation and expenditure of its own funds” (45 CFR 96.30(a)). In consequence, grantees will determine which expenses are “administrative” according to the laws and rules of their states.

Include the following in the Budget Justification narrative:

Personnel Costs: Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percentage of full-time equivalency, and annual salary. Personnel list should include a chart of personnel working across each of the applicant’s MIECHV grant programs.

Fringe Benefits: List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plans, and tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project.

Travel: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops. The budget must allocate sufficient funds to provide for at least one or two representatives from the State to attend two federally-initiated grantee meetings for the MIECHV program: one at the regional level and another at the national level. Please allow two to three days for each meeting. **Meeting attendance is a grant requirement.**

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of \$5,000 or more and a useful life of one or more years).

Supplies: List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes. Remember, they must be listed separately. Clear justification for the purchase of basic medical supplies must be included.

Contractual: Applicants are responsible for ensuring that their organization or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Applicants must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential subrecipients that entities receiving subawards must be registered in CCR (or SAM starting July 30, 2012 - See Section IV of this document for more SAM details) and provide the recipient with their DUNS number.

Note: contracting and subcontracting is allowable under this program. Grantees may not run a competitive subgrant program to carry out project activities outlined under this funding opportunity announcement.

Other: Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. In some cases, rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.

Applicants may include the cost of access accommodations as part of their project's budget, including sign interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.); and cultural/linguistic competence modifications such as use of cultural brokers, translation or interpretation services at meetings, clinical encounters, and conferences, etc.

Indirect Costs: Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term “facilities and administration” is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS’s Division of Cost Allocation (DCA). Visit DCA’s website at: <http://rates.psc.gov/> to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

v. *Staffing Plan and Personnel Requirements*

Applicants must present a staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position. Position descriptions that include the roles, responsibilities, and qualifications of proposed project staff must be included in Attachment 2. Biographical sketches for any key employed personnel that will be assigned to work on the proposed project must be included in Attachment 3. When applicable, biographical sketches should include training, language fluency and experience working with the cultural and linguistically diverse populations that are served by their programs.

vi. *Assurances*

Complete Application Form SF-424B Assurances – Non-Construction Programs provided with the application package.

vii. *Certifications*

Use the Certifications and Disclosure of Lobbying Activities Application Form provided with the application package.

viii. *Project Abstract*

Provide a summary of the application. Because the abstract is often distributed to provide information to the public and Congress, please prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including: the evidence-based model(s) or promising approach that will be supported by the competitive funding; the needs to be addressed; the proposed services; and, the population group(s) to be served.

Please place the following at the top of the abstract:

- Project Title
- Applicant Organization Name
- Address
- Project Director Name
- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable

The project abstract must be single-spaced and limited to one page in length.

ix. Project Narrative

This section provides a comprehensive framework and description of all aspects of the proposed program. It should be succinct, self-explanatory, and well organized so that reviewers can understand the proposed project.

Instructions for preparing each major section of the project narrative are outlined below. Follow them carefully, as they form the basis for addressing the Review Criteria (see **Section V**), which will be used for the evaluation and rating of applications submitted to the MIECHV program.

Use the following section headers for the Narrative:

▪ **INTRODUCTION**

The introduction must provide:

- A brief description of the project's proposed purpose;
- A description of the steps previously taken toward building a high-quality home visiting program. Applicants will be awarded points in the competitive review process for additional commitment to sustaining support for early childhood home visiting programs using State and Federal funds. Information regarding outreach and involvement in the development of a system-wide approach that includes ECCS and various early childhood initiatives should be discussed;
- A clear description of the problem, the proposed intervention, and the anticipated benefit of the project; and
- If applicable, the applicant should indicate the intent to address a MIECHV programmatic emphasis area in application. Discuss how the programmatic emphasis area identified will build on, or enhance, the applicant's existing MIECHV program.

▪ **NEEDS ASSESSMENT**

This section should provide a thorough discussion of the applicant's current home visiting program. Demographic data should be used and cited whenever possible to support the information provided. Accordingly, this discussion must:

- Identify the selected community(ies) to be served, briefly describe the community, and discuss the rationale for each selection taking into account the priority to provide services under the program to the high-risk populations as outlined in the Purpose section of this funding opportunity announcement;
- Provide the estimated number of families that will be reached by the proposed project; and
- Applicants electing to address a MIECHV Programmatic Area of Emphasis should explain how the emphasis area selected will assist in reaching the desired outcomes for the proposed program.

▪ *METHODOLOGY*

- Specify the evidence-based model(s) or promising approach(es) that will be supported by the competitive funding. Models that meet the HHS Criteria for Evidence of Effectiveness are located under Section III.
- Clearly describe the goals and objectives using an approach that is specific, time-oriented, measurable, and responds to the identified challenges facing the proposed project.
- Under each objective, provide a detailed list the activities that will be used to achieve each of the objectives proposed.

▪ *WORK PLAN*

- Develop a timeline that includes each activity listed under the methodology and identifies responsible staff. The description of the project methodology should extend across the two years of the project efforts. A project timeline that spans the two years of project effort should be formulated and attached as Attachment 6.
- As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing, implementing and evaluating all activities, including development of the application and, further, the extent to which these contributors reflect the cultural, racial, linguistic, and geographic diversity of the populations and communities served. A list of required and recommended partners is provided in Section VIII—Other Information. Consistent with the guidance in the 2nd Supplemental Information Request under HRSA-10-275, these partners have been identified to demonstrate agreement and support for the proposed initiative and to ensure that home visiting is part of a continuum of early childhood services within the State.
- Building on the elements of the State Home Visiting Plan, provide an implementation plan addressing the items listed below. Applicants should respond to each specific item as it pertains to the proposal for use of competitive funds. It is acceptable to address these items using information from the applicants FY 2011 Formula application to the extent that it is pertinent, and where responses differ, applicants should explain the rationale.

Discussion of implementation should include the following information:

- Plan to engage community;
- Plan for monitoring, program assessment and support, and technical assistance;
- Plan for professional development and training;
- Plan for staffing and subcontracting;
- Plan for recruiting and retaining participants;
- Continuous Quality Improvement plan;
- Plan to maintain fidelity to model;
- Plan to collect data on legislatively-mandated benchmarks;
- Plan to coordinate with appropriate entities/programs;
- Description of how the proposed activities would fit into the State administrative structure; and

- Plan to ensure incorporation of project goals, objectives, and activities into the ongoing work of the eligible applicant and any other partners at the end of the Federal grant.
- *RESOLUTION OF CHALLENGES*
Discuss challenges that are likely to be encountered in designing and implementing the activities described in the Work Plan, and approaches that will be used to resolve such challenges.
 - *EVALUATION AND TECHNICAL SUPPORT CAPACITY*
Describe an evaluation plan that will: (1) measure whether the intended outcomes of the project were attained, (2) monitor the efficiency of the proposed project activities, and (3) meet the definitions of rigor and other evaluation criteria above. Project level evaluation methodology should be specific and related to the stated goals, objectives, and priorities of the project.
 - Discuss how the evaluation will be conducted.
 - Articulate the proposed evaluation methods, measurement, data collection, sample and sampling (if appropriate), timeline for activities, plan for securing Institutional Review Board (IRB) review, and analysis.
 - Identify the evaluator, cost of the evaluation, and the source of funds.
 - Use an appropriate comparison condition, if the research is measuring the impact of the promising or new home visiting model on participant outcomes.
 - Include a logic model or conceptual framework that shows the linkages between the proposed planning and implementation activities and the outcomes that these are designed to achieve. The logic model should build on the logic model for the existing State MIECHV program; however, a distinction should be made between the existing program and what this additional grant would provide.
 - Describe current experience, skills, and knowledge, including individuals on staff, materials published, and previous work of a similar nature.
 - Demonstrate evidence of organizational experience and capability to coordinate and support planning, implementation, and evaluation of a comprehensive plan to meet the objectives of this initiative.

Guidelines for Evaluation

HRSA and ACF expect that initiatives funded under this grant will contribute to the development of a knowledge base around successful strategies for the effectiveness, implementation, adoption and sustainability of evidence-based home visiting programs.

HRSA and ACF have a particular interest in approaches that develop knowledge about:

- Efficacy in achieving improvements in the benchmark areas and participant outcomes specified in the legislation;
- Factors associated with developing or enhancing the State's capacity to support and monitor the quality of evidence-based programs; and
- Effective strategies for adopting, implementing, and sustaining evidence-based home visiting programs.

