

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

Maternal and Child Health Bureau
Division of MCH Workforce Development

Developmental-Behavioral Pediatrics Training Program

Announcement Type: New, Competing Continuation

Announcement Number: HRSA-13-137

Catalog of Federal Domestic Assistance (CFDA) No. 93.110

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2013

Application Due Date: August 21, 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: June 21, 2012

Issuance Date: June 22, 2012

Modification 7/25/12 – to amend the period of reporting in Attachment 6: Summary Progress Report

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Authority: Public Health Service Act, §399BB(e)(1), (codified at 42 U.S.C. 280i-1(e)(1)) and the Combating Autism Act of 2006 (P.L. 109–416), as amended by the Combating Autism Reauthorization Act of 2011 (P.L. 112–32).

EXECUTIVE SUMMARY

Thank you for your interest in applying for the Developmental-Behavioral Pediatrics (DBP) Training Program. Grant support is available from the Division of MCH Workforce Development, part of the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services (HHS). We are aware that preparation of this application will involve a considerable commitment of time and energy. Please read the funding opportunity announcement carefully before completing the application.

Purpose:

The purpose of the Developmental-Behavioral Pediatrics Training Program is to enhance behavioral, psychosocial, and developmental aspects of pediatric care. This is to be accomplished through: 1) support for fellows in developmental-behavioral pediatrics preparing for leadership roles as teachers, investigators, and clinicians advancing the field of developmental/behavioral pediatrics; and 2) providing pediatric practitioners, residents, and medical students with essential biopsychosocial knowledge and clinical expertise. Trainees in this program should: receive an appropriate balance of academic, clinical, and community opportunities; work towards being culturally competent; and demonstrate a capacity to evaluate, diagnose or rule out, develop, and provide evidence-based interventions to individuals with autism spectrum disorders (ASD) and other developmental disabilities (DD) after completion of their clinical training; and demonstrate an ability to use a family-centered approach. (Combating Autism Act of 2006 (P.L. 109–416), as amended by the Combating Autism Reauthorization Act of 2011 (P.L. 112–32)).

Number of Grants and Funds Available per Year:

Up to \$1,861,000 may be available to fund up to 10 DBP grants and one annual program meeting. It is anticipated that the **median** grant award will be approximately \$182,600 per budget period for up to five (5) years.

Project Period:

Approved projects will have a budget period start date of July 1, 2013. Applicants responding to this announcement may request funding for a project period of up to five (5) years.

Application Due Date: August 21, 2012

Programmatic Assistance:

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

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Business, Administrative and Fiscal Inquiries:

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

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Table of Contents

I. FUNDING OPPORTUNITY DESCRIPTION	1
1. PURPOSE.....	1
2. BACKGROUND	1
II. AWARD INFORMATION	4
1. TYPE OF AWARD	4
2. SUMMARY OF FUNDING.....	4
III. ELIGIBILITY INFORMATION.....	5
1. ELIGIBLE APPLICANTS.....	5
2. COST SHARING/MATCHING	5
3. OTHER	5
IV. APPLICATION AND SUBMISSION INFORMATION.....	5
1. ADDRESS TO REQUEST APPLICATION PACKAGE.....	5
2. CONTENT AND FORM OF APPLICATION SUBMISSION.....	7
i. <i>Application Face Page</i>	13
ii. <i>Table of Contents</i>	13
iii. <i>Budget</i>	13
iv. <i>Budget Justification</i>	14
v. <i>Staffing Plan and Personnel Requirements</i>	16
vi. <i>Assurances</i>	17
vii. <i>Certifications</i>	17
viii. <i>Project Abstract</i>	17
ix. <i>Project Narrative</i>	18
x. <i>Program Specific Forms</i>	32
xi. <i>Attachments</i>	33
3. SUBMISSION DATES AND TIMES.....	35
4. INTERGOVERNMENTAL REVIEW	35
5. FUNDING RESTRICTIONS.....	35
6. OTHER SUBMISSION REQUIREMENTS	37
V. APPLICATION REVIEW INFORMATION	38
1. REVIEW CRITERIA.....	38
2. REVIEW AND SELECTION PROCESS	41
3. ANTICIPATED ANNOUNCEMENT AND AWARD DATES	42
VI. AWARD ADMINISTRATION INFORMATION.....	42
1. AWARD NOTICES	42
2. ADMINISTRATIVE AND NATIONAL POLICY REQUIREMENTS.....	42
3. REPORTING	45
VII. AGENCY CONTACTS	47
VIII. OTHER INFORMATION.....	48
IX. TIPS FOR WRITING A STRONG APPLICATION.....	49
APPENDIX A: MCHB ADMINISTRATIVE FORMS AND PERFORMANCE MEASURES.....	50
APPENDIX B: TRAINEE/FELLOW GUIDELINES	109
APPENDIX C: MCH DBP TRAINING GRANTS BY STATE, 2011	112
APPENDIX D: KEY ELEMENTS OF COLLABORATIVE OFFICE ROUNDS (COR)	113

I. Funding Opportunity Description

1. Purpose

In 1999 the field of developmental-behavioral pediatrics reached a new milestone, when the American Board of Medical Specialties approved specialty certification status for developmental-behavioral pediatrics. The intent of the Developmental-Behavioral Pediatrics Training Program is to build upon past successes, to train the next generation of leaders in developmental-behavioral pediatrics and to provide pediatric practitioners, residents and medical students with essential biopsychosocial knowledge and clinical expertise.

The purpose of the Developmental-Behavioral Pediatrics Training Program is to enhance behavioral, psychosocial, and developmental aspects of pediatric care. This is to be accomplished through: 1) support for fellows in developmental-behavioral pediatrics preparing for leadership roles as teachers, investigators, and clinicians advancing the field of developmental/behavioral pediatrics; and 2) providing pediatric practitioners, residents, and medical students with essential biopsychosocial knowledge and clinical expertise. Trainees in this program should: receive an appropriate balance of academic, clinical, and community opportunities; work towards being culturally competent; and demonstrate a capacity to evaluate, diagnose or rule out, develop, and provide evidence-based interventions to individuals with autism spectrum disorders (ASD) and other developmental disabilities (DD) after completion of their clinical training; and demonstrate an ability to use a family-centered approach.

2. Background

This program is authorized by the Public Health Service Act, §399BB(e)(1), (codified at 42 U.S.C. 280i-1(e)(1)) and the Combating Autism Act of 2006 (P.L. 109–416), as amended by the Combating Autism Reauthorization Act of 2011 (P.L. 112–32).

Maternal and Child Health Bureau and Title V of the Social Security Act

In 1935, Congress enacted Title V of the Social Security Act authorizing the Maternal and Child Health Services Programs. This legislation has provided a foundation and structure for assuring the health of mothers and children in the nation for over 75 years. Title V was designed to improve health and assure access to high quality health services for present and future generations of mothers, infants, children and adolescents, including those with disabilities and chronic illnesses, with special attention to those of low income or with limited availability of health services.

Today, Title V is administered by the Maternal and Child Health Bureau (MCHB), which is a part of the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services (HHS). Under Title V of the Social Security Act, the Maternal and Child Health Services Block Grant program has three components—Formula Block Grants to States, Special Projects of Regional and National Significance (SPRANS) and Community Integrated Service Systems (CISS) grants. Using these authorities, the MCHB has forged partnerships with states, the academic community, health professionals, advocates, communities and families to better serve the needs of the nation’s children.

The mission of MCHB is to provide national leadership, in partnership with key stakeholders, to improve the physical and mental health, safety and well-being of the maternal and child health

(MCH) population which includes all of the nation's women, infants, children, adolescents, and their families, including fathers and children with special health care needs (CSHCN).

Emphasis in MCHB on Life Course Model as a Strategic Organizing Framework

On October 20, 2010, MCHB released a draft concept paper on the Life Course Model to inform the development of MCHB's next 5 year Strategic Plan. Life course development points to broad social, economic and environmental factors as underlying contributors to poor health and developmental outcomes for all children; including children with special health care needs. It also focuses on persistent disparities 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 a 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.

Division of MCH Workforce Development (DMCHWD)

The Maternal and Child Health Training Program is housed within the Maternal and Child Health Bureau's Division of MCH Workforce Development (DMCHWD). DMCHWD provides leadership and direction in educating and training our nation's future leaders in maternal and child health.

DMCHWD Training Program Goals

DMCHWD's vision for the 21st century is that all children, youth, and families will live and thrive in healthy communities served by a quality workforce that helps assure their health and well being. To achieve this vision, the Division is in the process of revising its strategic plan for 2012/20, which should be finalized in 2012. The goals drafted for this strategic plan to date are:

- Goal 1. Address current and emerging MCH workforce needs by engaging, and providing training for and support to MCH leaders in practice, academics and policy.
- Goal 2: Prepare and empower MCH leaders to promote health equity, wellness, and reduce disparities in health and healthcare.
- Goal 3: Promote interdisciplinary training and practice and interorganizational collaboration to enhance systems of care for MCH populations.
- Goal 4: Generate and translate new knowledge for the MCH field in order to advance science-based practice, innovation, and quality improvement in MCH training, policies, and programs.

The Division achieves these goals by supporting:

- *Trainees* who show promise to become leaders in the MCH field in the areas of teaching, research, clinical practice, and/or administration and policymaking.
- *Faculty* in public and private nonprofit institutions of higher learning who teach and mentor trainees and students in exemplary MCH public health practice, advance the field through research and dissemination of findings, develop curricula particular to MCH and public health, and provide technical assistance to the field.
- *Continuing education and technical assistance* to those already practicing in the MCH field to keep them abreast of the latest research and emerging better practices.

Combating Autism Act Initiative (CAAI)

The Combating Autism Act Initiative is an initiative to address autism and related developmental disabilities through education, early detection, and intervention. In September 2011, the Combating Autism Reauthorization Act continued this legislation to 2014. Specifically these activities are to:

- 1) Increase awareness;
- 2) Reduce barriers to screening and diagnosis;
- 3) Promote evidence based interventions for individuals with ASDs or other developmental disabilities;
- 4) Promote guideline development for interventions; and
- 5) Train professionals to utilize valid and reliable screening tools to identify or rule out and to provide evidence based interventions for children with autism spectrum disorders and other developmental disabilities through an interdisciplinary approach ("similar to the" programs developed under section 501(a)(2) of the Social Security Act).

In response to the CAAI, the Maternal and Child Health Bureau has initiated programs in four areas:

- 1) Combating Autism Training Programs
 - Forty-three interdisciplinary Leadership Education in Neurodevelopmental Disabilities (LEND) training programs;
 - Expansions to Developmental Behavioral Pediatrics (DBP) training programs; and
 - An Interdisciplinary Training Autism Resource Center cooperative agreement.
- 2) Combating Autism Research Programs
 - Three autism intervention research networks that focus on intervention research, guideline development and information dissemination—one network focused on physical health interventions, one network focused on behavioral health interventions, and one focused on the translation of multidisciplinary pediatric research to practice and fosters a new generation of developmental behavioral pediatric researchers. R40 Extramural MCH Research and Secondary Data Analysis Studies grants have been awarded in the area of family support, service, transition, and intervention.
- 3) Combating Autism Demonstration and Policy Programs
 - Thirteen State Autism Demonstration grants are implementing State Autism Plans and creating models for how to develop systems of services for children with autism and other developmental disabilities.
 - A State Public Health Coordinating Center coordinates with the State Autism Demonstration grants and develops and implements strategies for defining, supporting, and monitoring the role of state public health efforts in assuring that children and youth with autism receive early and timely identification, diagnosis, and intervention.
- 4) Combating Autism National Evaluation
 - Information and analysis from this evaluation contributed to the HHS Secretary's Report to Congress on progress related to ASD and other developmental disabilities as required in the CAAI. As a CAAI grantee, all DBP grantees will participate in the national evaluation of the program, providing both qualitative and quantitative data.

Current Status of Autism Spectrum Disorders and Other Developmental Disabilities

In the United States, approximately 13% of children under the age of 18 have been diagnosed with a developmental disability (<http://www.cdc.gov/ncbddd/dd/ddsurv.htm>), ranging from mild disabilities such as speech and language impairments to serious developmental disabilities, such as intellectual disabilities, cerebral palsy, and autism.

The most recent surveillance data collected in 2008 by the CDC's Autism and Developmental Disabilities Monitoring Network shows that approximately 1 in 88 children have an Autism Spectrum Disorder (ASD) (<http://www.cdc.gov/Features/CountingAutism/>). ASDs are almost 5 times more common among boys (1 in 54) than among girls (1 in 252). Comparison of 2008 findings indicates an increase in estimated ASD prevalence of 23% when the 2008 data were compared with the 2006 data (from 9.0 per 1,000 children aged 8 years in 2006 to 11.0 in 2008). An estimated increase of 78% when the 2008 data were compared with the 2002 data (from 6.4 per 1,000 children aged 8 years in 2002 to 11.4 in 2008). The largest increases over time were among Hispanic children (110%) and black children (91%), which is partially attributed to greater awareness and better identification among these groups. On average, children are not diagnosed until between the ages of 3 ½ and 5 years, a delay which compromises the outcomes and prevents effectiveness of early intervention treatments. Misdiagnosis is also common, especially among racial and ethnic minority groups (<http://iacc.hhs.gov/summary-advances/2009/index.shtml>).

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 during Federal fiscal years 2013-2017. Approximately \$1,861,000 is expected to be available annually to fund ten (10) grantees and one program meeting at \$35,000. The mean award amount will be \$182,600 and applicants may apply for a ceiling amount of up to \$195,000 per year. The project period is five (5) years. Funding beyond the first year is dependent on the availability of appropriated funds for DBP in subsequent fiscal years, grantee satisfactory performance, and a decision that continued funding is in the best interest of the Federal Government.

III. Eligibility Information

1. Eligible Applicants

Under PHS Act Section 399BB (e)(1)(A), as amended by the Combating Autism Act of 2006, “competitive grants or cooperative agreements are awarded to public or nonprofit agencies, including institutions of higher education, to expand existing or develop new maternal and child health interdisciplinary leadership education in neurodevelopmental and related disabilities programs (similar to the programs developed under section 501(1)(2) of the Social Security Act) in States that do not have such a program.”

2. Cost Sharing/Matching

Cost Sharing/Matching is not required for this program.

3. Other

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

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.

NOTE: Multiple applications from an organization are not allowable.

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. The 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 an 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. If requesting a waiver, include the following in the e-mail request: the HRSA announcement number for which the organization is 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 the submission along with a copy of the “Rejected with Errors” notification as 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
at the end of July 2012
(rev. 5/22/12)

The General Services Administration (GSA) is moving the implementation date of the System for Award Management (SAM) from May 29, 2012 to the end of July 2012. The additional sixty days will allow Federal agencies to continue preparing their staff, give agencies and commercial system providers even more time to test their data transfer connections, and will ensure SAM contains the critical, documented capabilities users need from the system.

This first phase of SAM will include the capabilities of Central Contractor Registration (CCR)/Federal Agency Registration (FedReg), Online Representations and Certifications Application (ORCA), and the Excluded Parties List System (EPLS). In preparation for the launch, GSA conducted extensive testing internally and in coordination with Federal agencies using the data from these systems in their own contracting, grants, finance, and other departments. The testing was very valuable and will focus the efforts of the next sixty days.

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](https://www.bpn.gov/ccr/NewsDetail.aspx?id=2012&type=N) 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. 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 the 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 number. The [CCR Website](#) provides user guides, renewal screen shots, FAQs and other resources.

Applicants that fail to allow ample time to complete registration with CCR (prior to late July 2012) / SAM (starting late July 2012) and/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 Research and Related (SF-424 R&R). 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. Specific instructions for preparing portions of the application that must accompany the SF-424 R&R 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. **HRSA strongly urges applicants to print their 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 R&R – Table of Contents

 **It is mandatory to follow the instructions provided in this section to ensure that the application can be printed efficiently and consistently for review.**

 **Failure to follow the instructions may make the 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
SF-424 R&R Cover Page	Form	Pages 1 & 2.	Not counted in the page limit.
Pre-application	Attachment	Can be uploaded on page 2 of SF-424 R&R - Box 20.	Not Applicable to HRSA; Do not use.
SF-424 R&R Senior/Key Person Profile	Form	Supports 8 structured profiles (PD + 7 additional)	Not counted in the page limit.
Senior Key Personnel Biographical Sketches	Attachment	Can be uploaded in SF-424 R&R Senior/Key Person Profile form or other text format. One per each senior/key person. The PD/PI biographical sketch should be the first biographical sketch. Up to 8 allowed.	Counted in the page limit.
Senior Key Personnel Current and Pending Support	Attachment	Can be uploaded in SF-424 R&R Senior/Key Person Profile form.	Not Applicable to HRSA; Do not use.
Additional Senior/Key Person Profiles	Attachment	Can be uploaded in SF-424 R&R Senior/Key Person Profile form. Single document with all additional profiles.	Counted in the page limit.
Additional Senior Key Personnel Biographical Sketches	Attachment	Can be uploaded in the Senior/Key Person Profile form. Single document with all additional sketches.	Counted in the page limit.
Additional Senior Key Personnel Current and Pending Support	Attachment	Can be uploaded in the Senior/Key Person Profile form.	Not Applicable to HRSA; Do not use.
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 SF-424 R&R Performance Site Location(s) form. Single document with all additional site location(s).	Counted in the page limit.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
Other Project Information	Form	Allows additional information and attachments.	Not counted in the page limit.
Project Summary/Abstract	Attachment	Can be uploaded in SF-424 R&R Other Project Information form, Box 6.	Required attachment. Counted in the page limit. Refer to funding opportunity announcement for detailed instructions.
Project Narrative	Attachment	Can be uploaded in SF-424 R&R Other Project Information form, Box 7.	Required attachment. Counted in the page limit. Refer to funding opportunity announcement for detailed instructions. If necessary, provide table of contents specific to this document only as the first page. Table of contents is not counted in the page limit.
Bibliography & References	Attachment	Can be uploaded in Other Project Information form, Box 9.	Required. Counted in the page limit.
Facilities & Other Resources	Attachment	Can be uploaded in Other Project Information form, Box 10.	Optional. Counted in the page limit.
Equipment	Attachment	Can be uploaded in Other Project Information form, Box 11.	Optional. Counted in the page limit.
Other Attachments	Attachment	Can be uploaded in SF-424 R&R Other Project Information form, Box 12. Supports multiple.	Not Applicable to HRSA; Do not use.
SF-424 R&R Budget Period (1-5) - Section A – B	Form	Supports structured budget for up to 5 periods.	Not counted in the page limit.
Additional Senior Key Persons	Attachment	SF-424 R&R Budget Period (1-5) - Section A - B, End of Section A. One for each budget period.	Counted in the page limit.
SF-424 R&R Budget Period (1-5) - Section C – E	Form	Supports structured budget for up to 5 periods.	Not counted in the page limit.
Additional Equipment	Attachment	SF-424 R&R Budget Period (1-5) - Section C – E, End of Section C. One for each budget period.	Counted in the page limit.
SF-424 R&R Budget Period (1-5) - Section F – K	Form	Supports structured budget for up to 5 periods.	Not counted in the page limit.
SF-424 R&R Cumulative Budget	Form	Total cumulative budget.	Not counted in the page limit.
Budget Justification	Attachment	Can be uploaded in SF-424 R&R Budget Period (1-5) - Section F - K form, Box K. Only one consolidated budget justification for the project period.	Required attachment. Counted in the page limit. Refer to funding opportunity announcement for detailed instructions. Provide table of contents specific to this

Application Section	Form Type	Instruction	HRSA/Program Guidelines
			document only as the first page.
SF-424 R&R Subaward Budget	Form	Supports up to 10 budget attachments. This form only contains the attachment list.	Not counted in the page limit.
Subaward Budget Attachment 1-10	Extracted Form to be attached	Can be uploaded in SF-424 R&R Subaward Budget form, Box 1 through 10. Extract the form from the SF-424 R&R Subaward Budget form and use it for each consortium/contractual/subaward budget as required by the program funding opportunity announcement. Supports up to 10.	Filename should be the name of the organization and unique. Not counted in the page limit.
SF-424B Assurances for Non-Construction Programs	Form	Assurances for the SF-424 R&R package.	Not counted in the page limit.
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Not counted in the page limit.
Attachments Form	Form	Supports up to 15 numbered attachments. This form only contains the attachment list.	Not counted in the page limit.
Attachments 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.**
-  Evidence of Non-Profit status and invention related documents, if applicable, must be provided in the other attachment form.
-  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 one attachment, ensure that a table of contents cover page is included specific to the attachment. 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.) Attachments will be rejected by Grants.gov if they include special characters or attachment names greater than 50 characters.

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Chart/Table of Partners and Collaboration. All items specified in Section IV.2.xi. must be identified in this section.
Attachment 2	Map(s)
Attachment 3	Organizational Chart
Attachment 4	Curriculum

Attachment Number	Attachment Description (Program Guidelines)
Attachment 5	Position Descriptions of Key Personnel
Attachment 6	Summary Progress Report – for COMPETING CONTINUATIONS ONLY (Limit to 20 pages). These pages in the progress report WILL be counted in the 80 page limit.
Attachments 7-15	Other relevant documents, such as budgets and budget justifications for subcontracts, etc.

Application Format

i. Application Face Page

Complete Standard Form 424 Research and Related (SF-424 R&R) provided with the application package. Prepare according to instructions provided in the form itself. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is 93.110.

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 form SF-424 R&R – item 5 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 conduct 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 the applicant organization CCR (or SAM) registration is active and the 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 at the end of July 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

Please complete the Research & Related Budget form included with the application kit (Sections A – J and the Cumulative Budget) for each budget period. Upload the Budget Justification Narrative for the entire project period (all budget periods) in Section K of the Research & Related Budget Form. Following completion of Budget Period 1, click on the “NEXT PERIOD” button on the final page to allow for completion of Budget Period 2, etc. Repeat this instruction to complete Budget Periods 3 through 5.

The Cumulative Budget is automatically generated and provides the total budget information for the three-year grant request. Errors found in the Cumulative Budget must be corrected within the incorrect field(s) in Budget Period 1, 2, 3, etc; corrections cannot be made to the Cumulative Budget itself.

Salary Limitation:

The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is \$179,700. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts under a HRSA grant or cooperative agreement.

As an example of the application of this limitation: If an individual's base salary is \$350,000 per year plus fringe benefits of 25% (\$87,500) and that individual is devoting 50% of their time to this award, their base salary should be adjusted to \$179,700 plus fringe of 25% (\$44,925) and a total of \$112,312.50 may be included in the project budget and charged to the award in salary/fringe benefits for that individual. See the breakdown below:

Individual's <i>actual</i> base full time salary: \$350,000 50% of time will be devoted to project	
Direct salary	\$175,000
Fringe (25% of salary)	\$43,750
Total	\$218,750
Amount that may be claimed on the application budget due to the legislative salary limitation: Individual's base full time salary <i>adjusted</i> to Executive Level II: \$179,700 50% of time will be devoted to the project	
Direct salary	\$89,850
Fringe (25% of salary)	\$22,462.50
Total amount	\$112,312.50

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. Line item information must be provided to explain the costs entered in the SF-424 Research and Related 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 one 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 five (5) years. Awards, on a competitive basis, will be for a one-year budget period; although the project period may be for up to five (5) years. Submission and HRSA approval of the 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 five-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.

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. Also, list each trainee supported, stipend and/or tuition support provided. Reminder: Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II or \$179,700. An individual's base salary, per se, is NOT constrained by the legislative provision for a limitation of salary. The rate limitation simply limits the amount that may be awarded and charged to HRSA grants and cooperative agreements. Please provide an individual's actual base salary if it exceeds the cap. See the sample below.

Sample:

Name	Position Title	% of FTE	Annual Salary	Amount Requested
J. Smith	Chief Executive Officer	50	\$179,700*	\$89,850
R. Doe	Nurse Practitioner	100	\$75,950	\$75,950
D. Jones	Data/AP Specialist	25	\$33,000	\$8,250

*Actual annual salary = \$350,000

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. (If an individual's base salary exceeds the legislative salary cap, please adjust fringe accordingly.)

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.

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.

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 in late July 2012 - See Section IV of this document for more SAM details.) and provide the recipient with their DUNS number.

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. Discussion of costs associated with annual grantee meeting for the year in which the grantee provides oversight for the meeting should be in this section.

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. The indirect cost rate agreement will not count toward the page limit.

Indirect costs under training grants to organizations other than state, local or Indian tribal governments will be budgeted and reimbursed at 8% of modified total direct costs rather than on the basis of a negotiated cost agreement, and are not subject to upward or downward adjustment. Direct cost amounts for equipment and capital expenditures, tuition and fees, and subgrants and contracts in excess of \$25,000 are excluded from the direct cost base for purposes of this calculation. Training grant applications from State, local, or Indian tribal governmental agencies may request full indirect cost reimbursement. State universities and hospitals are subject to the 8% cap.

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 5. 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.

Biographical Sketch Instructions

Provide a biographical sketch for senior key professionals contributing to the project. The information must be current, indicating the position which the individual fills and including

sufficient detail to assess the individual's qualifications for the position as specified in the program announcement and position description. Each biographical sketch must be limited to one (1) page or less, including recent selected publications. Include all degrees and certificates. When listing publications under Professional Experience, list authors in the same order as they appear on the paper, the full title of the article, and the complete reference as it is usually cited in a journal. The sketches should be arranged in alphabetical order, after the project director's sketch and attached to SF 424 Senior/Key Person profile form. The biographical sketch must include:

Name (Last, first, middle initial),
Title on Training Grant,
Education, and,
Professional Experience, beginning with the current position, then in reverse chronological order, a list of relevant previous employment and experience. Also, a list, in reverse chronological order, of relevant publications, or most representative, must be provided. Please provide information on one (1) page or less.

vi. Assurances

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

If research involving human subjects is anticipated, you must meet the requirements of the HHS regulations to protect human subjects from research risks as specified in the Code of Federal Regulations, Title 45 – Public Welfare, Part 46 – Protection of Human Subjects (45 CFR 46), available online at www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html.

vii. Certifications

Use the Certifications and Disclosure of Lobbying Activities Application Form provided with the application package. Any organization or individual that is indebted to the United States, and has a judgment lien filed against it for a debt to the United States, is ineligible to receive a Federal grant. By signing the SF-424 R&R, the applicant is certifying that they are not delinquent on Federal debt in accordance with OMB Circular A-129. (Examples of relevant debt include delinquent payroll or other taxes, audit disallowances, guaranteed and direct student loans, benefits that were overpaid, etc.). If an applicant is delinquent on Federal debt, they should attach an explanation that includes proof that satisfactory arrangements have been made with the Agency to which the debt is owed. This explanation should be uploaded as an attachment.

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 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

Abstract content:

PROBLEM: Briefly (in one or two paragraphs) state the principal needs and problems which are addressed by the project.

GOAL(S) AND OBJECTIVES: Identify the major goal(s) and objectives for the project period. Typically, the goal is stated in a sentence or paragraph, and the objectives are presented in a numbered list.