Furthermore, HRSA and ACF are especially interested in evaluation strategies that emphasize the use of research to help guide program planning and implementation (e.g., participatory or empowerment evaluation).²² To support the State's evaluation efforts, states must allocate an appropriate level of funds for a rigorous evaluation in all years of the grant.

HRSA and ACF expect States to engage in an evaluation of sufficient rigor to demonstrate potential linkages between project activities and improved outcomes. Rigorous research incorporates the four following criteria:

Credibility: Ensuring what is intended to be evaluated is actually what is being evaluated; making sure that descriptions of the phenomena or experience being studied are accurate and recognizable to others; ensuring that the method used is the most definitive and compelling approach that is available and feasible for the question being addressed. If conclusions about program efficacy are being examined, the study design should include a comparison group (i.e., randomized control trial or quasi-experimental design); see the HomVEE website for standards for study design in estimating program impacts: <http://www.acf.hhs.gov/programs/opre/homvee>).

Applicability: Generalizability of findings beyond current project (i.e., when findings "fit" into contexts outside the study situation). Ensuring the population being studied represents one or more of the population being served by the program.

Consistency: When processes and methods are consistently followed and clearly described, someone else could replicate the approach, and other studies can confirm what is found.

Neutrality: Producing results that are as objective as possible and acknowledge the bias brought to the collection, analysis, and interpretation of the results.

Applicants are expected to ground their proposed methods in relevant empirical work and have an articulated theory of change. For the purposes of this funding opportunity announcement, empirical work includes evidence from research, theory, practice, context, or cultural knowledge. Furthermore, applicants are expected to participate in a community of practice relevant to the goal of the grant award.

²² Participatory evaluation engages stakeholders in the development, implementation, and interpretation of evaluation results to maximize the usefulness of the results for stakeholders. Empowerment evaluation supports stakeholders to learn the tools on conducting effective evaluation to foster inquiry and self-evaluation or installation of continuous quality improvement.

If the State does not have the in-house capacity to conduct an objective, comprehensive evaluation, then HRSA and ACF advise that the State subcontract with an institution of higher education, or a third-party evaluator specializing in social sciences research and evaluation, to conduct the evaluation. It is important that the evaluators have the necessary independence from the project to assure objectivity. A skilled evaluator can help develop a logic model and assist in designing an evaluation strategy that is rigorous and appropriate given the goals and objectives of the proposed project.

Additional assistance may be found in a document titled "Program Manager's Guide to Evaluation." A copy of this document can be accessed at:

http://www.acf.hhs.gov/programs/opre/other_resrch/pm_guide_eval/reports/pmguide/pmguide_toc.html.

HHS has already initiated a contract for the provision of technical assistance for evaluation of the initiatives funded by this grant and will be providing information about the technical assistance available to States.

▪ **ORGANIZATIONAL INFORMATION**

- Provide information on the applicant organization's current mission and structure, and the scope of the organization's current activities related to home visiting and early childhood systems. Include an organizational chart of the project (Attachment 5). Describe how the organization's mission, structure and current activities contribute to the organization's ability to conduct the program requirements and meet program expectations.
- Identify additional home visiting infrastructure support needed to achieve the proposed goal and objectives of the program.
- Provide information on the applicant's resources and capabilities to support provision of culturally and linguistically competent and health literate services.
- Describe how the unique needs of target populations of the communities served are routinely assessed and improved. Also describe the organizational capacity of any partnering agencies or organizations involved in the implementation of the project.
- Describe the availability of resources to continue the proposed project after the grant period ends and the State's demonstrated commitment to home visiting.

xii. Attachments

Please provide the following items to complete the content of the application. Please note that these are supplementary in nature, and are not intended to be a continuation of the project narrative. Unless otherwise noted, attachments count toward the application page limit. **Each attachment must be clearly labeled.**

Attachment 1: Tables, Charts, etc.

The applicant may include tables, charts, or other graphics to give further details about the proposal (e.g., Gantt or PERT charts, flow charts, etc.).

Attachment 2: Job Descriptions for Key Personnel

Keep each to one page in length as much as is possible. Include the role, responsibilities, and qualifications of proposed project staff.

Attachment 3: Biographical Sketches of Key Personnel

Include biographical sketches for persons occupying the key positions described in Attachment 2, not to exceed two pages in length. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the biographical sketch.

Attachment 4: Letters of Agreement or Description(s) of Proposed/Existing Contracts (project specific)

Provide any documents that describe working relationships between the applicant organization and other agencies and programs cited in the proposal. Documents that confirm actual or pending contractual agreements should clearly describe the roles of the subcontractors and any deliverable. Letters of agreement must be dated. **Include only letters of support which specifically indicate a commitment to the project/program (e.g., in-kind services, dollars, staff, space, equipment, etc.). Letters of agreement and support must be dated. List all other support letters on one page.**

Attachment 5: Project Organizational Chart

Provide a one-page figure that depicts the organizational structure of the project, including subcontractors and other significant collaborators.

Attachment 6: Timeline (Required. To be developed by applicant)

The timeline links activities to project objectives and should cover the two-year project period for the grant. This table, chart, or figure details activities necessary to carry out each methodological approach, including approaches to major categories of activities and appropriate tracking methods. It includes a format to describe the “who, what, when, where, and how” of each approach.

Attachment 7: Model Developer Approval Letter(s)

States electing to implement an approved evidence-based model must provide documentation of approval by the developer(s) to implement the model(s) as proposed. The documentation should include verification that the model developer has reviewed and agreed to the plan as submitted, including any proposed adaptation, support for participation in the national evaluation, and any other related HHS efforts to coordinate evaluation and programmatic technical assistance. This documentation should include the State’s status with regard to any required certification or approval process required by the developer(s).

Attachment 8: Logic Model

Include a logic model or conceptual framework that shows the linkages between the proposed planning and implementation activities and the outcomes that these are designed to achieve.

Attachment 9: Maintenance of Effort Chart

Applicants must complete and submit the following information:

NON-FEDERAL EXPENDITURES

FY 2011 (Actual)	FY 2012 (Estimated)
Actual FY 2011 non-federal funds, including in-kind, expended for activities proposed in this application. If proposed activities are not currently funded by the institution, enter \$0.	Estimated FY 2012 non-federal funds, including in-kind, designated for activities proposed in this application.
Amount: \$ _____	Amount: \$ _____

Attachments 10–15: Other Relevant Documents

Include here any other documents that are relevant to the application.

3. Submission Dates and Times

Application Due Date

The due date for applications under this funding opportunity announcement is *August 8, 2012 at 8:00 P.M. ET*. Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by your organization’s Authorized Organization Representative (AOR) through Grants.gov and has been validated by Grants.gov on or before the deadline date and time.

Receipt acknowledgement: Upon receipt of an application, Grants.gov will send a series of email messages advising you of the progress of your application through the system. The first will confirm receipt in the system; the second will indicate whether the application has been successfully validated or has been rejected due to errors; the third will be sent when the application has been successfully downloaded at HRSA; and the fourth will notify the applicant of the Agency Tracking Number assigned to the application.

The Chief Grants Management Officer (CGMO) or designee may authorize an extension of published deadlines when justified by circumstances such as natural disasters (e.g., floods or hurricanes) or other disruptions of services, such as a prolonged blackout. The CGMO or designee will determine the affected geographical area(s).

Late applications:

Applications which do not meet the criteria above are considered late applications and will not be considered in the current competition.

4. Intergovernmental Review

The MIECHV program is subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. Executive Order 12372 allows states the option of setting up a system for reviewing applications from within their states for assistance under certain Federal programs. Application packages made available under this funding opportunity will contain a listing of

states which have chosen to set up such a review system, and will provide a State Single Point of Contact (SPOC) for the review. Information on states affected by this program and State Points of Contact may also be obtained from the Grants Management Specialist listed in the Agency Contact(s) section, as well as from the following Web site:
http://www.whitehouse.gov/omb/grants_s poc.

All applicants other than federally recognized Native American Tribal Groups should contact their SPOC as early as possible to alert them to the prospective applications and receive any necessary instructions on the State process used under this Executive Order.

Letters from the SPOC in response to Executive Order 12372 are due sixty days after the application due date.

5. Funding Restrictions

Applications with budget requests exceeding the specified ceiling (up to \$3 million per year) **will be deemed non-responsive, and will not be considered for funding.** Awards to support projects beyond the first budget year will be contingent upon Congressional appropriation, satisfactory progress in meeting the project's objectives, and a determination that continued funding would be in the best interest of the Federal Government.

Administrative cap applicable to state government entity applicants/grantees:

No more than 10 percent of the award amount may be spent on administrative expenditures. The requirements of the Social Security Act, §504(d) (relating to a limitation on administrative expenditures) apply to this award. Of the amounts paid to a state under §503 from an allotment for a fiscal year under §502(c), not more than 10 percent may be used for administering the funds paid under such section. Per Section 511 [42 U.S.C. 711] (i)(2)(C) of the Social Security Act, MIECHV grants need to be administered "in the same manner" as the MCH Block Grant. The administration of the MCH Block Grant is governed by 45 CFR Part 96 which states that "a State shall obligate and expend block grant funds in accordance with the laws and procedures applicable to the obligation and expenditure of its own funds" (45 CFR 96.30(a)). In consequence, grantees will determine which expenses are "administrative" according to the laws and rules of their states.

6. Other Submission Requirements

As stated in Section IV.1, except in very rare cases HRSA will no longer accept applications in paper form. Applicants submitting for this funding opportunity are **required** to submit **electronically** through Grants.gov. To submit an application electronically, please use the APPLY FOR GRANTS section at <http://www.grants.gov>. When using Grants.gov you will be able to download a copy of the application package, complete it off-line, and then upload and submit the application via the Grants.gov site.

It is essential that your organization **immediately register** in Grants.gov and become familiar with the Grants.gov site application process. If you do not complete the registration process you will be unable to submit an application. The registration process can take up to one month.

To be able to successfully register in Grants.gov, it is necessary that you complete all of the following required actions:

- Obtain an organizational Data Universal Numbering System (DUNS) number
- Register the organization with Central Contractor Registration (CCR) (or System for Award Management (SAM) starting July 30, 2012. See Section IV of this document for more SAM details.)
- Identify the organization's E-Business Point of Contact (E-Biz POC)
- Confirm the organization's CCR (or SAM – starting July 30, 2012) “Marketing Partner ID Number (M-PIN)” password
- Register and approve an Authorized Organization Representative (AOR)
- Obtain a username and password from the Grants.gov Credential Provider

Instructions on how to register, tutorials and FAQs are available on the Grants.gov web site at <http://www.grants.gov>. Assistance is also available 24 hours a day, 7 days a week (excluding Federal holidays) from the Grants.gov help desk at support@grants.gov or by phone at 1-800-518-4726. Applicants should ensure that all passwords and registration are current well in advance of the deadline.

It is incumbent on applicants to ensure that the AOR is available to submit the application to HRSA by the published due date. HRSA will not accept submission or re-submission of incomplete, rejected, or otherwise delayed applications after the deadline. Therefore, you are urged to submit your application in advance of the deadline. If your application is rejected by Grants.gov due to errors, you must correct the application and resubmit it to Grants.gov before the deadline date and time. Deadline extensions will not be provided to applicants who do not correct errors and resubmit before the posted deadline.

If, for any reason, an application is submitted more than once prior to the application due date, HRSA will only accept the applicant's last validated electronic submission prior to the application due date as the final and only acceptable submission of any competing application submitted to Grants.gov.

Tracking your application: It is incumbent on the applicant to track their application by using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking your application can be found at <https://apply07.grants.gov/apply/checkApplStatus.faces>. Be sure your application is validated by Grants.gov prior to the application deadline.

V. Application Review Information

1. Review Criteria

Procedures for assessing the technical merit of applications have been instituted to provide for an objective review of applications and to assist the applicant in understanding the standards against which each application will be judged. Critical indicators have been developed for each review criterion to assist the applicant in presenting pertinent information related to that criterion and to provide the reviewer with a standard for evaluation. Review criteria are outlined below with specific detail and scoring points.

Review criteria are used to review and rank applications for the MIECHV Competitive Grant program. This competitive grant application has six (6) review criteria for each type of grant:

1) NEED (10 points) — *Refer to the following Narrative Section(s): ‘Introduction’ and ‘Needs Assessment’*

Building on the targeted community needs assessment and the State Home Visiting Plan, the extent to which the proposal justifies the selection of communities it is proposing to serve (or improvements/enhancements proposed) and the rationale.

In determining the need for the project, the following factor will be considered:

- The extent to which the applicant clearly describes the problem and the proposed intervention.
- The extent to which the applicant provides characteristics of the targeted communities and the estimated number of families to be reached.
- The extent to which the applicant clearly describes the anticipated benefit of the project.

2) RESPONSE (20 points) — *Refer to the following Narrative Section(s): ‘Introduction,’ ‘Methodology,’ ‘Work Plan,’ and ‘Resolution of Challenges’*

(a) Purpose, Goals and Objectives:

The extent to which the proposed project responds to the “purpose” included in the program description as well as the strength of the proposed goals and objectives and the relationship to the identified project. In determining these aspects of the proposal, the following factors will be considered:

- The extent to which the activities described in the application are capable of addressing the problem and attaining the project objectives.
- The extent to which the proposed project has a clear set of goals, objectives, activities, and an explicit strategy (i.e., logic model), that are (i) aligned with the priorities the applicant is seeking to meet, and (ii) expected to result in achieving outcomes of the proposed project.
- The extent to which required partners are identified and show meaningful involvement and support in all proposed activities.

(b) Strength of Evidence:

- In determining alignment with goals and objectives, the following factors will be considered:
 - The alignment of the selected model’s evidence-base with each of the program goals, capacities, and needs of the at-risk community(ies), as identified by the

applicant (Reviewers are looking for proposals that emphasize alignment, not just those that argue that the selected home visiting models have a high-quality evidence-base).

- The applicant's experience with the selected model(s).
- The strength of documented local conditions and capacities that increase the likelihood of successful model implementation.
- The extent to which the effectiveness of the home visiting model(s) selected has been supported by rigorous research and aligns with the applicant's goals and capacities.
- The degree to which the evidence, taken together, supports that the model will improve outcomes for the targeted population consistent with the goals identified by the State.

3) IMPACT (20 points) — *Refer to the following Narrative Section(s): 'Work Plan'*

- The strength of the proposed implementation plan and the extent to which the activities described in the application are capable of:
 - Engaging the community(ies) around the proposed plan.
 - Providing program assessment and support, monitoring, and technical assistance.
 - Providing training and professional development.
 - Recruiting and retaining program participants.
 - Ensuring effective implementation, with fidelity to the model.
 - Collecting benchmark data.

4) EVALUATIVE MEASURES (15 points) — *Refer to the following Narrative Section(s): 'Methodology,' 'Background,' 'Evaluation Technical Support Capacity.'*

The effectiveness of the method proposed to monitor and evaluate the proposed activities. Evaluative measures must be able to assess: 1) the extent to which the program objectives have been met for scale-up or innovations, and 2) the extent to which the attainment of program objectives can be attributed to the project. In determining the quality of the evaluation, the following factors will be considered:

- The extent to which the methods of the evaluation will include a rigorous, well-implemented design.
- The extent to which the methods of the evaluation will provide high quality implementation data and performance feedback.

- The extent to which the proposed project plan includes sufficient resources to effectively carry out the project evaluation.
- The extent to which the proposed evaluation meets the standards of a high or moderate quality study design as defined by the HomVEE²³ review, and is independent.²⁴

5) RESOURCES/CAPABILITIES (25 points) — *Refer to the following Narrative Section(s): ‘Introduction,’ ‘Evaluation Technical Support Capacity,’ and ‘Organizational Information’*

The capabilities of the applicant organization, the facilities, and the personnel to fulfill the needs and requirements of the proposed project. In determining this review criterion, the following factors will be considered:

- The extent to which the applicant has demonstrated commitment to implementing a high-quality home visiting program and successfully embedding the program into a comprehensive, high-quality early childhood system.
- The extent to which the applicant proposes to reach an appropriate number of individuals by the proposed project and has the capacity to reach the proposed number of individuals during the course of the grant period.
- The extent to which the applicant proposes to implement the proposed activity in a manner that considers and responds to the cultural diversity of the targeted communities.
- The extent to which project personnel are qualified by training or experience to implement and carry out the projects.
- The extent to which the applicant demonstrates capacity (e.g., in terms of qualified personnel, financial resources, management capacity) to bring the project to scale on a regional or State-level working directly or through partners.
- The extent to which the applicant demonstrates a commitment to home visiting and the adequacy of resources to continue the proposed project after the grant period ends. The following will be taken into consideration:
 - The extent to which the applicant demonstrates:
 - The resources to operate the project beyond the length of the grant; and
 - Evidence of broad support from stakeholders critical to the project’s long-term success.
 - A plan for incorporating the project’s goals, objectives, and activities into the applicant’s and/or stakeholders’ ongoing efforts at the end of the Federal grant.