METHODOLOGY: Describe the programs and activities used to attain the objectives and comment on innovation, cost, and other characteristics of the methodology. This section is usually several paragraphs long and describes the activities which have been proposed or are being implemented to achieve the stated objectives. Lists with numbered items are sometimes used in this section as well.

HP 2020 OBJECTIVES: List the primary Healthy People 2020 goal(s) that the project will address. Healthy People 2020 goals can be found online at <http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx>

COORDINATION: Describe the coordination planned with appropriate national, regional, State and/or local health agencies and/or organizations in the area(s) served by the project.

EVALUATION: Briefly describe the evaluation methods used to assess program outcomes and the effectiveness and efficiency of the project in attaining goals and objectives. This section is usually one or two paragraphs in length.

ANNOTATION: Provide a three- to - five-sentence description of your project that identifies the project's purpose, the needs and problems, which are addressed, the goals and objectives of the project, the activities, which will be used to attain the goals and the materials which will be developed.

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 project. It should be succinct, self-explanatory, and organized by the following sections in order for reviewers to understand the proposed project. Use the following section headers for the Project Narrative:

A. PURPOSE/NEED

In this section, the applicant should briefly describe the background of the proposal, critically evaluating the national, regional and local need/demand for the training and specifically identifying problem(s) to be addressed and gaps which the project is intended to fill. If available, a summary of needs assessment findings should be included. State concisely the importance of the project by relating the specific objectives to the potential of the project to meet the purposes

of the grant program described in the program announcement and demonstrate strong knowledge of health and related issues for the target population.

B. METHODOLOGY/RESPONSE

1) Goals and Objectives

State the overall goal(s) of the project and list the specific objectives that respond to the stated need/purpose for this project. The objectives must be **observable** and **measurable** with specific **outcomes** for each project year which are attainable in the stated **time frame**. These outcomes are the criteria for evaluation of the program.

2) Curriculum

The Developmental-Behavioral Pediatrics Training Program is designed to support high quality education for health professionals who will advance the field of MCH and enhance systems of care for children (infants through adolescents), including those with special health care needs, and their families. The educational curricula, in addition to promoting excellence in scholarship and leadership, should emphasize the integration of services supported by States, local agencies, organizations, private providers, and communities. Influences on the health status of children such as their families, the environment, life-style and cultural values, economic, legal and political conditions, and technical advances are vital components of leadership training. By focusing on the importance of health promotion, disease prevention, and the benefits of coordinated health care, families and practitioners can develop creative approaches for improving the health of children and families, particularly vulnerable groups whose needs are not currently being met by our systems of care.

The curriculum must clearly define how the training program incorporates the following content to assure an adequate base of knowledge and experience. Content and philosophy must be geared toward the purposes specified above. Programs must develop clear, measurable educational objectives for an interdisciplinary core curriculum, clinical and didactic, which incorporate the acquisition of knowledge of:

- all aspects of developmental and behavioral pediatrics, with a focus on ASD and other developmental disabilities;
- the social environment—the family, community, school as well as cultural competency and family-centered services;
- life course and social determinants of health;
- interdisciplinary team skills;
- leadership skills; and
- communication skills (e.g. verbal, written, team-building, conflict resolution).

Content and philosophy must be geared to preparation of graduates to assume leadership roles in the development, improvement and integration of systems of care, especially in programs providing maternal and child health services, including those for children with special health care needs, with special emphasis on ASD or other developmental disabilities, in community-based, family-centered settings. Attention to the needs of children living in underserved communities is strongly encouraged.

Curricula must include acquisition of in-depth knowledge of the following: relevant psychosocial and biological sciences, growth and development, adaptation, injury prevention,

and disease prevention and health promotion. The curriculum must include didactic content on the following: intellectual, social, and emotional functioning; psychological implications of physical illness; the child's environments (home and family, school, community, etc.); interviewing children and family members; screening and assessment for all developmental domains; public and private health resources; and formulating management and treatment plans.

Projects will be evaluated on having a three-year fellowship program with clear educational objectives and a comprehensive curriculum which meets the Program Requirements for Residency Education in Developmental-Behavioral Pediatrics, a subspecialty residency (post-doctoral fellowship) program in developmental-behavioral pediatrics which meets the accreditation standards of the Accreditation Council for Graduate Medical Education (ACGME). The applicant must be currently accredited by ACGME. The Developmental-Behavioral Pediatrics Training curricula must emphasize leadership development; interdisciplinary training and practice; cultural competence; a population-based, public health approach; and integration of service systems.

a. Leadership

The MCH Training Program places a particular emphasis on leadership education. The curriculum must include content and experiences to foster development of leadership attributes. Leadership training prepares MCH health care professionals to move beyond excellent clinical or health administration practice to leadership, through practice, research, teaching, administration, academia and advocacy.

Maternal and Child Health Leadership Competencies, Version 3.0 was published in November 2009. The definition developed by the MCH Leadership Competencies Workgroup is “An MCH leader inspires and brings people together to achieve sustainable results to improve the lives of the MCH population.”¹ A more extensive definition was also provided in the document. “An MCH leader is one who understands and supports MCH values, mission, and goals² with a sense of purpose and moral commitment. He or she values interdisciplinary collaboration and diversity and brings the capacity to think critically about MCH issues at both the population and individual levels, as well as to communicate and work with others and use self-reflection. The MCH leader possesses core knowledge of MCH populations and their needs and demonstrates professionalism in attitudes and working habits. He or she continually seeks new knowledge and improvement of abilities and skills central to effective, evidence-based leadership. The MCH leader is also committed to sustaining an infrastructure to recruit, train and mentor future MCH leaders to ensure the health and well-being of tomorrow’s children and families. Finally, the MCH leader is responsive to the changing political, social, scientific, and demographic context and demonstrates the capability to change quickly and adapt in the face of emerging challenges and opportunities.”

Graduates of MCH Leadership training programs improve the system of care for women (including women of reproductive age), mothers, children, youth and adolescents. The goal of leadership training is to prepare trainees who have shown evidence of leadership attributes and who have the potential for further growth and development as public health leaders. In order to accomplish this goal, trainees must achieve and excel in a variety of competencies. A complete

¹ Adapted from: George, B. (2006, October 30). Truly authentic leadership. *U.S. News & World Report*, 52.

² Maternal and Child Health Bureau (MCHB). *Strategic Plan, FY 2003–2007*. <http://www.mchb.hrsa.gov/about/stratplan03-07.htm#1>.

description of the competencies, including definitions, knowledge areas, and basic and advanced skills for that competence is included at <http://leadership.mchtraining.net>. Clearly describe how these MCH Leadership Competencies will be directly cultivated by the training curriculum.

Identify the competencies expected of the graduates and the required curriculum, including didactic and experiential components. A brief syllabus, including descriptions of courses, workshops, seminars, and experiences should be included in the Appendix 4 of the application.

b. Interdisciplinary Training and Practice

While the primary purpose of the Developmental-Behavioral Pediatrics Training program is to support DBP fellows, the training curriculum must use an interdisciplinary approach as leaders in DBP will work with other health professionals. Knowledge of interdisciplinary practice will enhance the individual skills needed to be a more successful team member. Interdisciplinary training and practice should include professionals such as nurses, psychologists, child and adolescent psychiatrists, nutritionists, social workers, child neurologists, speech and language pathologists, educators, physical therapists, occupational therapists, and public health professionals. The applicant must define the content and process which will assure that the interdisciplinary training and practice requirement is satisfied in the content of the program.

c. Cultural Competence

Cultural competence is defined as the knowledge, interpersonal skills and behaviors that enable a system, organization, program, or individual to work effectively cross culturally by understanding, appreciating, honoring, and respecting cultural differences and similarities within and between cultures. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

The applicant must demonstrate how the training program will address issues of cultural competence, such as including cultural competence training in the curriculum, administrative procedures, faculty and staff development, and recruiting culturally, racially and ethnically diverse faculty and students. Training must be structured on a broad range of exemplary, interdisciplinary, comprehensive services which provide family-centered, coordinated care that is responsive to the cultural, social, linguistic, and ethnic diversity of the community. For additional resources and information, applicants are encouraged to refer to the National Center for Cultural Competence at <http://gucchd.georgetown.edu/67212.html>.

For more information about cultural competence, please visit http://www.mchb.hrsa.gov/training/goal_workforce_diversity.asp.

For more information about the Curricula Enhancement Module Series created by the National Center for Cultural Competence, please visit <http://www.ncccurrricula.info/>.

Besides teaching concepts of cultural and linguistic competence, the Bureau's intent is to ensure that project interventions are responsive to the cultural and linguistic needs of special populations, that services are accessible to consumers, and that the broadest possible representation of culturally distinct and historically under-represented groups is supported through programs and projects sponsored by MCHB. In order to assure access and cultural competence, it is expected that projects will involve individuals from populations to be served in the planning and implementation of the project.

d. Medical Home and Family-Centered Care

The curriculum must also include content about family-centered care that assures the health and well-being of clients and their families through a respectful family-professional partnership. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-Centered Care is the standard of practice which results in high quality services.

For more information about family-centered care, please visit http://www.mchb.hrsa.gov/training/goal_workforce_diversity.asp.

e. Public Health, Title V and Related Legislation

The curriculum must address public health issues and use an interdisciplinary approach. It should emphasize, either as discrete topics or as topics integrated in other components, appropriate didactic and experiential content relative to MCH/Title V and related legislation, as well as to the development, implementation and evaluation of systems of health care. At a minimum, the curriculum should include analysis of core public health functions applied to Developmental-Behavioral Pediatrics issues, program planning and evaluation, community needs assessment, public policy, financing, budgeting, consultation, and advocacy. The curriculum should also address emerging public health issues relevant to developmental-behavioral pediatrics. The curriculum must include content about various service provision models and approaches, the differing social, cultural and health practices of various ethnic and nationality groups, and the implications of these relative to health status and provision of health care.

The curriculum must also emphasize content relating to: science-based judgment, evidenced-based practice and documentation of quality outcomes and performance within an established plan of care; expansion of the direct service roles to include consultation, and collaboration and supervision; and, various service delivery models and approaches. The curriculum must also address emerging public health issues relevant to developmental-behavioral pediatrics.

f. Research

Applicants must document research and other scholarly activities of faculty and students relating to developmental-behavioral pediatrics, and must define the relevance of these activities to the training program. Programs must provide for the conduct of collaborative research by fellows under joint supervision of faculty from relevant disciplines, e.g., contributing new knowledge, validating effective intervention strategies, assessing quality, or linking intervention to functional outcomes and quality of life. Each fellow is expected to engage in one or more active research projects during his/her tenure, and to seek to disseminate findings at scientific symposia, through published articles in peer reviewed journals and to practitioners and policymakers.

g. Technology

The curriculum shall incorporate the use of web-based technology for communication and information acquisition and processing, including distance learning modalities for lifelong learning, and continuing education. Programs should use principles of adult learning and effective education models utilizing available technologies such as e-learning systems, course management software, web-based conferencing, social media and social networking tools.

h. Innovation

MCH Training program should include training content and experiences, as well as trainee and faculty practice that contribute to the accomplishment of the objectives listed above. MCH funded training programs play a vital role in the development of new knowledge and the

promotion of innovation in practice, research and policy. The applicant must clearly describe how the curricula and trainee experiences within the program assure trainees are equipped to practice, respond and lead utilizing multiple sources of information and can synthesize, recognize and contribute to the MCH science and related practice. Program experiences should be designed to implement new and emerging technologies in clinical practice and assure trainees have access to and can practice utilizing these technologies in their respective fields.

i. Emerging Issues

The curriculum must reflect emerging health problems and practice issues, such as autism and other developmental disabilities. The curriculum should also reflect the Healthy People 2020 National Health Promotion and Disease Prevention Objectives. Please visit <http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx> to identify objectives that should be infused into didactic curriculum and other training components of a developmental-behavioral pediatrics program. Programs must include the implementation of the health promotion/disease prevention initiative, *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents* and *Bright Futures in Practice: Mental Health* in their curriculum.

j. MCH/Title V and Related Legislation

The curriculum must emphasize appropriate content relative to MCH/Title V and related legislation, as well as content relating to: science-based judgment, evidenced-based practice and documentation of quality outcomes and performance within an established plan of care; expansion of the direct service roles to include consultation, and collaboration and supervision; and, various service delivery models and approaches. The curriculum must include theoretical and clinical components which provide students with working knowledge of Title V of the Social Security Act as amended, and other programs such as Title X (Family Planning), XIX (Medicaid/EPSDT), XXI (State Children's Health Insurance Program); etc.

k. Life Course Framework

In alignment with MCHB's concept paper and plans to focus on life course, the curriculum will address health promotion issues for developmental-behavioral pediatrics by implementing a curriculum that emphasizes the life course development and socio-ecological framework. This framework emphasizes the cumulative impact of children with developmental or behavioral challenges developing within families, families existing within a community, and the community embedding within the larger society. The curriculum will prepare trainees to understand how 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 for these children. DMCHWD is cultivating this comprehensive, evidence-based framework into curricula, programs, and policies, assuring that health professionals are trained in this framework.

3) Training

Training should not be limited to didactic strategies to achieve educational objectives and leadership competencies. The Developmental-Behavioral Pediatrics programs should offer fellows a balance of learning experiences which are interdisciplinary in nature, including didactic, skills-based, seminar, mentoring, community service projects, research skills, and peer leadership in addition to required oral and written presentation experiences. All fellows are expected to work on the development of clinical communication and teaching skills. Fellows are expected to achieve communication and pedagogical skills appropriate for a variety of

professional and community audiences. In addition, fellows are expected to advance administrative and or academic skills through assigned administrative/academic responsibility for at least one focused service or teaching activity.

a. Clinical Preparation

Training, with emphasis on ASD and other developmental disabilities, should be based on a comprehensive, exemplary, interdisciplinary clinical services model which is family-centered, and culturally and linguistically appropriate. Focus must be on prevention, early detection, assessment, care coordination, and treatment, including care at home and follow up, of children. In terms of ASD, trainees should demonstrate a capacity to evaluate, diagnose or rule out, develop, and provide evidence-based interventions to individuals with ASD and other developmental disabilities. The intent is to increase the number of individuals who are able to provide information and education on ASD and other developmental disabilities to increase public awareness of developmental milestones, confirm or rule out a diagnosis of ASD and other developmental disabilities, and increase the number of individuals able to provide evidence-based interventions for individuals diagnosed with ASD or other developmental disabilities.

It is essential for the program to provide a broad range of clinical experiences with all pediatric age groups, in all socioeconomic strata, and in multiple settings (inpatient, outpatient, office-based, community-based and, especially, primary care continuity clinics) emphasizing integration of services. Services should include health promotion, disease prevention and care coordination, as well as diagnosis and treatment of conditions that range from simple to highly complex. The medical home model must also be promoted. Programs may provide clinical services that are interdisciplinary and involve families and youth, as appropriate. Programs must identify a mechanism to receive input from families who utilize health services, plus involve them in the decision making process.

b. Community-Based Preparation

Training must be structured on exemplary, comprehensive, interdisciplinary service models in a variety of institutional and rural/urban community-based settings with a MCH client population representative of the cultural, linguistic, social and ethnic diversity of the community. Examples include schools, community and migrant health centers (Federally Qualified Health Centers) supported by the Bureau of Primary Health Care, and free clinics. Working in an interdisciplinary program site is recommended.

Fellows

Fellowship training should be organized to meet the ACGME Program Requirements for Graduate Medical Education in Developmental-Behavioral Pediatrics (http://www.acgme.org/acWebsite/RRC_320/320_prIndex.asp). The program methodology should include the criteria for and a description of methods of recruitment, selection and retention of fellows whose career goals are consonant with program goals, as well as special efforts directed toward recruitment of qualified fellows who are culturally, racially, and ethnically diverse. MCHB strives to support faculty and trainees who reflect the diversity of the MCH population that we serve. This is a program priority and a proposed performance measure for the MCHB.

Programs must provide evidence of the productivity of the training program in terms of the number of fellows who have completed training in developmental-behavioral pediatrics and their

current professional activities. The applicant should present a plan for tracking and reporting on the accomplishments of former trainees.

During the course of their fellowship, physician fellows will be expected to meet eligibility requirements for the subspecialty certification in developmental-behavioral pediatrics as established by the American Board of Pediatrics (<https://www.abp.org/abpwebsite/publicat/certboi.pdf>).

Long-Term Trainees

The purpose of this grant is to enhance behavioral, psychosocial, and developmental aspects of pediatric care. This is to be accomplished through: 1) support for fellows in developmental-behavioral pediatrics preparing for leadership roles as teachers, investigators, and clinicians advancing the field of developmental/behavioral pediatrics; and 2) providing pediatric practitioners, residents, and medical students with essential biopsychosocial knowledge and clinical expertise.

As used in this section, fellowships refer to non-degree-related training and traineeships refer to degree-related training. As used elsewhere the term "trainee" is generic.

Appendix B, Trainee/Fellow Guidelines, defines trainees and fellows and provides guidelines for support.

To be considered a long-term trainee, the trainee must have completed 300 hours or more of DBP leadership, clinical and didactic training.

The application could include criteria for and a description of methods of trainee recruitment and selection of trainees whose career goals are consonant with the program objectives, including an interest in acquiring knowledge and skills to evaluate, diagnose or rule out, develop, and provide evidence-based interventions in DBP and related developmental disabilities.

Diversity in MCH Training: MCHB strives to develop an MCH workforce that is more reflective of the diversity of the nation. This strategy requires that we focus on increasing the diversity of MCH faculty and students. By addressing faculty and trainee diversity, and incorporating cultural competence and family centered care into training programs, the MCH Training Program aims to improve the quality of care for the MCH population. Over time, the Program must evaluate whether the emphases on diversity, cultural competence and family centered care might also help to reduce health disparities

A Peer Learning Collaborative was launched in 2009. With a focus on helping MCH Training Programs in developing a workforce that reflects the ethnic and racial diversity of the US population, the goals of the Collaborative are as follows: 1) Cultivate further success in site-specific efforts to increase racial and ethnic diversity within the MCH Training Program; 2) Document promising strategies for increasing racial and ethnic diversity in MCH Training Programs; 3) Identify support needed for grantees to successfully implement promising strategies; and 4) Develop diversity peer mentors among MCH Training Program grantees. Increasing diversity is a priority for all MCHB supported training programs.

The applicant should describe the plan for encouraging recruitment of trainees from culturally, racially, and ethnically diverse backgrounds and for evaluating the success of the recruitment

efforts. Performance Measure #9 requires annual reporting on the percentage of trainees from underrepresented racial and ethnic groups. See Appendix A for the performance measures and administrative data required for this program.

There should also be a plan for tracking and reporting on the field leadership of former trainees. This plan should include longitudinal follow-up data about graduates' employment, research, advocacy efforts, programs initiated, publications submitted, etc. These data will be reported on Performance Measure #8.

Other Trainees

Faculty time not required for meeting the primary training mission, as described above, may be applied to other types of training which are related to the basic goals of the Developmental-Behavioral Pediatrics Training Program. Programs are expected to develop exemplary, innovative models of education and training that may include, for example, elective experiences for trainees not supported by the training grant, such as medical students, residents, psychologists, psychiatrists, social workers, educators, and others. Fellows are expected to participate in these teaching activities, and to serve as role models for students, residents, and other short and medium term trainees.

Medium-term. Medium-term trainees are defined as trainees receiving equal to or more than 40 and less than 300 contact hours in a program. MCHB has further refined the definition of Medium Term Trainees as those who have completed either 40-149 hours or 150-299 hours of training. See Appendix A in the attached "MCH Training and Education Programs Data Form" for more information on definition and data collected.

Contact hours are defined as hours spent in didactic training (ex: hours of course work or number of academic hours for which a trainee is registered); on site clinical work or "hands-on supervised" clinical work; and experiential activities and projects conducted under the supervision of faculty (ex: research, presentations, proposal development). Applicants should describe activities in which medium term trainees will be engaged, and identify measurable training objectives, expected outcomes and outcome measures appropriate to the medium term training activities conducted.

Short-term. Short term trainees are defined as trainees receiving less than 40 contact hours (as defined above) in a training program. Programs are expected to identify specific short-term training objectives and the training activities in which short-term trainees are engaged. Continuing Education students should not be included this category.

4) Interchange with Other Programs

Interchange with other programs is required. The applicants should document how they will interact with other grantees in their training category. Each developmental-behavioral pediatrics program is expected to send two faculty members to the DBP program meeting which will be held once a year. The purpose of this meeting is to share fellows' research in progress, promote interchange, disseminate new information, and enhance national-level, long-term development in developmental-behavioral pediatrics with regard to training, health services, and research issues. It is expected that through these meetings programs will coordinate their individual efforts and collaborate in the development of mutual efforts and projects.

DBP Program Meeting:

Programs awarded under this competition will be required to plan to develop and convene the DBP Program national meeting during one of the years of the project period in the amount of \$35,000, pending availability of funds. Funds will be made available on a rotating basis to one grantee each year to host this meeting. Responsibilities of the host program include agenda development, arrangements and payment for the program, speakers, meeting logistics and lodging, plus meeting meals in lieu of one-half the per diem, for approximately 50 participants. The time of the meeting will be announced at a later date.

5) Continuing Education and Development

Although the primary purpose of MCHB support for training in the Developmental-Behavioral Pediatrics Training Program is the long-term training of health professionals for leadership roles, as outlined above, each program should also conduct a minimum of one continuing education activity per year for the provider community to enhance skills or disseminate new information. Such programs should target health and related care providers and should be based on specific needs identified interactively with the group(s) to be served. The plan for the conduct of such activities should be defined in the application.

Programs are strongly encouraged to use the Collaborative Office Rounds (COR) study group approach as a continuing education mechanism. See Appendix D for a list of the key elements of the COR model. It is expected that the Developmental-Behavioral Pediatrics programs will both coordinate their individual efforts and collaborate in the development of mutual projects of significance to the MCH community.

6) Technical Assistance/Consultation and Collaboration with State Title V/MCH Agencies and Other Related Programs

Applicants are encouraged to offer technical assistance and consultation to pediatric residency training programs that are in the early stages of developing their own developmental-behavioral pediatrics program. Such assistance might take a variety of forms including on-site consultation or providing brief mini-fellowships for the pediatric faculty from the residency programs.

Applicants should document that they have active, functional relationships with State Title V MCH programs. Such collaboration includes consultation, in-service education, and continuing education geared to the needs of one or several states. Collaboration with agencies or programs providing educational, legal, social, rehabilitative or similar services; or service on boards, commissions, advisory groups or similar entities which set standards, help define public policy or otherwise influence service on a State, regional or national basis should also be documented. The curriculum must provide opportunities for trainees to interact with MCH personnel, and other public health professionals. Program faculty should provide consultation and technical assistance to develop or improve community-based services, and such technical assistance should be utilized to enhance trainee exposure to and understanding of such services. Collaboration must be documented in the application, i.e., descriptions of committees, copies of agreements/contracts, etc.

Linkages with other MCHB-supported programs in general and with Developmental-Behavioral Pediatrics training programs in particular are strongly encouraged.

7) Addressing the MCH Training Strategic Plan

As outlined in Section I.2, Background of this funding opportunity announcement, the Division is in the process of revising its strategic plan for 2012- 2020, which should be finalized in 2012. Throughout the Methodology and Response section, applicants have addressed many of the goals and objectives of the strategic plan. In this section, address any goals that have NOT been addressed in Sections 1-6. This provides the applicant the opportunity to highlight other unique activities or strategies used in the project that address the MCH Training Strategic Plan.

Below are outlined the MCH Training Strategic plan draft goals and instructions. This narrative should augment, not repeat, what has been described in Sections 1-6.

Goal 1: Address current and emerging MCH workforce needs by engaging, and providing training for and support to MCH leaders in practice, academics and policy.

Describe how the training program will ensure a workforce in clinical and public health practice, academia and policy arenas knowledgeable in the fundamentals of the field of maternal and child health, and possessing the skills and attitudes to meet the unique needs of MCH populations; support ongoing learning opportunities that engage the practicing MCH workforce and students in self assessment and in mastering the MCH Leadership Competencies; implement structures for leadership development that provide mentoring and other learning opportunities for families, and for MCH professionals at all stages of their career; and support environments and practices that promote work-life balance and sustain MCH leaders throughout the span of their careers.

Goal 2: Prepare and empower MCH leaders to promote health equity, wellness, and reduce disparities in health and healthcare.

Describe how the training program will ensure racial and ethnic diversity of the MCH professional population consistent with state, regional and/or national demographics; integrate values, policies, structures, and practices of cultural and linguistic competence into program and practice environments, staff conduct and community engagement; provide professional development programs on an ongoing basis to strengthen the capacity of the existing public health workforce to serve the needs of a culturally and linguistically diverse nation; and address health disparities or inequities (and their underlying causes including racism and other forms of marginalization) in MCH programs' structure, practice environments, staff conduct and community engagement.

Goal 3: Promote interdisciplinary training and practice and interorganizational collaboration to enhance systems of care for MCH populations.

Describe project plans that facilitate, develop and/or maintain mutually beneficial partnerships with state Title V programs and within HRSA and other agencies and organizations that support MCH populations, programs, services and workforce; conduct research to explore the necessary components and processes and the value added of interdisciplinary and interprofessional training and service provision; extend opportunities for students and faculty in MCH academic training programs to engage in practice activities in community, state, and/or national agencies and partner organizations; and strengthen the role of family members in interprofessional training and practice.

Goal 4: Generate and translate new knowledge for the MCH field in order to advance science-based practice, innovation, and quality improvement in MCH training, policies, and programs.

Describe project plans around that demonstrate that MCH individuals, programs, and systems create and evaluate innovative training approaches that improve recruitment and engagement of trainees of diverse or non-traditional backgrounds to address emerging MCH workforce needs; create, implement, and evaluate innovative approaches to practice and policy to improve the delivery of clinical and public health services and health outcomes for MCH populations; facilitate timely translation of research findings into training, policy, and practice; and develop, monitor and improve measurement, data and reporting methods to effectively assess the impact of MCH professional development , including implementing quality improvement principles and processes.

C. RESOURCES/CAPABILITIES

Describe briefly the administrative and organizational structure within which the program will function, including relationships with other departments, institutions, organizations or agencies relevant to the program. Charts outlining these relationships must be included as an attachment or in the narrative.

Describe briefly the physical setting(s) in which the program will take place, including the planned location and time of Developmental-Behavioral Pediatrics training activities. Provide an explanation as to how the location and time were determined.

Include a brief, specific description of the available resources (faculty, staff, space, equipment, clinical facilities, etc.), and related community services that are available and will be used to carry out the program. Include biographical sketches of faculty/staff on SF 424 R&R Senior Key Personnel form.

Project Director

The project director must be a board-certified pediatrician with subspecialty certification in developmental-behavioral pediatrics. The project director should be at the associate professor level or higher and have demonstrated leadership and expertise in developmental-behavioral pediatrics, experience in post-graduate level teaching and demonstrated productivity in the conduct of scholarly research in developmental-behavioral pediatrics. The project director must be the person having direct, functional responsibility for the program for which support is directed. He/she must spend at least 20% effort on this project.