²³ See HomVEE Executive Summary: <http://homvee.acf.hhs.gov/document.aspx?rid=5&sid=20&mid=2>.

²⁴ As defined for the purposes of this funding opportunity announcement, in an ‘independent evaluation’, the project implementer does not evaluate the impact of the project.

6) SUPPORT REQUESTED (10 points) — *Refer to the following Narrative Section(s):*
'Budget'

Includes the reasonableness of the proposed budget for each year of the project period in relation to the objectives, the complexity of the research project activities, and the anticipated results. The following will be taken into consideration:

- The extent to which costs, as outlined in the budget and required resources sections, are reasonable given the scope of work; and
- The extent to which key personnel have adequate time devoted to the project to achieve project objectives.

2. Review and Selection Process

The Division of Independent Review is responsible for managing objective reviews within HRSA. Applications competing for Federal funds receive an objective and independent review performed by a committee of experts qualified by training and experience in particular fields or disciplines related to the program being reviewed. In selecting review committee members, other factors in addition to training and experience may be considered to improve the balance of the committee, e.g., geographic distribution. Each reviewer is screened to avoid conflicts of interest and is responsible for providing an objective, unbiased evaluation based on the review criteria noted above. The committee provides expert advice on the merits of each application to program officials responsible for final selections for award.

Applications that pass the initial HRSA eligibility screening will be reviewed and rated by a panel based on the program elements and review criteria presented in relevant sections of this funding opportunity announcement. The review criteria are designed to enable the review panel to assess the quality of a proposed project and determine the likelihood of its success. The criteria are closely related to each other and are considered as a whole in judging the overall quality of an application.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the budget period start date of September 30, 2012.

VI. Award Administration Information

1. Award Notices

Each applicant will receive written notification of the outcome of the objective review process, including a summary of the expert committee's assessment of the application's strengths and weaknesses, and whether the application was selected for funding. Applicants who are selected for funding may be required to respond in a satisfactory manner to conditions placed on their application before funding can proceed. Letters of notification do not provide authorization to begin performance.

The Notice of Award sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-Federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant's Authorized Organization Representative, and reflects the only authorizing document. It will be sent prior to the start date of September 30, 2012.

2. Administrative and National Policy Requirements

Successful applicants must comply with the administrative requirements outlined in 45 CFR Part 74 [Uniform Administrative Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, Other Nonprofit Organizations, and Commercial Organizations](#) or 45 CFR Part 92 [Uniform Administrative Requirements For Grants And Cooperative Agreements to State, Local, and Tribal Governments](#), as appropriate.

HRSA grant and cooperative agreement awards are subject to the requirements of the HHS Grants Policy Statement (HHS GPS) that are applicable based on recipient type and purpose of award. This includes, as applicable, any requirements in Parts I and II of the HHS GPS that apply to the award. The HHS GPS is available at <http://www.hrsa.gov/grants/>. The general terms and conditions in the HHS GPS will apply as indicated unless there are statutory, regulatory, or award-specific requirements to the contrary (as specified in the Notice of Award).

Non-Discrimination Requirements

To serve persons most in need and to comply with Federal law, services must be widely accessible. Services must not discriminate on the basis of age, disability, sex, race, color, national origin or religion. The HHS Office for Civil Rights provides guidance to grant and cooperative agreement recipients on complying with civil rights laws that prohibit discrimination on these bases. Please see <http://www.hhs.gov/ocr/civilrights/understanding/index.html>. HHS also provides specific guidance for recipients on meeting their legal obligation under Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin in programs and activities that receive Federal financial assistance (P.L. 88-352, as amended and 45 CFR Part 80). In some instances a recipient's failure to provide language assistance services may have the effect of discriminating against persons on the basis of their national origin. Please see <http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html> to learn more about the Title VI requirement for grant and cooperative agreement recipients to take reasonable steps to provide meaningful access to their programs and activities by persons with limited English proficiency.

Trafficking in Persons

Awards issued under this funding opportunity announcement are subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104). For the full text of the award term, go to <http://www.hrsa.gov/grants/trafficking.html>. If you are unable to access this link, please contact the Grants Management Specialist identified in this funding opportunity to obtain a copy of the Term.

Smoke-Free Workplace

The Public Health Service strongly encourages all award recipients to provide a smoke-free workplace and to promote the non-use of all tobacco products. Further, Public Law 103-227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

Cultural and Linguistic Competence

HRSA programs serve culturally and linguistically diverse communities and multiple cultures. Although race and ethnicity are often thought to be dominant elements of culture, HRSA funded programs embrace a broader definition to include language, gender, socio-economic status, sexual orientation and gender identity, physical and mental capacity, age, religion, housing status, and regional differences. Organizational behaviors, practices, attitudes, and policies across all HRSA-supported entities respect and respond to the cultural diversity of communities, clients and students served. HRSA is committed to ensuring access to quality health care for all. Quality care means access to services, information, and materials delivered by competent providers in a manner that factors in the language needs, cultural richness, and diversity of populations served. Quality also means that, where appropriate, data collection instruments used should adhere to culturally competent and linguistically appropriate norms. For additional information and guidance, refer to the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) published by HHS and available online at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>. Additional cultural competency and health literacy tools, resources and definitions are available online at <http://www.hrsa.gov/culturalcompetence> and <http://www.hrsa.gov/healthliteracy>.

Healthy People 2020

Healthy People 2020 is a national initiative led by HHS that sets priorities for all HRSA programs. The initiative has four overarching goals: (1) attain high-quality, longer lives free of preventable disease, disability, injury, and premature death; (2) achieve health equity, eliminate disparities, and improve the health of all groups; (3) create social and physical environments that promote good health for all; and (4) promote quality of life, healthy development, and healthy behaviors across all life stages. The program consists of over 40 topic areas, containing measurable objectives. HRSA has actively participated in the work groups of all the topic areas and is committed to the achievement of the Healthy People 2020 goals. More information about Healthy People 2020 may be found online at <http://www.healthypeople.gov/>.

National HIV/AIDS Strategy (NHAS)

The National HIV/AIDS Strategy (NHAS) has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities. The NHAS states that more must be done to ensure that new prevention methods are identified and that prevention resources are more strategically deployed. Further, the NHAS recognizes the importance of early entrance into care for people living with HIV to protect their health and reduce their potential of transmitting the virus to others.

HIV disproportionately affects people who have less access to prevention, care and treatment services and, as a result, often have poorer health outcomes. Therefore, the NHAS advocates adopting community-level approaches to identify people who are HIV-positive but do not know their serostatus and reduce stigma and discrimination against people living with HIV.

To the extent possible, program activities should strive to support the three primary goals of the NHAS. As encouraged by the NHAS, programs should seek opportunities to increase collaboration, efficiency, and innovation in the development of program activities to ensure success of the NHAS. Programs providing direct services should comply with Federally-approved guidelines for HIV Prevention and Treatment (see <http://www.aidsinfo.nih.gov/Guidelines/Default.aspx> as a reliable source for current guidelines). More information can also be found at <http://www.whitehouse.gov/administration/eop/onap/nhas>

Health IT

Health information technology (Health IT) provides the basis for improving the overall quality, safety and efficiency of the health delivery system. HRSA endorses the widespread and consistent use of health IT, which is the most promising tool for making health care services more accessible, efficient and cost effective for all Americans.

Related Health IT Resources:

- [Health Information Technology \(HHS\)](#)
- [What is Health Care Quality and Who Decides? \(AHRQ\)](#)

3. Reporting

The successful applicant under this funding opportunity announcement must comply with the following reporting and review activities:

a. Audit Requirements

Comply with audit requirements of Office of Management and Budget (OMB) Circular A-133. Information on the scope, frequency, and other aspects of the audits can be found on the Internet at http://www.whitehouse.gov/omb/circulars_default.

b. Payment Management Requirements

Submit a quarterly electronic Federal Financial Report (FFR) Cash Transaction Report via the Payment Management System. The report identifies cash expenditures against the authorized funds for the grant or cooperative agreement. The FFR Cash Transaction Reports must be filed within 30 days of the end of each calendar quarter. Failure to submit the report may result in the inability to access award funds. Go to <http://www.dpm.psc.gov> for additional information.

c. Status Reports

1) **Federal Financial Report.** The Federal Financial Report (SF-425) is required within 90 days of the end of each budget period. The report is an accounting of expenditures under the project that year. Financial reports must be submitted electronically through EHB. More specific information will be included in the Notice of Award.

2) **Progress Report(s).** The awardee must submit a progress report to HRSA on an annual basis. Submission and HRSA approval of your Progress Report(s) triggers the budget period renewal and release of subsequent year funds. This report has two parts. The first part demonstrates grantee progress on program-specific goals. The second part collects core performance measurement data including performance

measurement data to measure the progress and impact of the project. Further information will be provided in the award notice.

3) **Final Report(s).** A final report is due within 90 days after the project period ends. The final report collects program-specific goals and progress on strategies; core performance measurement data; impact of the overall project; the degree to which the grantee achieved the mission, goal and strategies outlined in the program; grantee objectives and accomplishments; barriers encountered; and responses to summary questions regarding the grantee's overall experiences over the entire project period. The final report must be submitted on-line by awardees in the Electronic Handbooks system at <https://grants.hrsa.gov/webexternal/home.asp>.

d. Transparency Act Reporting Requirements

New awards ("Type 1") issued by HRSA are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act (FFATA) of 2006 (Pub. L. 109–282), as amended by section 6202 of Public Law 110–252, and implemented by 2 CFR Part 170. Grant and cooperative agreement recipients must report information for each first-tier subaward of \$25,000 or more in Federal funds and executive total compensation for the recipient's and subrecipient's five most highly compensated executives as outlined in Appendix A to 2 CFR Part 170 (FFATA details are available online at <http://www.hrsa.gov/grants/ffata.html>). Competing continuation awardees, etc. **may** be subject to this requirement and will be so notified in the Notice of Award.

VII. Agency Contacts

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this funding opportunity announcement by contacting:

Mickey Reynolds
Grants Management Specialist
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 11A-02
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-0724
Fax: (301) 443-6686
Email: mreynolds@hrsa.gov

Additional information related to the overall program issues or technical assistance regarding this funding announcement may be obtained by contacting:

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
Parklawn Building, Room 10-64
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-4292

Email: ayowell@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. Applicants should always obtain a case number when calling for support. For assistance with submitting the application in Grants.gov, contact Grants.gov 24 hours a day, seven days a week, excluding Federal holidays at:

Grants.gov Contact Center
Telephone: 1-800-518-4726
E-mail: support@grants.gov
iPortal: <http://grants.gov/iportal>

VIII. Other Information

1. Models That Meet The HHS Criteria for Evidence of Effectiveness

As of the date of release of this funding opportunity announcement, the following models meet the criteria for evidence of effectiveness for the MIECHV program (as described above). HHS intends to continue to review the available evidence of effectiveness for other home visiting models and, as described above, will review models that have not been reviewed at the request of a State and will re-review models that were determined not to meet the evidence-based criteria at the request of a State, model developer, researcher, or others.

All states will be notified of determinations made as a result of a request for a review or re-review of a program model.

As noted, extensive information about these and other programs that have been reviewed is available on the HomVEE website (<http://www.acf.hhs.gov/programs/opre/homvee>).

(Note: Models are listed alphabetically)

Child FIRST

Population Served: Child FIRST provides services to pregnant women and families with children from birth to age 6 years, in cases in which the child has emotional, behavioral, or developmental concerns or the family faces multiple risks that are likely to lead to negative child outcomes. Families are served without regard for ability to pay, legal status, or number of children in the family.

Program Focus: The goal of Child FIRST is to decrease the incidence of emotional and behavioral disturbance, developmental and learning problems, and abuse and neglect among high-risk young children and their families. The Child FIRST model is based on the most current research on brain development, which shows that extremely high-stress environments (including poverty, maternal depression, domestic violence, abuse and neglect, substance abuse, and homelessness) are “toxic” to the developing brain of the young child. The presence of a nurturing, consistent, and contingent parent-child relationship is able to buffer and protect the brain from these damaging insults.

Early Head Start – Home-Based Option

Population served: Early Head Start (EHS) targets low-income pregnant women and families with children birth to age three years, most of whom are at or below the Federal poverty level or who are eligible for Part C services under the Individuals with Disabilities Education Act in their State.

Program focus: The program focuses on providing high quality, flexible, and culturally competent child development and parent support services with an emphasis on the role of the parent as the child's first, and most important, relationship. EHS programs include home- or center-based services, a combination of home- and center-based programs, and family child care services (services provided in family child care homes).

Early Intervention Program for Adolescent Mothers

Population served: The Early Intervention Program (EIP) targeted pregnant Latina and African American adolescents who were referred to the county health department for public health nursing care. The women were eligible for EIP if they were 14 to 19 years of age; no more than 26 weeks gestation; pregnant with their first child; and planning to keep the infant. Expectant mothers who were chemically dependent or had serious medical or obstetric problems were ineligible.

Program Focus: EIP was designed to help young mothers gain social competence and achieve program objectives. The construct of social competence was conceived to have two facets: internal and external. EIP aimed to improve internal competence—the mother's ability to manage her inner world—through training in self-management skills and techniques for coping with stress and depression. EIP aimed to improve external competence—the mother's ability to interact effectively with partners, family, peers, and social agencies—through training in communication and social skills.

Family Check-Up

Population served: Family Check-Up is designed as a preventative program to help parents address typical challenges that arise with young children before these challenges become more serious or problematic. The target population for this program includes families with risk factors including: socioeconomic; family and child risk factors for child conduct problems; academic failure; depression; and risk for early substance use. Families with children age 2 to 17 years old are eligible for Family Check-Up.

Program focus: The program focuses on the following outcomes: (1) child development and school readiness and (2) positive parenting practices.

Healthy Families America (HFA)

Population served: HFA is designed for parents facing challenges such as single parenthood, low income, childhood history of abuse, substance abuse, mental health issues, or domestic violence. Individual programs select the specific characteristics of the target population they plan to serve. Families must be enrolled prenatally or within the first three months after a child's birth. Once enrolled, services are provided to families until the child enters kindergarten.

Program focus: HFA aims to (1) reduce child maltreatment; (2) increase use of prenatal care; (3) improve parent-child interactions and school readiness; (4) ensure healthy child development; (5) promote positive parenting; (6) promote family self-sufficiency and decrease dependency on welfare and other social services; (7) increase access to primary care medical services; and (8) increase immunization rates.

Healthy Steps

Population served: Healthy Steps is designed for parents with children from birth to age 30 months. Healthy Steps can be implemented by any pediatric or family medicine practice. Residency training programs can also implement Healthy Steps. Community health organizations, private practices, hospital based clinics, child health development organizations, and other types of clinics can also become Healthy Steps sites if a health care clinician is involved and the site is based in or linked to a primary health care practice. Any family served by the participating practice or organization can be enrolled in Healthy Steps.

Program focus: The program focuses on the following outcomes: (1) child development and school readiness; and (2) positive parenting practices.

Home Instruction for Parents of Preschool Youngsters (HIPPY)

Population served: Home Instruction for Parents of Preschool Youngsters (HIPPY) aims to promote preschoolers' school readiness by supporting parents in the instruction provided in the home. The program is designed for parents who lack confidence in their ability to prepare their children for school, including parents with past negative school experiences or limited financial resources. HIPPY offers weekly activities for 30 weeks of the year, alternating between home visits and group meetings (two one-on-one home visits per month and two group meetings per month). HIPPY sites are encouraged to offer the three-year program serving three to five year olds, but may offer the two-year program for four to five year olds. The home visiting paraprofessionals are typically drawn from the same population that is served by a HIPPY site, and each site is staffed by a professional program coordinator who oversees training and supervision of the home visitors.

Program focus: Home Instruction for Parents of Preschool Youngsters aims to promote preschoolers' school readiness.