Faculty Qualifications

Projects must have faculty with demonstrated leadership and appropriate education and experience in developmental-behavioral pediatrics necessary to fulfill the training goals and objectives. Outstanding faculty leadership—excellence in teaching, research, and community service—is expected.

The faculty must include not only well qualified professionals from pediatrics, including liaison faculty from community-based pediatric practices, but also representatives of other relevant disciplines such as MCH nursing, child development, psychology, child and adolescent psychiatry, nutrition, social work, child neurology, speech and language pathology, education,

physical therapy, occupational therapy, and public health (e.g., health policy, organization and administration of services, program development, evaluation).

The purpose of providing grant support for faculty salaries is to assure dedicated time for meeting the objectives of the training program. Core faculty must commit adequate time to participate fully in all components of the Developmental-Behavioral Pediatric Training Program. Deans, department chairs, and others in similar positions may not serve as Project Director or core faculty, or receive payment from project funds, unless special permission from the MCHB Training program is obtained.

Faculty Responsibilities

Core faculty have the primary responsibility for planning, designing, implementing, supervising, and evaluating all training and service elements of the overall Developmental-Behavioral Pediatrics Training Program. These responsibilities include definition of appropriate criteria for recruitment of trainees. Administrative responsibility must in all cases be to the Project Director for the Developmental-Behavioral Pediatrics training grant. These requirements constitute the basis for development of the minimum qualifications section of the job description for each faculty position. Functional and program responsibilities should be specified in the narrative and position descriptions.

D. SUPPORT REQUESTED

Describe briefly what additional resources are needed to accomplish the stated goals and objectives, i.e., what is requested through project support and why. See also IV.2.iii and iv for assistance in preparing the budget and budget justification.

The following principles are vital when describing the need for additional resources:

- All budgets must provide satisfactory details to fully explain and justify the resources needed to accomplish the training objectives. This justification must provide explicit qualitative and quantitative documentation of required resources, productivity, and expected outcomes. Components to highlight include current strengths, number of trainees (specifying the number of masters, pre-doctoral and post-doctoral trainees), proposed program activities, Title V activities, and continuing education efforts.
- Budget justification must document support provided to long term trainees (fellows) either through this grant or through other sources.
- In addition, budgets may reflect certain economic factors that may cause amounts to be higher or lower than the average costs of \$182,600 per grant, e.g., special program emphasis, features or accomplishments, cost of living, type of institution of higher learning, community resources, etc.
- Programs must fully justify their requests by describing and identifying goals, objectives, activities, and outcomes that will be achieved by the program during the project period. It must be documented that the program plays a significant role in regional and/or national matters, including the extent to which the graduates have played major leadership roles related to maternal and child health.

Approximately \$1,861,000 is available for this competition. HRSA anticipates awarding 10 grants. Approximately \$35,000 of this amount will be set aside annually to support the DBP program meeting.

E. EVALUATIVE MEASURES

Evaluation and self-assessment are critically important for quality improvement and assessing the value-added contribution of Title V investments. Consequently, discretionary grant projects, including training projects, are expected to incorporate a carefully designed and well-planned evaluation protocol capable of demonstrating and documenting measurable progress toward achieving the stated goals. The measurement of progress toward goals should focus on systems, health and performance outcome indicators, rather than solely on intermediate process measures. The protocol should be based on a clear rationale relating to the identified needs of the target population with project goals, grant activities, and evaluation measures. A project lacking a complete and well-conceived evaluation protocol may not be funded. A formal plan for evaluating the DBP program must address how the major goals and objectives of the project will be achieved.

If there is any possibility that an applicant's evaluation may involve human subjects research as described in 45 CFR part 46, the applicant must comply with the regulations for the protection of human subjects as applicable.

Monitoring and evaluation activities must be ongoing and, to the extent feasible, must be structured to gain information which is quantifiable and which permits objective rather than subjective judgments. Explain what data will be collected, the methods for collection and the manner in which data will be analyzed and reported. Data analysis and reporting must facilitate evaluation of the project outcomes.

The applicant should describe who on the project will be responsible for refining and collecting, and analyzing data for the evaluation and how the applicant will make changes to the program based on evaluation findings. The applicant should present a plan for collecting the data elements described in Appendix A, MCHB Administrative Forms and Performance Measures.

F. IMPACT

The applicant must document the extent and effectiveness of plans for dissemination of project results and the extent to which project results may be national in scope, and the degree to which the project activities are shared with other stakeholders to strengthen the MCH network.

Development and Dissemination of Educational Resources

As programs revise and develop new curricular materials, teaching models, and other educational resources and references in developmental-behavioral pediatrics in response to new research findings and developments in the field, they must disseminate these products to other developmental-behavioral pediatric, clinical and public health programs or other relevant programs in order to promote enhanced attention to this specialized area.

MCH Network Development

The applicant must articulate a plan for demonstrating and teaching others to promote enhanced access to MCH expertise, values, initiatives and products through increased visibility and

outreach. Within this plan, emphasis must be placed on how MCH Trainees and alumni will be connected to one another, adding to the network of MCH professionals working together to improve maternal and child health. Efforts to assure trainee involvement in wider MCH related opportunities must be clearly described, along with other methods to develop the MCH identity amongst trainees.

x. Program Specific Forms

1) Performance Standards for Special Projects of Regional or National Significance (SPRANS) and Other MCHB Discretionary Projects

The Health Resources and Services Administration (HRSA) has modified its reporting requirements for SPRANS projects, CISS projects, and other grant programs administered by the Maternal and Child Health Bureau (MCHB) to include national performance measures that were developed in accordance with the requirements of the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). This Act requires the establishment of measurable goals for Federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures for States have also been established under the Block Grant provisions of Title V of the Social Security Act, the MCHB's authorizing legislation. Performance measures for other MCHB-funded grant programs have been approved by the Office of Management and Budget and are primarily based on existing or administrative data that projects should easily be able to access or collect. An electronic system for reporting these data elements has been developed and is now available.

*2) Performance Measures for the **Developmental Behavioral Pediatrics** and Submission of Administrative Data*

To prepare successful applicants of their reporting requirements, the administrative forms and performance measures are presented in the appendices of this funding opportunity announcement. In summary, the forms and performance measures for this program are:

- Form 1, MCHB Project Budget Details
- Form 2, Project Funding Profile
- Form 4, Project Budget and Expenditures by Types of Services (Note,
- Form 6, Abstract
- Form 7, Discretionary Grant Project Summary Data
- Project Performance/Outcome Measures(See Individual PM's below)
 - PM07: The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities
 - PM08: The percentage of graduates of MCHB long-term training programs that demonstrate field leadership after graduation
 - PM09: The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups
 - PM10: The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts, and training
 - PM59: The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs.
 - PM84: The percent of long-term training graduates who are engaged in work related to MCH populations.

- PM85: The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.
- Training Data Form – All Sections
- Products, Publications and Submissions Data Form

If there is any possibility that an applicant’s performance evaluation may involve human subjects research as described in 45 CFR part 46, the applicant must comply with the regulations for the protection of human subjects as applicable.

Monitoring and evaluation of performance measure activities must be ongoing and, to the extent feasible, should be structured to gain information which is quantifiable and which permits objective rather than subjective judgments.

Discretionary grant projects, including training projects, are expected to incorporate a carefully designed and well-planned protocol capable of demonstrating and documenting measurable progress toward MCH Training Performance Measures. The measurement of progress toward goals must focus on systems, health and performance outcome indicators, rather than solely on intermediate process measures. The protocol must be based on a clear rationale relating to the identified needs of the target population with project goals, grant activities, and evaluation measures. A project lacking a complete and well-conceived evaluation protocol may not be funded. A formal plan for evaluating the DBP program must address how the major goals and objectives of the project will be achieved.

The applicant must describe who on the project will be responsible for refining and collecting, and analyzing data for the evaluation and how the applicant will make changes to the program based on evaluation findings. The applicant must present a plan for collecting the data elements described in Appendix A, MCHB Administrative Forms and Performance Measures.

xi. *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. **Each attachment must be clearly labeled. Unless otherwise noted, all attachments count against the 80-page limit.**

Attachment 1: Chart/Table of Partners and Collaboration: Please provide a chart of letters of collaboration between the proposed program and collaborating departments, institutions, organizations or agencies. The chart should provide the following information: Institution, Person as appropriate, Responsibilities/Activities agreed to be provided, Date, Type of commitment (e.g., in kind, dollars, staff, equipment), and how HRSA can access a copy if requested.

Attachment 2: Map(s): Provide a map which indicates the location(s) and settings of primary training activities.

Attachment 3: Organizational Chart: Provide a one-page figure that depicts the organizational structure of the project, including subcontractors and other significant collaborators.

Attachment 4: Curriculum: Provide a syllabus or other curriculum description as appropriate for the DBP program. The syllabus should include descriptions of courses, workshops, seminars, and experiences.

Attachment 5: Position Descriptions of Key Personnel: Position descriptions that include the roles, responsibilities, and qualifications of proposed staff can be limited to a paragraph in length, not to exceed one (1) page. Because of the 80 page limit of this application, only include key personnel.

Attachment 6: Summary Progress Report: The Detailed Description of Project may be less than, but must not exceed **20 pages, including the narrative and all attachments.** Applicants under this announcement have the option of submitting a report covering the preceding four (4) years (July 1, 2008-June 30, 2012) for activities that are related to the program for which support is being requested. Submit the progress report with the application, as an attachment.

For current MCHB training projects, use the outline below to structure your summary progress report. For new applicants, use the summary progress report to demonstrate your capacity to implement a DBP training project.

The statement should include:

- i. **The period covered** in the report.
- ii. **Specific Objectives:** Briefly summarize the specific objectives of the project as actually funded.
- iii. **Results:** Describe the program activities conducted for each objective and the accomplishments. Include negative results or technical problems that may be important. Include summary performance measure data. Identify, by year, the length of training, numbers, disciplines, and levels of trainees in the program. Each MCH-supported trainee who completed training during the approved project period should be listed along with his/her racial/ethnic identity and current employment. Separate identification should be made of continuing education attendees; these attendees should not be counted as short-term trainees.
- iv. **Evaluation:** Enumerate the quantitative and qualitative measures used to evaluate the activities and objectives. Specify project outcomes and the degree to which stated objectives were achieved. Include any important modifications to your original plans.
- v. **Title V Program Relationship:** Describe the activities related to, or resulting from, established relationships of the program and faculty with state and local Title V agencies and programs in the community, state, and region.
- vi. **Regional and National Significance:** Describe significant contributions of the program beyond the state in which it is located.

vii. **Value Added:** Explain how this training grant has made a difference in your program, department, university, and beyond. What accomplishments and benefits would not have been possible without this support?

Attachments 7-15: Other relevant documents, such as budgets and budget justifications for subcontracts, etc.

3. Submission Dates and Times

Application Due Date

The due date for applications under this funding opportunity announcement is *August 21, 2012 at 8:00 P.M. ET*. Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by the organization's Authorized Organization Representative (AOR) through Grants.gov and 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 to document the progress of an application through the system.

- 1) The first will confirm receipt in the system;
- 2) The second will indicate whether the application has been successfully validated or has been rejected due to errors;
- 3) The third will be sent when the application has been successfully downloaded at HRSA; and
- 4) 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 MCH Training program is not a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100.

5. Funding Restrictions

1) **Concurrent Income**

In most instances stipends may not be granted to persons receiving a concurrent salary, fellowship or traineeship stipend, or other financial support related to his/her training or employment.

2) **Non-related Duties**

The training institution shall not require trainees or fellows to perform any duties which are not directly related to the purpose of the training for which the grant was awarded.

3) **Field Training**

Training institutions may not utilize grant funds to support field training, except when such training is part of the specified requirements of a degree program, or is authorized in the approved application.

4) **Other**

Grant funds may **not** be used: (a) for the support of any trainee who would not, in the judgment of the institution, be able to use the training or meet the minimum qualifications specified in the approved plan for the training; (b) to continue the support of a trainee who has failed to demonstrate satisfactory participation; or (c) for support of candidates for undergraduate or pre-professional degrees, or the basic professional degree.

Applicants responding to this announcement may request funding for a project period of up to five (5) years. 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.

Salary Limitation: The Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, limits the salary amount that may be awarded and charged to HRSA grants and cooperative agreements. Award funds may not be used to pay the salary of an individual at a rate in excess of Executive Level II. The Executive Level II salary of the Federal Executive Pay scale is \$179,700. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to the applicant organization. This salary limitation also applies to subawards/subcontracts under a HRSA grant or cooperative agreement.

Per Division F, Title V, Section 503 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011 (a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself. (b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government. (c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

Per Division F, Title V, Section 523 of the Consolidated Appropriations Act, 2012 (P.L. 112-74) enacted December 23, 2011, no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

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 applicants 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 organizations **immediately register** in Grants.gov and become familiar with the Grants.gov site application process. Applicants that do not complete the registration process 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 to complete all of the following required actions:

- Obtain an organizational Data Universal Number System (DUNS) number
- Register the organization with Central Contractor Registration (CCR) (or System for Award Management (SAM) starting late July 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 late July 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, an organization is urged to submit an application in advance of the deadline. If an application is rejected by Grants.gov due to errors, it must be corrected and resubmitted 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 Grants.gov application due date as the final and only application submitted.