Nurse-Family Partnership (NFP)

Population served: The Nurse-Family Partnership (NFP) is designed for first-time, low-income mothers and their children. It includes one-on-one home visits by a trained public health nurse to participating clients. The visits begin early in the woman's pregnancy (with program enrollment no later than the 28th week of gestation) and conclude when the woman's child turns two years old. During visits, nurses work to reinforce maternal behaviors that are consistent with program goals and that encourage positive behaviors and accomplishments. Topics of the visits include: prenatal care; caring for an infant; and encouraging the emotional, physical, and cognitive development of young children.

Program focus: The Nurse-Family Partnership program aims to improve maternal health and child health; improve pregnancy outcomes; improve child development; and improve economic self-sufficiency of the family.

Parents as Teachers

Population served: The goal of the Parents as Teachers (PAT) program is to provide parents with child development knowledge and parenting support. The PAT model includes home visiting for families and professional development for home visiting. The home visiting component of PAT provides one-on-one home visits, group meetings, developmental screenings, and a resource network for families. Parent educators conduct the home visits, using the Born to Learn curriculum. Local sites decide on the intensity of home visits, ranging from weekly to monthly and the duration during which home visiting is offered. PAT may serve families from pregnancy to kindergarten entry.

Program focus: The Parents as Teachers program aims to provide parents with child development knowledge and improve parenting practices.

2. List of Required and Recommended Partners

Both the initial announcement (HRSA-10-275) and the subsequent Supplemental Information Requests required sign-off by the agencies listed below. For purposes of meeting requirements of this competitive funding opportunity announcement, states must provide evidence of substantive involvement in the project planning, implementation, and evaluation by representatives of the agencies listed below:

- Director of the State's Title V agency;
- Director of the State's agency for Title II of the Child Abuse Prevention and Treatment Act (CAPTA);
- The State's child welfare agency (Title IV-E and IV-B), if this agency is not also administering Title II of CAPTA;
- Director of the State's Single State Agency for Substance Abuse Services;
- The State's Child Care and Development Fund (CCDF) Administrator;
- Director of the State's Head Start State Collaboration Office; and
- The State Advisory Council on Early Childhood Education and Care authorized by 642B(b)(1)(A)(i) of the Head Start Act.
- The State's Medicaid/Children's Health Insurance program (or the person responsible for Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program).

To ensure that home visiting is part of a continuum of early childhood services, HRSA and ACF also strongly urge states to seek consensus from:

- The State's Individuals with Disabilities Education Act (IDEA) Part C and Part B Section 619 lead agency(ies);
- The State's Elementary and Secondary Education Act Title I or State pre-kindergarten program; and

The State is encouraged to coordinate this application to the extent possible with:

- The State's Domestic Violence Coalition;

- The State’s Mental Health agency;
- The State’s Public Health agency, if this agency is not also administering the State’s Title V program;
- The State’s identified agency charged with crime reduction;
- The State’s Temporary Assistance for Needy Families agency;
- The State’s Supplemental Nutrition Assistance Program agency; and
- The State’s Injury Prevention and Control (Public Health Injury Surveillance and Prevention) program (if applicable).

3. Public Burden Statement

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0351. Public reporting burden for this collection of information is estimated to average 45 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-29, Rockville, Maryland, 20857.

IX. Tips for Writing a Strong Application

A concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at:

<http://www.hhs.gov/asrt/og/grantinformation/apptips.html>.

APPENDIX A: MIECHV PROGRAMMATIC EMPHASIS AREAS

As previously mentioned, HRSA and ACF have identified the following areas of emphasis as important components of a home visiting program or system, and of a comprehensive, high-quality early childhood system:

Emphasis 1: Improvements in maternal, child, and family health. Such innovations may include, but are not limited to, the following:

- Home visiting to women at high medical risk;
- Interconception care and counseling;
- The provision of mental health services;
- Obesity prevention;
- Establishing a medical home;
- Tobacco cessation programs;
- Behavioral health (including services for substance abusing caregivers);
- Engaging health service providers in at-risk communities to encourage identification and referral of pregnant women, young children, and families to home visiting programs;
- Fostering partnerships between home visiting programs and other State and local partners to reduce health disparities;
- Innovations to address child development within the framework of life course development and a socio-ecological perspective; or,
- Innovations to support the use of technology in delivery of home visiting services.

Emphasis 2: Effective implementation and expansion of evidence-based home visiting programs or systems with fidelity to the evidence-based model selected.

Such innovations may include, but are not limited to, the following:

- Supporting, recruiting, training, and retaining staff;
- High-quality supervision;
- Recruiting and retaining participants; or
- Building strong local organizational and management capacity for implementation (e.g., innovations regarding fidelity assessment, monitoring and continuous quality improvement, training and technical assistance, and other quality improvement strategies to support high quality statewide implementation).

Emphasis 3: Development of statewide or multi-State home visiting programs.

These innovations may include, but are not limited to, the following:

- Developing cross-model program standards;
- Developing core competencies for home visitors and supervisors;
- Integrated home visiting data systems;
- Common benchmarks across models or states;
- Centralized intake systems; or
- Integrating home visiting services with other medical services (e.g., community health centers, medical homes, etc.).

Emphasis 4: Development of comprehensive early childhood systems that span the prenatal-through-age-eight continuum. These innovations may include, but are not limited to, the following:

- Integrated early childhood data systems that include home visiting programs;
- Coordinated early childhood workforce and professional development systems that include home visitors (including career ladders and pathways, and centralized professional development and training systems);
- The use of home visiting as a “hub” for the development of local place-based early childhood systems that leverage public-private partnerships, data and measurement tools (such as the Early Development Instrument (EDI)); and
- Centralized intake and referral systems to facilitate coordinated strategic planning and service delivery to improve the community environment and support positive child and family health, learning, and development outcomes.

Emphasis 5: Outreach to high-risk and hard-to-engage populations. These innovations may include, but are not limited to, the following:

- Families at greatest risk for negative outcomes related to child maltreatment, substance abuse, domestic violence, or other adversities;
- Families with children involved with the child welfare system;
- Families with dual language learner children;
- Children with developmental delays; parents with disabilities; or
- Families with members in the Armed Forces.

Emphasis 6: Development of a family-centered approach to home visiting. These innovations may include, but are not limited to, the following:

- Engagement of fathers;
- Engagement of non-custodial parents; or
- Engagement of other primary caregivers including grandparents, other relatives and kinship caregivers, or foster parents.

Emphasis 7: Outreach to families in rural or frontier areas through home visiting programs.

Emphasis 8: The development of fiscal leveraging strategies to enhance program sustainability. These innovations may include, but are not limited to, the following:

- Public/private partnerships;
- Medicaid reimbursement; or
- Medicaid/CHIP partnerships.

APPENDIX B: SPECIFIC GUIDANCE REGARDING INDIVIDUAL BENCHMARK AREAS

Listed below are the given constructs under each of the six legislatively mandated benchmark areas for which performance measures need to be proposed and tracked. Under each benchmark area, we offer illustrations and comments relevant to the constructs listed. These examples and suggestions are organized under the following generally accepted steps involved in indicator development: A) name and type of performance measure, B) operational definition, C) measurement tool utilized or question(s) posed, D) definition of measurable improvement, and E) plan for data collection and analysis).

I. Improved Maternal and Newborn Health

A. Name of performance measure

Constructs for which performance data must be reported under this benchmark area follow (all constructs must be measured that are relevant for the population served; if newborns are not being served, constructs related to birth outcomes will not need to be reported):

- Prenatal care
- Parental use of alcohol, tobacco, or illicit drugs
- Preconception care
- Inter-birth intervals
- Screening for maternal depressive symptoms
- Breastfeeding
- Well-child visits
- Maternal and child health insurance status (note: these data may also be utilized under the family economic self-sufficiency benchmark area)

B. Operational definition

- Percentages and rates are frequent metrics utilized for indicators corresponding to the above constructs. Examples include the percentage of children birth-to-age-three in families participating in the program who receive the recommended schedule of well-child visits during the reporting period or the percentage of mothers enrolled in the program prenatally who breastfeed their infants at six months of age.
- For certain constructs under benchmark area I, such as breastfeeding, smoking for pregnant women or prenatal care, grantees may select performance measures currently operationally defined and utilized for federal reporting under Title V Maternal and Child Health Block Grant. For information about these performance measures see:
 - <https://perfddata.hrsa.gov/MCHB/TVISReports/MeasurementData/MeasurementDataMenu.aspx>

- For information on other nationally utilized indicators under this benchmark area (e.g., well child visits, maternal depression screening, health insurance coverage), see the list of measurement standards endorsed by the National Quality Forum (such as NQF # 1401, NQF #1332, NQF # 1392, NQF # 0723) at http://www.qualityforum.org/Measures_List.aspx#.
- See also *Healthy People 2020* at <http://www.healthypeople.gov/hp2020>.