Tracking an 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 an application can be found at <https://apply07.grants.gov/apply/checkAppStatus.faces>. Be sure the 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. All DBP Program applications will be reviewed and ranked according to the following six (6) criteria:

Criterion 1.	Purpose/Need	10 points
Criterion 2.	Methodology/Response	40 points
Criterion 3.	Evaluative Measures	10 points
Criterion 4.	Impact	10 points
Criterion 5.	Resources/Capabilities	20 points
Criterion 6.	Support Requested	<u>10 points</u>
Total		100 points

CRITERION 1: PURPOSE/NEED (10 points)

This criterion corresponds to Section A. PURPOSE/NEED of the program narrative in this funding opportunity announcement. The extent to which:

- the critical national, regional, and local needs that the DBP training program will address pertains to efforts related to the stated purpose of the DBP grant program announcement;
- the project addresses these identified needs and the degree to which this program addresses the purpose of the DBP grant program;
- the applicant documents a strong knowledge of health and related issues for the target population.

CRITERION 2: METHODOLOGY/RESPONSE (40 points)

The extent to which the proposed project responds to the Section B. METHODOLOGY/RESPONSE of the program narrative, and the clarity of the proposed goals and objectives. The extent to which the proposed activities (scientific or other) meet the goals of the DBP training program, and address the goals and attain project objectives.

Goals and Objectives (5 points)

- *The degree to which the project goals and objectives address the stated needs/purpose outlined in Section A and the objectives are time-framed and measurable.*

MCH Curriculum (10 points)

- *Evidence that there is a three-year fellowship program with clear educational objectives and a comprehensive curriculum meeting the Program Requirements for Residency Education in Developmental-Behavioral Pediatrics.*
- *Evidence that the program meets the Program Requirements for Residency Education in Developmental-Behavioral Pediatrics and is accredited by Accreditation Council for Graduate Medical Education (ACGME).*
- *Evidence that there is in-depth knowledge of relevant psychosocial and biological sciences, growth and development, adaptation, injury prevention, and disease prevention and health promotion as components of developmental-behavioral pediatrics.*
- *The extent to which the MCH Leadership competencies are taught.*
- *The extent to which interdisciplinary education about developmental-behavioral pediatric is demonstrated method in training.*
- *Evidence that the curricula address issues of cultural and linguistic competence and diversity.*
- *The extent to which the project integrates a public health perspective in the planned curricula.*
- *The extent to which the curricula address research, technology, innovation, and emerging issues.*
- *The effectiveness and strength of the collaboration with those outside of the university – (families, State Title V agencies, MCH or other appropriate agencies, other MCH Partners) through agreed-upon collaboration.*
- *The extent to which the MCH Life course framework is used in teaching.*

Trainee Recruitment and Retention (10 points)

- *Completeness, strength, and innovation of recruiting and retention plans and/or strategies, including those focused on racially, ethnically and culturally diverse trainees.*
- *Completeness of plans for tracking field leadership post-graduation.*
- *Plans addressing continuing education, including medium-term and short-term trainee programs and activities.*

Training elements (Training program design, clinical and didactic training): (15 points)

- *The extent to which the approach to training is thoughtful, logical and innovative.*
- *The extent to which the project utilizes the MCH Leadership competencies framework and assessment of trainees and faculty on the leadership competencies.*
- *The extent to which the project addresses didactic and experiential (clinical and community-based) training, including the trainee role in provision of clinical services, extensive of clinical preparation, and clinical supervision, and clinical rotation in diverse service settings and regular interactions with interdisciplinary staff with particular focus on DD and ASD*
- *The strength and feasibility of the proposed plan for development of trainee understanding, use and translation of research, including collaborative research approach.*
- *The extent to which the application provides evidence of a collaborative research approach among faculty and trainees.*

- *The extent of continuing education, consultation and technical assistance to those practicing in the field.*
- *Evidence of planned collaboration within the university (through shared courses, curriculum innovations, and collaborative research.*
- *Evidence of collaboration under the Combating Autism Act (e.g., research networks, state demonstration projects, LEND programs).*
- *Extent to which trainees interact with MCH public health professionals in various settings*
- *Coordination of the project's plan and objectives with the MCH Training Strategic Plan.*

CRITERION 3: EVALUATIVE MEASURES (10 points)

This section corresponds to the Section E. EVALUATIVE MEASURES of the program narrative. The effectiveness of the method proposed to monitor and evaluate the project results. Evaluative measures must be able to assess: 1) to what extent the program objectives have been met; and 2) to what extent these can be attributed to the project.

- *The strength and feasibility of the evaluation strategy to measure project objectives and proposed performance measures*
- *Strength of the proposed project's evaluation plan, including tracking and reporting on the accomplishments of former trainees*
- *The extent to which data and evaluation informs changes to the project based on evaluation findings*
- *The extent to which the applicant presents a plan for collecting the data elements, methods of data collection, required by MCHB described in Appendix A - MCHB Administrative Forms and Performance Measures*

CRITERION 4: IMPACT (10 points)

This section corresponds to the Section F. IMPACT of the program narrative. The extent and effectiveness of plans for dissemination of project results, the extent to which project results may be national in scope, and the degree to which the project activities are shared with other stakeholders.

- *Effectiveness of the dissemination plan to share curricula, assessment and other tools, training approaches, research findings (if any), and successes.*
- *Effectiveness of the dissemination plan to share the above mentioned items with MCHB funded entities.*
- *Effectiveness of a plan for strengthening the MCH network through connections of program faculty, staff, trainees and alumni with the broader MCH network.*

CRITERION 5: RESOURCES/CAPABILITIES (20 points)

This criterion corresponds to Section C. RESOURCES/CAPABILITIES of the program narrative. This is an evaluation of the proposed administrative structure, governance, relationships of the participants, and resources to conduct the proposed project, including the extent to which the project's personnel are qualified by training and/or experience to implement and carry out the project, including the following:

Faculty

- *Strength of proposed project faculty and staff as evidenced by their qualifications and experience for teaching leadership education in developmental-behavioral pediatrics.*
- *Extent to which faculty members are effective in recruiting, teaching, collaborating, mentoring students and serving as leaders in the field of developmental-behavioral pediatrics.*
- *Effectiveness of the plan for recruiting racially, ethnically and culturally diverse faculty.*

Organizational:

- *Demonstrated project leadership as a board-certified pediatrician with subspecialty certification in developmental-behavioral pediatrics dedicating 20 percent time on the project.*
- *Evidence of administrative and organizational capacity to conduct the proposed project (e.g., the physical resources described are adequate to perform the training, existing resources to support the types of educational methods described).*
- *Adequacy of the project setting and training sites.*
- *Documentation of relevant affiliation/collaborative agreements with key partners.*
- *Planned collaboration with those outside of the university (i.e., families and/or consumers, MCH or other appropriate state agencies and resources, and other MCHB investments).*

CRITERION 6: SUPPORT REQUESTED (10 points)

This criterion corresponds to Section D. SUPPORT REQUESTED of the program narrative. The proposed budget for each year of the project period is reasonable and relational to the objectives, complexity of the activities and the anticipated results for the project.

Overall:

- *Extent to which the costs outlined in the budget and required resources sections reasonably map to the scope of work.*
- *Degree of completeness of the budget line items being well described and justified in the budget justification.*

Trainee, faculty, and staffing related costs:

- *Extent to which the number of doctoral trainee stipends are described in the budget.*
- *Adequacy of the time planned for key personnel to the project to achieve project objectives.*
- *Program budget and documentation on innovative national efforts, with an emphasis on developmental behavioral health, as a part of the budget.*
- *Extent to which funds are allocated for applicants to attend an annual grantee meeting.*
- *Extent to which the application reflects adequate costs for managing the DBP annual meeting for one year during the five-year grant period.*

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 Section V. 1. Review Criteria 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 start date of July 1, 2013.

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 (NoA) 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 July 1, 2013.

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/hhsgrantspolicy.pdf>. 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 NoA).

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>.

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 incorporate diversity within specific cultural groups including but not limited to cultural uniqueness within Native American populations, Native Hawaiian, Pacific Islanders, and other ethnic groups, 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, 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 according to the following schedule:

<http://www.hrsa.gov/grants/manage/technicalassistance/federalfinancialreport/ffrschedule.pdf>. 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 NoA.

2) **Progress Report(s).** The awardee must submit a progress report to HRSA on an annual basis. Submission and HRSA approval of grantee Progress Report(s) triggers the budget period renewal and release of subsequent year funds. This report demonstrates grantee progress on program-specific goals. Further information will be provided in the NoA.

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>.

4) **Performance Report(s)**

The Health Resources and Services Administration (HRSA) has modified its reporting requirements for SPRANS projects, CISS projects, and other grant programs administered by the Maternal and Child Health Bureau (MCHB) to include national performance measures that were developed in accordance with the requirements of the Government Performance and Results Act (GPRA) of 1993 (Public Law 103-62). This Act requires the establishment of measurable goals for Federal programs that can be reported as part of the budgetary process, thus linking funding decisions with performance. Performance measures for States have also been established under the Block Grant provisions of Title V

of the Social Security Act, the MCHB's authorizing legislation. Performance measures for other MCHB-funded grant programs have been approved by the Office of Management and Budget and are primarily based on existing or administrative data that projects should easily be able to access or collect.

1. Performance Measures and Program Data

To prepare applicants for these reporting requirements, the designated performance measures for this program and other program data collection are presented in the appendices of this funding opportunity announcement. Data collection activities are required by the Combating Autism Initiative through the National Interdisciplinary Resource Center.

2. Performance Reporting

Successful applicants receiving grant funds will be required, within 120 days of the NoA, to register in HRSA's Electronic Handbooks (EHBs) and electronically complete the program specific data forms that appear in the appendices of this funding opportunity announcement. This requirement entails the provision of budget breakdowns in the financial forms based on the grant award amount, the project abstract and other grant summary data as well as providing objectives for the performance measures.

Performance reporting is conducted for each grant year of the project period. Grantees will be required, within 120 days of the NoA, to enter HRSA's EHBs and complete the program specific forms. This requirement includes providing expenditure data, finalizing the abstract and grant summary data as well as finalizing indicators/scores for the performance measures.

3. Project Period End Performance Reporting

Successful applicants receiving grant funding will be required, within 90 days from the end of the project period, to electronically complete the program specific data forms that appear in the appendices of this funding opportunity announcement. The requirement includes providing expenditure data for the final year of the project period, the project abstract and grant summary data as well as final indicators/scores for the performance measures.

5) Tangible Personal Property Report. If applicable, the awardee must submit the Tangible Personal Property Report (SF-428) and any related forms. The report must be submitted within 90 days after the project period ends. Awardees are required to report all federally-owned property and acquired equipment with an acquisition cost of \$5,000 or more per unit. Tangible personal property means property of any kind, except real property, that has physical existence. It includes equipment and supplies. Property may be provided by HRSA or acquired by the recipient with award funds. Federally-owned property consists of items that were furnished by the Federal Government. Tangible personal property reports must be submitted electronically through EHB. More specific information will be included in the NoA.

d. Transparency Act Reporting Requirements

New awards issued under this funding opportunity announcement 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 NoA.

VII. Agency Contacts

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

Ernsley Charles, Grants Management Specialist
HRSA, Division of Grants Management Operations
5600 Fishers Lane, Room 11A-02
Rockville, MD 20857
E-mail: ECharles@hrsa.gov
Telephone: (301) 443-0563
Fax: (301) 443-6686

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

Christopher Dykton
Division of MCH Workforce Development
Maternal and Child Health Bureau
5600 Fishers Lane, Room 18A-55
Rockville, MD 20857
E-Mail: cdykton@hrsa.gov
Telephone: (301) 443-9534
Fax: (301) 443-4842

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>

Successful applicants/awardees may need assistance when working online to submit information and reports electronically through HRSA's Electronic Handbooks (EHBs). For assistance with submitting the remaining information in HRSA's EHBs, contact the HRSA Contact Center, Monday-Friday, 9:00 a.m. to 5:30 p.m. ET:

HRSA Contact Center
Telephone: (877) 464-4772
TTY: (877) 897-9910
E-mail: CallCenter@HRSA.GOV

VIII. Other Information

MCH Training Program Web Site
<http://www.mchb.hrsa.gov/training>

Developmental Behavioral Pediatrics Training Program Web Site
<http://DBP.mchtraining.net/>

National Plan for Maternal and Child Health Training 2012-2020 - Draft
http://www.mchb.hrsa.gov/training/strategic_plan.asp

MCH Leadership Competencies
<http://leadership.mchtraining.net/>

Healthy People 2020
<http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx>

Institute of Medicine (IOM)
“In the Nation’s Compelling Interest: Ensuring Diversity in the Health Care Workforce”
<http://www.iom.edu/Reports/2004/In-the-Nations-Compelling-Interest-Ensuring-Diversity-in-the-Health-Care-Workforce.aspx>

Surgeon General’s Health Reports
<http://www.surgeongeneral.gov/library/>

Bright Futures (American Academy of Pediatrics)
<http://brightfutures.aap.org/web/>

National Center for Cultural Competence
<http://www11.georgetown.edu/research/gucchd/nccc/>

Making Websites Accessible: Section 508 of the Rehabilitation Act
<http://www.section508.gov/>

Title V Information System (TVIS) website:
<http://mchdata.hrsa.gov/TVISReports>

IX. Tips for Writing a Strong Application

HRSA has designed a technical assistance webpage to assist applicants in preparing applications. Resources include help with system registration, finding and applying for funding opportunities, writing strong applications, understanding the review process, and many other topics which applicants will find relevant. The website can be accessed online at:

<http://www.hrsa.gov/grants/apply/index.html>.

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: MCHB Administrative Forms and Performance Measures

To prepare successful applicants for their future performance reporting requirements, the Administrative Forms and Performance Measures assigned to this MCHB program are presented below.

- Form 1, MCHB Project Budget Details
- Form 2, Project Funding Profile
- Form 4, Project Budget and Expenditures by Types of Services
- Form 6, MCH Abstract
- Form 7, Discretionary Grant Project Summary Data
- Performance Measures
 - PM07: The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities
 - PM08: The percentage of graduates of MCHB long-term training programs that demonstrate field leadership after graduation
 - PM09: The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups
 - PM10: The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts, and training
 - PM59: The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs.
 - PM84: The percent of long-term training graduates who are engaged in work related to MCH populations.
 - PM85: The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.
- Training Data Form
- Products, Publications and Submissions Data Form

FORM 1
MCHB PROJECT BUDGET DETAILS FOR FY _____

1. MCHB GRANT AWARD AMOUNT	\$ _____
2. UNOBLIGATED BALANCE	\$ _____
3. MATCHING FUNDS	\$ _____
(Required: Yes [] No [] If yes, amount)	
A. Local funds	\$ _____
B. State funds	\$ _____
C. Program Income	\$ _____
D. Applicant/Grantee Funds	\$ _____
E. Other funds: _____	\$ _____
4. OTHER PROJECT FUNDS (Not included in 3 above)	\$ _____
A. Local funds	\$ _____
B. State funds	\$ _____
C. Program Income (Clinical or Other)	\$ _____
D. Applicant/Grantee Funds (includes in-kind)	\$ _____
E. Other funds (including private sector, e.g., Foundations)	\$ _____
5. TOTAL PROJECT FUNDS (Total lines 1 through 4)	\$ _____
6. FEDERAL COLLABORATIVE FUNDS	\$ _____
(Source(s) of additional Federal funds contributing to the project)	
A. Other MCHB Funds (Do not repeat grant funds from Line 1)	
1) Special Projects of Regional and National Significance (SPRANS)	\$ _____
2) Community Integrated Service Systems (CISS)	\$ _____
3) State Systems Development Initiative (SSDI)	\$ _____
4) Healthy Start	\$ _____
5) Emergency Medical Services for Children (EMSC)	\$ _____
6) Traumatic Brain Injury	\$ _____
7) State Title V Block Grant	\$ _____
8) Other: _____	\$ _____
9) Other: _____	\$ _____
10) Other: _____	\$ _____
B. Other HRSA Funds	
1) HIV/AIDS	\$ _____
2) Primary Care	\$ _____
3) Health Professions	\$ _____
4) Other: _____	\$ _____
5) Other: _____	\$ _____
6) Other: _____	\$ _____
C. Other Federal Funds	
1) Center for Medicare and Medicaid Services (CMS)	\$ _____
2) Supplemental Security Income (SSI)	\$ _____
3) Agriculture (WIC/other)	\$ _____
4) Administration for Children and Families (ACF)	\$ _____
5) Centers for Disease Control and Prevention (CDC)	\$ _____
6) Substance Abuse and Mental Health Services Administration (SAMHSA)	\$ _____
7) National Institutes of Health (NIH)	\$ _____
8) Education	\$ _____
9) Bioterrorism	\$ _____
10) Other: _____	\$ _____
11) Other: _____	\$ _____
12) Other: _____	\$ _____
7. TOTAL COLLABORATIVE FEDERAL FUNDS	\$ _____

**INSTRUCTIONS FOR COMPLETION OF FORM 1
MCH BUDGET DETAILS FOR FY _____**

- Line 1. Enter the amount of the Federal MCHB grant award for this project.
- Line 2. Enter the amount of carryover (e.g, unobligated balance) from the previous year's award, if any. New awards do not enter data in this field, since new awards will not have a carryover balance.
- Line 3. If matching funds are required for this grant program list the amounts by source on lines 3A through 3E as appropriate. Where appropriate, include the dollar value of in-kind contributions.
- Line 4. Enter the amount of other funds received for the project, by source on Lines 4A through 4E, specifying amounts from each source. Also include the dollar value of in-kind contributions.
- Line 5. Displays the sum of lines 1 through 4.
- Line 6. Enter the amount of other Federal funds received on the appropriate lines (A.1 through C.12) **other** than the MCHB grant award for the project. Such funds would include those from other Departments, other components of the Department of Health and Human Services, or other MCHB grants or contracts.
- Line 6C.1. Enter only project funds from the Center for Medicare and Medicaid Services. Exclude Medicaid reimbursement, which is considered Program Income and should be included on Line 3C or 4C.
- If lines 6A.8-10, 6B .4-6, or 6C.10-12 are utilized, specify the source(s) of the funds in the order of the amount provided, starting with the source of the most funds. .
- Line 7. Displays the sum of lines in 6A.1 through 6C.12.

**FORM 2
 PROJECT FUNDING PROFILE**

	<u>FY</u>		<u>FY</u>		<u>FY</u>		<u>FY</u>		<u>FY</u>	
	<u>Budgeted</u>	<u>Expended</u>								
1 <u>MCHB Grant</u> <u>Award Amount</u> <i>Line 1, Form 2</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
2 <u>Unobligated</u> <u>Balance</u> <i>Line 2, Form 2</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
3 <u>Matching Funds</u> <u>(If required)</u> <i>Line 3, Form 2</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
4 <u>Other Project</u> <u>Funds</u> <i>Line 4, Form 2</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
5 <u>Total Project</u> <u>Funds</u> <i>Line 5, Form 2</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
6 <u>Total Federal</u> <u>Collaborative</u> <u>Funds</u> <i>Line 7, Form 2</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**INSTRUCTIONS FOR THE COMPLETION OF FORM 2
PROJECT FUNDING PROFILE**

Instructions:

Complete all required data cells. If an actual number is not available, use an estimate. Explain all estimates in a note.

The form is intended to provide funding data at a glance on the estimated budgeted amounts and actual expended amounts of an MCH project.

For each fiscal year, the data in the columns labeled Budgeted on this form are to contain the same figures that appear on the Application Face Sheet (for a non-competing continuation) or the Notice of Grant Award (for a performance report). The lines under the columns labeled Expended are to contain the actual amounts expended for each grant year that has been completed.

FORM 4
PROJECT BUDGET AND EXPENDITURES
By Types of Services

<u>TYPES OF SERVICES</u>	FY _____		FY _____	
	<u>Budgeted</u>	<u>Expended</u>	<u>Budgeted</u>	<u>Expended</u>
I. <u>Direct Health Care Services</u> (Basic Health Services and Health Services for CSHCN.)	\$ _____	\$ _____	\$ _____	\$ _____
II. <u>Enabling Services</u> (Transportation, Translation, Outreach, Respite Care, Health Education, Family Support Services, Purchase of Health Insurance, Case Management, and Coordination with Medicaid, WIC and Education.)	\$ _____	\$ _____	\$ _____	\$ _____
III. <u>Population-Based Services</u> (Newborn Screening, Lead Screening, Immunization, Sudden Infant Death Syndrome Counseling, Oral Health, Injury Prevention, Nutrition, and Outreach/Public Education.)	\$ _____	\$ _____	\$ _____	\$ _____
IV. <u>Infrastructure Building Services</u> (Needs Assessment, Evaluation, Planning, Policy Development, Coordination, Quality Assurance, Standards Development, Monitoring, Training, Applied Research, Systems of Care, and Information Systems.)	\$ _____	\$ _____	\$ _____	\$ _____
V. <u>TOTAL</u>	\$ _____	\$ _____	\$ _____	\$ _____

**INSTRUCTIONS FOR THE COMPLETION OF FORM 4
PROJECT BUDGET AND EXPENDITURES BY TYPES OF SERVICES**

Complete all required data cells for all years of the grant. If an actual number is not available, make an estimate. Please explain all estimates in a note. Administrative dollars should be allocated to the appropriate level(s) of the pyramid on lines I, II, III or IV. If an estimate of administrative funds use is necessary, one method would be to allocate those dollars to Lines I, II, III and IV at the same percentage as program dollars are allocated to Lines I through IV.

Note: Lines I, II and III are for projects providing services. If grant funds are used to build the infrastructure for direct care delivery, enabling or population-based services, these amounts should be reported in Line IV (i.e., building data collection capacity for newborn hearing screening).

Line I Direct Health Care Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Direct Health Care Services are those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Line II Enabling Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Enabling Services allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Line III Population-Based Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Population Based Services are preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Line IV Infrastructure Building Services - enter the budgeted and expended amounts for the appropriate fiscal year completed and budget estimates only for all other years.

Infrastructure Building Services are the base of the MCH pyramid of health services and form its foundation. They are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems and resources including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Line V Total – Displays the total amounts for each column, budgeted for each year and expended for each year completed.

FORM 6
MATERNAL & CHILD HEALTH DISCRETIONARY GRANT
PROJECT ABSTRACT
FOR FY_____

PROJECT: _____

I. PROJECT IDENTIFIER INFORMATION

1. Project Title:
2. Project Number:
3. E-mail address:

II. BUDGET

- | | |
|---|----------|
| 1. MCHB Grant Award
(Line 1, Form 2) | \$ _____ |
| 2. Unobligated Balance
(Line 2, Form 2) | \$ _____ |
| 3. Matching Funds (if applicable)
(Line 3, Form 2) | \$ _____ |
| 4. Other Project Funds
(Line 4, Form 2) | \$ _____ |
| 5. Total Project Funds
(Line 5, Form 2) | \$ _____ |

III. TYPE(S) OF SERVICE PROVIDED (Choose all that apply)

- Direct Health Care Services
- Enabling Services
- Population-Based Services
- Infrastructure Building Services

IV. PROJECT DESCRIPTION OR EXPERIENCE TO DATE

A. Project Description

1. Problem (in 50 words, maximum):

2. Goals and Objectives: (List up to 5 major goals and time-framed objectives per goal for the project)

Goal 1:

Objective 1:

Objective 2:

Goal 2:

Objective 1:

Objective 2:

Goal 3:

Objective 1:

Objective 2:

- Goal 4:
 - Objective 1:
 - Objective 2:
- Goal 5:
 - Objective 1:
 - Objective 2:

3. Activities planned to meet project goals

4. Specify the primary *Healthy People 2020* objectives(s) (up to three) which this project addresses:

- a.
- b.
- c.

5. Coordination (List the State, local health agencies or other organizations involved in the project and their roles)

6. Evaluation (briefly describe the methods which will be used to determine whether process and outcome objectives are met)

- B. Continuing Grants ONLY
1. Experience to Date (For continuing projects ONLY):

2. Website URL and annual number of hits

V. KEY WORDS

VI. ANNOTATION

INSTRUCTIONS FOR THE COMPLETION OF FORM 6 PROJECT ABSTRACT

NOTE: All information provided should fit into the space provided in the form. The completed form should be no more than 3 pages in length. Where information has previously been entered in forms 1 through 5, the information will automatically be transferred electronically to the appropriate place on this form.

Section I – Project Identifier Information

Project Title: Displays the title for the project.

Project Number: Displays the number assigned to the project (e.g., the grant number)

E-mail address: Displays the electronic mail address of the project director

Section II – Budget - These figures will be transferred from Form 1, Lines 1 through 5.

Section III - Types of Services

Indicate which type(s) of services your project provides, checking all that apply.

Section IV – Program Description OR Current Status (DO NOT EXCEED THE SPACE PROVIDED)

A. New Projects only are to complete the following items:

1. A brief description of the project and the problem it addresses, such as preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for Children with Special Health Care Needs.
2. Provide up to 5 goals of the project, in priority order. Examples are: To reduce the barriers to the delivery of care for pregnant women, to reduce the infant mortality rate for minorities and “services or system development for children with special healthcare needs.” MCHB will capture annually every project’s top goals in an information system for comparison, tracking, and reporting purposes; you must list at least 1 and no more than 5 goals. For each goal, list the two most important objectives. The objective must be specific (i.e., decrease incidence by 10%) and time limited (by 2005).
3. Displays the primary Healthy people 2020 goal(s) that the project addresses.
4. Describe the programs and activities used to attain the goals and objectives, and comment on innovation, cost, and other characteristics of the methodology, proposed or are being implemented. Lists with numbered items can be used in this section.
5. Describe the coordination planned and carried out, in the space provided, if applicable, with appropriate State and/or local health and other agencies in areas(s) served by the project.
6. Briefly describe the evaluation methods that will be used to assess the success of the project in attaining its goals and objectives.

B. For continuing projects ONLY:

- Provide a brief description of the major activities and accomplishments over the past year (not to exceed 200 words).
- Provide website and number of hits annually, if applicable.

Section V – Key Words

Provide up to 10 key words to describe the project, including populations served. Choose key words from the included list.

Section VI – Annotation

Provide a three- to five-sentence description of your project that identifies the project’s purpose, the needs and problems, which are addressed, the goals and objectives of the project, the activities, which will be used to attain the goals, and the materials, which will be developed.