C. Measurement tools utilized or questions posed

- For constructs such as depression screening that require a measurement tool grantees may define their program performance measure in such a way that accommodates the use of different scales by individual home visiting models as long as all scales utilized are considered valid and reliable for the construct and population of interest.
- Grantees should articulate the question(s) posed to participants to capture constructs that do not require a measurement tool (e.g., timing of the first prenatal care visit or actual duration of inter-birth interval).

D. Definition of measurable improvement

- For prenatal care, preconception care, inter-birth intervals, screening of maternal depression, breastfeeding, adequacy of well-child visits, and health insurance coverage, increases over time for participating mothers and infants or maintenance would constitute instances of improvement. As with other benchmark areas, once an acceptable level is reached, maintenance of performance at or above that threshold (during a period to consolidate the gains achieved) could also count as improvement for a given construct.
- For pre- and post-natal parental use of alcohol, tobacco, or illicit drugs decreases in use over time would indicate improvement. A reduction in the percentage of adult participants who use alcohol, illicit drugs or tobacco may be documented for the same population or across different cohorts of participants. Alternatively, an illustration of improvement utilizing a process measure for this construct would be an increase in the rate of screening among program participants to assess use of these substances noted between the baseline year and a subsequent year.

E. Data collection plan

- Data for the constructs under this benchmark area can be collected from interviews with family members, from observations by the home visitor or through administrative data, if available, at the individual and family level.

II. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits

A. Name of performance measure

Constructs that must be captured and reported under this benchmark area are:

- Visits for children to the emergency department from all causes

- Visits of mothers to the emergency department from all causes
- Information provided or training of adult participants on prevention of child injuries including topics such as safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety (e.g., drowning; unsafe levels of lead in tap water), and playground safety
- Incidence of child injuries requiring medical treatment
- Reported suspected maltreatment for children in the program (allegations that were screened in by the child protective service agency but not necessarily substantiated)
- Reported substantiated maltreatment (substantiated/indicated/alternative response victim) for children in the program
- First-time victims of maltreatment for children in the program

B. Operational definition

- For reductions in emergency department visits: the operational definition could include emergency department visits divided by the number of children or mothers enrolled in the program.
- For training or information related to child injury prevention: the construct may be reported as the percentage of participants who receive information or training on injury prevention by the total number of families participating in the program. Criteria for what constitutes adequate training or information should be spelled out (i.e., operationalized).
- For reduction of incidence of child injuries: The performance measure selected would likely include child injuries requiring medical treatment (i.e., ambulatory care, emergency department visits or hospitalizations) for children participating in the program.
- For child abuse, neglect and maltreatment, the denominator used in the calculation of the rate or percentage in the definition could include all children participating in the program.
 - The rate for **suspected maltreatment** is the number of cases of suspected maltreatment of children in the program, divided by the number of children in the program.
 - The rate for **substantiated maltreatment** should be calculated by counting the number of cases of substantiated maltreatment of children in the program and dividing by the number of children in the program.
 - To calculate the rate of **first-time victims** count the number of children in the program who are first-time victims divided by the total number of enrolled children in the program. A first time victim is defined as a child who:
 - had a maltreatment disposition of “victim” and
 - never had a prior disposition of victim.

- Demographic data should be broken down for each relevant construct in this benchmark area by age category of participating children (i.e., under 1 year, 1-3 years, and 3-5 years)²⁵
 - For child abuse, neglect or maltreatment only: by maltreatment type (i.e., neglect, physical abuse, sexual abuse, emotional maltreatment, other).

C. Measurement tools or questions posed to participants

- Injury-related medical treatment includes ambulatory care, emergency department visits, and hospitalizations due to injury or ingestions.
- For child abuse, neglect and maltreatment it is preferred that data be collected through administrative data provided by the State and local child welfare agencies. Grantees may propose collecting the data through self-report or direct measurement if the assessment utilizes a valid and reliable tool.
- Please see the Compendium issued by HRSA and ACF for resources and measurement tools for this and other benchmark areas.²⁶

For additional information on child injury and maltreatment, see:

- List of the State contacts for National Child Abuse and Neglect Data System collection, available at:
<http://www.acf.hhs.gov/programs/cb/pubs/cm08/appendd.htm>
- Child Maltreatment: <http://www.acf.hhs.gov/programs/cb/pubs/cm08>
- National Data Archive on Child Abuse and Neglect (NDACAN):
<http://www.ndacan.cornell.edu>.
- Centers for Disease Control Injury Prevention:
http://apps.nccd.cdc.gov/NCIPC_SII/Default/Default.aspx?pid=2
- National Health Survey:
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2010/english
- Children's Safety Network and Child Death Review Resource Center's Best Practices website: www.childinjuryprevention.org
- State Injury Prevention Profiles:
<http://www.childrensafetynetwork.org/Stateprofiles/State.asp>

²⁵ Age is expressed x-y, meaning for example that 3-5 years includes age 3 through to age 5 but not including age 6).

²⁶ http://www.mdrc.org/dohve/dohve_resources.html

D. Definition of measurable improvement

- Improvement for individual performance measures under this benchmark area would include decreases over time for constructs other than information provided or training on preventing child injuries, for which an increase over time would count as improvement.

E. Data collection plan

- For reductions in emergency department visits and child injury prevention: data source options include participant report, medical records, emergency department patient records or hospital discharge systems.

III. Improvements in School Readiness and Achievement

A. Name of performance measure

Constructs for which an indicator must be selected and reported under this benchmark area are:

- Parent support for children's learning and development (e.g., having appropriate toys available, talking and reading with their child)
- Parent knowledge of child development and of their child's developmental progress
- Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)
- Parent emotional well-being or parenting stress (note: some of these data may also be captured for maternal health under benchmark area I)
- Child's communication, language and emergent literacy
- Child's general cognitive skills
- Child's positive approaches to learning including attention
- Child's social behavior, emotion regulation, and emotional well-being
- Child's physical health and development

For more information see:

- http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/index.html
- http://eclkc.ohs.acf.hhs.gov/hslc/ecdh/eecd/Assessment/Child%20Outcomes/educ_art_00090_080905.html
- Kagan, S. L., Moore, E., & Bradekamp, S. (1995). Reconsidering children's early development and learning: Toward common views and vocabulary. Washington, DC: National Education Goals Panel, Goal 1 Technical Planning Group. (See Child Trends summary here: http://www.childtrends.org/schoolreadiness/testsr.htm#_Toc502715209)

B. Operational definition

- Depending on the measure selected and the grantee plan for using the data, the definition of the performance measure could incorporate scale scores and thresholds when available. A score would be the calculated score for the individual scale utilized. The scale scores should be calculated as instructed in the manual or other documentation provided by the measurement tool developer. The operational definition for the performance measures under this benchmark area could center on, for instance, the percentage of participants who are screened as at risk at a point in time (e.g., the proportion of enrolled children screened at age one during the reporting period who appear at risk for language delay).

C. Measurement tools or questions posed to participants

- Suggested ideas or sources for scales within the area of “Improvements in School Readiness and Achievement” are included in the Compendium of measurement tools or scales issued by HRSA and ACF mentioned above, which can be found at http://www.mdrc.org/dohve/dohve_resources.html.

D. Definition of measurable improvement

- For example, an increase over time (e.g., between baseline year 1 and year 3) in the screening rates for children of a certain age (e.g., one year old) enrolled in the program would constitute an instance of improvement utilizing a process measure (in this case involving a comparison across cohorts).
- For example, the reduction between two assessment points in the percentage of enrolled children (who are screened utilizing age-appropriate scales) at risk of developmental delays would show desirable change utilizing an outcome measure.

E. Data collection plan

- Data can be collected from a variety of sources including observation (e.g., by teacher, home visitor or other independent observer), direct assessment with a measurement tool, administrative data or health records (e.g. program-specific clinical information systems), parent-report, or teacher-report.

IV. Crime or Domestic Violence

The legislation includes a requirement for States to report on reduction in “crime or domestic violence.” States are not required to report on both domains, but must report on at least one.

Crime

A. Name of performance measure

If the grantee chooses to report crime, constructs that must be reported for this benchmark area for caregivers served by the home visiting program are:

- Arrests
- Convictions

B. Operational definition

- Data may be reported as annual aggregate rates for adults participating in the program.

C. Measurement tools

- Questions posed could distinguish the reason for the arrest or conviction.

D. Definition of measurable improvement

- For family-level crime rates, improvement may be defined as rate decreases over time in the arrests and/or convictions.

E. Data collection plan

- Data may be collected from interviews and surveys with families (i.e. with validated and reliable instruments) or through administrative data if available at the individual level.

Domestic Violence

A. Name of performance measure

If the grantee chooses to report on domestic violence, constructs for which performance measures must be reported under this benchmark area (all constructs must be measured) include:

- Screening for domestic violence
- Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters)
- Of families identified for the presence of domestic violence, number of families for which a safety plan was completed

B. Operational definition

- Depending on the measure used for each construct and the grantee plan for using the data, the data reported could incorporate the following:
 - Percentage of screenings for domestic violence of program participants.
 - With respect to referrals and safety plans, indicators for these constructs that are scored as percentages could include in the numerator the number of referrals to appropriate identified services and the number of safety plans completed respectively; the denominator would include the total number of identified participants in need of these services.

C. Measurement tools or questions

- For more information please see the Compendium of measures at http://www.mdrc.org/dohve/dohve_resources.html.

D. Definition of measurable improvement

- For screenings, improvement could be defined as increases in the percentage of participants screened over time.
- For referrals related to domestic violence, improvement could be defined as an increase in the proportion of participants referred over time.
- For completion of safety plans related to domestic violence, improvement could be defined as an increase over time in the proportion of completed plans for participants who need them.

E. Data collection plan

- For family-level data, data can be collected from interviews and surveys with families using either administrative data or reliable and valid measures.

For more information see:

- http://www.mdrc.org/dohve/dohve_resources.html
- http://www.cdc.gov/ncipc/dvp/Compendium/Measuring_IPV_Victimization_and_Perpetration.htm
- <http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/datasources.html>

V. Family Economic Self-Sufficiency.

A. Name of performance measure

Constructs for which performance measures must be reported under this benchmark area (all constructs must be measured) are:

- Household income (including earnings, cash benefits, and in-kind and non-cash benefits)
- Employment or education of participating adults
- Health insurance status of participating adults and children

B. Operational definition

- Household includes the person(s) enrolled in the home visiting program funded by MIECHV. At a minimum this category should include the primary enrolled adult in the home visiting program. This unit of analysis can extend to more than one member of the household if more than one adult are enrolled in the program, participate in home visits or otherwise contribute to the support of the index child or pregnant woman.

- Income is defined as estimated earnings from work, plus other sources of cash support. These sources may be private, e.g., rent from tenants/boarders, cash assistance from friends or relatives, or they may be linked to public systems, i.e. child support payments, TANF, Social Security (SSI/SSDI/OAI), and Unemployment Insurance. In-kind benefits include non-cash benefits such as nutrition assistance programs (including SNAP, WIC, etc), energy assistance, housing vouchers, etc. and could be estimated as the value of the benefit received.

C. Measurement tools or questions

- Programs may collect all sources of income and the amount gathered from each source. Alternatively, grantees could report on the aggregate amount received from all sources during the reporting period by the adults in the household participating in the program.
- For in-kind and non-cash benefits, programs should capture program participation among eligible participant households. At their discretion, programs can collect/impute the value of in-kind benefits and add such benefits as a source of income. In either case, HHS strongly recommends that home visitors discuss with participants available benefits for which the family may qualify.
- With respect to employment, grantees should collect the number of months employed in a year or the average hours per month worked by those participating adults.
- With respect to educational achievement, data collected should include either program completion/degree attainment or hours per month spent by participating adult household member in educational programs.
- Include health insurance status of all participants in the program or, at a minimum, of index child and primary enrolled adult.

D. Definition of measurable improvement

- For household income, improvement could be defined as: an increase in total household income over time; or an increase in income from earnings or employment; or an increase in the take-up of in-kind benefits among program participants; or an increase in the total amount of income and the value of in-kind benefits.
- Note: The second construct above refers to employment *or* education. We recognize that there can be an inverse relationship between the two in the short-run, i.e., while people are pursuing education, they may reduce their participation in the labor force, and vice versa. Therefore, sites should measure both of these related components but reporting on and improvement in one or the other shall be considered sufficient to show positive results for this construct.
 - For employment, improvement could be defined as an increase between two comparison points in time in the number of paid hours worked plus (up to 30) unpaid hours devoted to care of an infant by all participating adults.
 - For education, improvement could be defined as an increase in the educational attainment of participating adults over time or hours per month spent by participating adult household members in educational programs. Educational attainment may be

defined by the completion not only of academic degrees, but also of training or certification programs.

- For health insurance status, improvement could be defined as an increase over time in the number of participating household members (or at a minimum of the index child and primary enrolled adult) who have adequate health insurance or maintenance of adequate insurance coverage for all participants.

E. Data collection plan

- Data may come from interviews or surveys with families. Data on child support and public benefit receipt may be gathered or verified from the relevant agencies, if data-sharing agreements can be developed. For employment, family-level data may also be gathered or verified using Unemployment Insurance data.
- For the purposes of Federal reporting, family economic self-sufficiency data would be collected for the month of enrollment and the month one-year post enrollment.

The following are suggested sources for ideas, questions or measures within the area of “Family Self-Sufficiency:”

- “Observations from the Interagency Technical Working Group on Developing a Supplemental Poverty Measure,” March 2010, http://www.census.gov/hhes/www/povmeas/SPM_TWGObservations.pdf.
- “National Directory of New Hires,” <http://www.acf.hhs.gov/programs/cse/newhire/ndnh/ndnh.htm>
- Evaluation Data Coordination Project http://www.acf.hhs.gov/programs/opre/other_resrch/eval_data/index.html

VI. Coordination and Referrals for Other Community Resources and Supports

For the purposes of the measurement system for improvement in home visiting, referrals include both internal referrals (to other services provided by the local agency implementing the program) and external referrals (to services provided in the community but outside of the local agency). As part of their initial and ongoing needs assessments, grantees should track the number of services available and appropriate for the participants in the program. The constructs related to coordination include capturing linkages both at the agency and the individual family level.

A. Name of performance measure

Constructs for which performance measures must be reported under this benchmark area are:

- Number of families identified for necessary services;
- Number of families that required services and received a referral to available community resources;

- Number of completed referrals (i.e., the home visiting provider is able to track individual family referrals and assess their completion, e.g., by obtaining a report of the service provided);
- MOUs: Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community; and
- Information sharing: Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies.

B. Operational definition

- With respect to families identified for necessary services, a percentage could be calculated, for example, as the number of families screened divided by the total number of families enrolled in the program during the reporting period. The need or needs for which participants are screened and the corresponding services provided should be defined.
- For families that required a specific service and received the appropriate referral, the performance measure could be calculated as a percentage (with the numerator and denominator respectively being the number of families who received the referral and the total number of families or participants identified as needing the service of interest).
- For completed referrals, the definition of the performance measure could involve the proportion of referrals of participating families with identified needs whose receipt of service was verified divided by the total number of participating families with identified needs or by the total number of families who received a referral from the home visitor.
- With respect to formal agreements and communications with other agencies, grantees could report the total number of social service agencies with which the implementing agencies have an MOU and/or regular communication.

C. Measurement tools and/or questions posed to participants

For resources and examples of measures in this benchmark area, please see the *Optional Tool for the Measurement of Coordination and Referral Benchmark Constructs* issued by HRSA and ACF and available at http://www.mdrc.org/dohve/dohve_resources.html.

D. Definition of measurable improvement

- A meaningful definition of improvement for the first construct would involve an increase in the proportion of families screened for needs, particularly those relevant for affecting participant outcomes.
- For families in need of specific services, program improvement would entail an increase over time in the proportion of families identified with a need who receive an appropriate referral, when there are services available in the communities.
- For number of completed referrals: Increase in the percentage of families or individual participants with referrals for whom receipt of services can be confirmed.

- For MOUs: Increase in the number of formal agreements with other social service agencies.
- Information sharing: Increase in the number of social service agencies that engage in regular communication with the home visiting provider.

E. Data collection plan

- Data for each of the constructs can be collected through direct measurement by the home visitors and/or administrative data provided by the local agency.