FORM 7
DISCRETIONARY GRANT PROJECT
SUMMARY DATA

- 1. Project Service Focus**
 Urban/Central City Suburban Metropolitan Area (city & suburbs)
 Rural Frontier Border (US-Mexico)

- 2. Project Scope**
 Local Multi-county State-wide
 Regional National

- 3. Grantee Organization Type**
 State Agency
 Community Government Agency
 School District
 University/Institution Of Higher Learning (Non-Hospital Based)
 Academic Medical Center
 Community-Based Non-Governmental Organization (Health Care)
 Community-Based Non-Governmental Organization (Non-Health Care)
 Professional Membership Organization (Individuals Constitute Its Membership)
 National Organization (Other Organizations Constitute Its Membership)
 National Organization (Non-Membership Based)
 Independent Research/Planning/Policy Organization
 Other _____

- 4. Project Infrastructure Focus** (from MCH Pyramid) if applicable
 Guidelines/Standards Development And Maintenance
 Policies And Programs Study And Analysis
 Synthesis Of Data And Information
 Translation Of Data And Information For Different Audiences
 Dissemination Of Information And Resources
 Quality Assurance
 Technical Assistance
 Training
 Systems Development
 Other

5. Demographic Characteristics of Project Participants

Indicate the service level:

<input type="checkbox"/> Direct Health Care Services	<input type="checkbox"/> Population-Based Services
<input type="checkbox"/> Enabling Services	<input type="checkbox"/> Infrastructure Building Services

	RACE (Indicate all that apply)							Total	ETHNICITY			
	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More than One Race	Unrecorded		Hispanic or Latino	Not Hispanic or Latino	Unrecorded	Total
Pregnant Women (All Ages)												
Infants <1 year												
Children and Youth 1 to 25 years												
CSHCN Infants <1 year												
CSHCN Children and Youth 1 to 25 years												
Women 25+ years												
Men 25+ years												
TOTALS												

6. Clients' Primary Language(s)

7. Resource/TA and Training Centers ONLY

Answer all that apply.

a. Characteristics of Primary Intended Audience(s)

Policy Makers/Public Servants

Consumers

Providers/Professionals

b. Number of Requests Received/Answered: _____/_____

c. Number of Continuing Education credits provided: _____

d. Number of Individuals/Participants Reached: _____

e. Number of Organizations Assisted: _____

f. Major Type of TA or Training Provided:

continuing education courses,

workshops,

on-site assistance,

distance learning classes

other

INSTRUCTIONS FOR THE COMPLETION OF FORM 7 PROJECT SUMMARY

Section 1 – Project Service Focus

Select all that apply

Section 2 – Project Scope

Choose the one that best applies to your project.

Section 3 – Grantee Organization Type

Choose the one that best applies to your organization.

Section 4 – Project Infrastructure Focus

If applicable, choose all that apply.

Section 5 – Demographic Characteristics of Project Participants

Indicate the service level for the grant program. Multiple selections may be made. Please fill in each of the cells as appropriate.

Direct Health Care Services are those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and sub-specialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

Population Based Services are preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

Infrastructure Building Services are the base of the MCH pyramid of health services and form its foundation. They are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems and resources including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Section 6 – Clients Primary Language(s)

Indicate which languages your clients speak as their primary language, other than English, for the data provided in Section 6.
List up to three languages.

Section 7 – Resource/TA and Training Centers (Only)

Answer all that apply.

07 PERFORMANCE MEASURE

The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities.

Goal 1: Provide National Leadership for MCHB (Promote family participation in care)

Level: Grantee

Category: Family/Youth/Consumer Participation

GOAL

To increase family/youth/consumer participation in MCHB programs.

MEASURE

The degree to which MCHB-funded programs ensure family/youth/consumer participation in program and policy activities.

DEFINITION

Attached is a checklist of eight elements that demonstrate family participation, including an emphasis on family-professional partnerships and building leadership opportunities for families and consumers in MCHB programs. Please check the degree to which the elements have been implemented.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16.23. Increase the proportion of Territories and States that have service systems for Children with Special Health Care Needs to 100 percent.

DATA SOURCE(S) AND ISSUES

Attached data collection form is to be completed by grantees.

SIGNIFICANCE

Over the last decade, policy makers and program administrators have emphasized the central role of families and other consumers as advisors and participants in policy-making activities. In accordance with this philosophy, MCHB is facilitating such partnerships at the local, State and national levels.

Family/professional partnerships have been incorporated into the MCHB Block Grant Application, the MCHB strategic plan. Family/professional partnerships are a requirement in the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) and part of the legislative mandate that health programs supported by Maternal and Child Health Bureau (MCHB) Children with Special Health Care Needs (CSHCN) provide and promote family centered, community-based, coordinated care.

DATA COLLECTION FORM FOR DETAIL SHEET #07

Using a scale of 0-3, please rate the degree to which the grant program has included families, youth, and consumers into their program and planning activities. Please use the space provided for notes to describe activities related to each element and clarify reasons for score.

0	1	2	3	Element
				. Family members/youth/consumers participate in the planning, implementation and evaluation of the program's activities at all levels, including strategic planning, program planning, materials development, program activities, and performance measure reporting.
				. Culturally diverse family members/youth/consumers facilitate the program's ability to meet the needs of the populations served.
				. Family members/youth/consumers are offered training, mentoring, and opportunities to lead advisory committees or task forces.
				. Family members/youth/consumers who participate in the program are compensated for their time and expenses.
				. Family members/youth/consumers participate on advisory committees or task forces to guide program activities.
				. Feedback on policies and programs is obtained from families/youth/consumers through focus groups, feedback surveys, and other mechanisms as part of the project's continuous quality improvement efforts.
				. Family members/youth/consumers work with their professional partners to provide training (pre-service, in-service and professional development) to MCH/CSHCN staff and providers.
				. Family /youth/consumers provide their perspective to the program as paid staff or consultants.

- 0=Not Met
- 1=Partially Met
- 2=Mostly Met
- 3=Completely Met

Total the numbers in the boxes (possible 0-24 score) _____

NOTES/COMMENTS:

08 PERFORMANCE MEASURE

The percentage of graduates of MCHB long-term training programs that demonstrate field leadership after graduation.

Goal 1: Provide National Leadership for Maternal and Child Health
(Provide both graduate level and continuing education training to assure interdisciplinary MCH public health leadership nationwide)
Level: Grantee
Category: Training

GOAL

To increase the percentage of graduates of long-term training programs that demonstrate field leadership five years after graduation.

MEASURE

The percentage of graduates of MCHB long-term training programs that demonstrate field leadership after graduation.

DEFINITION

Attached is a checklist of four elements that demonstrate field leadership. For each element, identify the number of graduates of MCHB long-term training programs that demonstrate field leadership five years after graduation. Please keep the completed checklist attached.

“Field leadership” refers to but is not limited to providing MCH leadership within the clinical, advocacy, academic, research, public health, public policy or governmental realms. Refer to attachment for complete definition.

Cohort is defined as those who graduate in a certain project period. Data form for each cohort year will be collected five years following graduation.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 1.7: (Developmental) Increase the proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.

Related to Objective 23.8: (Developmental) Increase the proportion of Federal, Tribal, State, and local agencies that incorporate specific competencies in the essential public health services into personnel systems.

DATA SOURCE(S) AND ISSUES

Attached data collection form to be completed by grantees.

SIGNIFICANCE

An MCHB trained workforce is a vital participant in clinical, administrative, policy, public health and various other arenas. MCHB long-term training programs assist in developing a public health workforce that addresses MCH concerns and fosters field leadership in the MCH arena.

DATA COLLECTION FORM FOR DETAIL SHEET #08

- A. The total number of graduates, five years following completion of program _____
- B. The total number of graduates lost to follow up _____
- C. The total number of respondents (A-B) _____
- D. Number of respondents demonstrating MCH leadership in **at least one** of the following areas below _____
- E. Percent of respondents demonstrating MCH leadership in at least one of the following areas below _____

Please use the notes field to detail data sources and year of data used.
(Individual respondents may have leadership activities in multiple areas below)

- 1. Number of trainees that have participated in **academic** leadership activities _____
 - Disseminated information on MCH Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
 - Conducted research or quality improvement on MCH issues
 - Provided consultation or technical assistance in MCH areas
 - Taught/mentored in my discipline or other MCH related field
 - Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
 - Procured grant and other funding in MCH areas
 - Conducted strategic planning or program evaluation
- 2. Number of trainees that have participated in **clinical** leadership activities _____
 - Participated as a group leader, initiator, key contributor or in a position of influence/authority on any of the following: committees of State, national, or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
 - Served in a clinical position of influence (e.g. director, senior therapist, team leader, etc)
 - Taught/mentored in my discipline or other MCH related field
 - Conducted research or quality improvement on MCH issues
 - Disseminated information on MCH Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
 - Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
- 3. Number of trainees that have participated in **public health practice** leadership activities _____
 - Provided consultation, technical assistance, or training in MCH areas
 - Procured grant and other funding in MCH areas
 - Conducted strategic planning or program evaluation
 - Conducted research or quality improvement on MCH issues
 - Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process)
 - Participated in public policy development activities (e.g., Participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation (provided testimony, educated legislators, etc)

4. Number of trainees that have participated in **public policy & advocacy** leadership activities _____

- Participated in public policy development activities (e.g., participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation, provided testimony, educated legislators)
- Participated on any of the following as a group leader, initiator, key contributor, or in a position of influence/authority: committees of State, national, or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
- Disseminated information on MCH public policy Issues (e.g., Peer-reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)

NOTES/COMMENTS:

09 PERFORMANCE MEASURE

Goal 2: Eliminate Health Barriers and Disparities (Train an MCH Workforce that is culturally competent and reflects an increasingly diverse population)
Level: Grantee
Category: Training

The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups.

GOAL

To increase the percentage of trainees participating in MCHB long-term training programs who are from underrepresented racial and ethnic groups.

MEASURE

The percentage of participants in MCHB long-term training programs who are from underrepresented racial and ethnic groups.

DEFINITION

Numerator:

Total number of long-term trainees (≥ 300 contact hours) participating in MCHB training programs reported to be from underrepresented racial and ethnic groups. (Include MCHB-supported and non-supported trainees.)

Denominator:

Total number of long-term trainees (≥ 300 contact hours) participating in MCHB training programs. (Include MCHB-supported and non-supported trainees.)

Units: 100

Text: Percentage

The definition of “underrepresented racial and ethnic groups” is based on the categories from the U.S. Census.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 1.8: In the health professions, allied and associated health professions, and the nursing field, increase the proportion of all degrees awarded to members of underrepresented racial and ethnic groups.

DATA SOURCE(S) AND ISSUES

Data will be collected annually from grantees about their trainees.
MCHB does not maintain a master list of all trainees who are supported by MCHB long-term training programs.

References supporting Workforce Diversity:

- In the Nation’s Compelling Interest: Ensuring Diversity in the Healthcare Workforce (2004). Institute of Medicine.

- Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2002).
Institute of Medicine.

SIGNIFICANCE

HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care. Training a diverse group of professionals is necessary in order to provide a diverse public health workforce to meet the needs of the changing demographics of the U.S. and to ensure access to culturally competent and effective services. This performance measure provides the necessary data to report on HRSA's initiatives to reduce health disparities.

DATA COLLECTION FORM FOR DETAIL SHEET #09

Report on the percentage of long-term trainees (≥ 300 contact hours) who are from any underrepresented racial/ethnic group (i.e., Hispanic or Latino, American Indian or Alaskan Native, Asian, Black or African-American, Native Hawaiian or Pacific Islander, two or more race (OMB). Please use the space provided for notes to detail the data source and year of data used.

- Report on all long-term trainees (≥ 300 contact hours) including MCHB-funded and non MCHB-funded trainees
- Report race and ethnicity separately
- Trainees who select multiple ethnicities should be counted once
- Grantee reported numerators and denominator will be used to calculate percentages

Total number of long-term trainees (≥ 300 contact hours) participating in the training program.
(Include MCHB-supported and non-supported trainees.)

**NOTES/
COMME
NTS:**

Ethnic Categories

Number of long-term training participants who are Hispanic or Latino (Ethnicity)

Racial Categories

Number of long-term trainees who are American Indian or Alaskan Native

Number of long-term trainees who are of Asian descent

Number of long-term trainees who are Black or African-American

Number of long-term trainees who are Native Hawaiian or Pacific Islanders

Number of long-term trainees who are two or more races

10 PERFORMANCE MEASURE

**Goal 2: Eliminate Health Barriers & Disparities
(Develop and promote health services and
systems of care designed to eliminate disparities
and barriers across MCH populations)**

Level: Grantee

Category: Cultural Competence

The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts and training.

GOAL

To increase the number of MCHB-funded programs that have integrated cultural and linguistic competence into their policies, guidelines, contracts and training.

MEASURE

The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts and training.

DEFINITION

Attached is a checklist of 15 elements that demonstrate cultural and linguistic competence. Please check the degree to which the elements have been implemented. The answer scale for the entire measure is 0-45. Please keep the completed checklist attached.

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989; sited from DHHS Office of Minority Health--
<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlid=11>)

Linguistic competence is the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competence requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity. (Goode, T. and W. Jones,

2004. National Center for Cultural Competence;
<http://www.ncccurricula.info/linguisticcompetence.html>)

Cultural and linguistic competence is a process that occurs along a developmental continuum. A culturally and linguistically competent program is characterized by elements including the following: written strategies for advancing cultural competence; cultural and linguistic competence policies and practices; cultural and linguistic competence knowledge and skills building efforts; research data on populations served according to racial, ethnic, and linguistic groupings; participation of community and family members of diverse cultures in all aspects of the program; faculty and other instructors are racially and ethnically diverse; faculty and staff participate in professional development activities related to cultural and linguistic competence; and periodic assessment of trainees' progress in developing cultural and linguistic competence.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to the following HP2010 Objectives:

16.23: Increase the proportion of States and jurisdictions that have service systems for children with or at risk for chronic and disabling conditions as required by Public Law 101-239.

23.9: (Developmental) Increase the proportion of schools for public health workers that integrate into their curricula specific content to develop competence in the essential public health services.

23.11:(Developmental) Increase the proportion of State and local public health agencies that meet national performance standards for essential public health services.

23.15: (Developmental) Increase the proportion of Federal, Tribal, State, and local jurisdictions that review and evaluate the extent to which their statutes, ordinances, and bylaws assure the delivery of essential public health services.

DATA SOURCE(S) AND ISSUES

Attached data collection form is to be completed by grantees.

There is no existing national data source to measure the extent to which MCHB supported programs have incorporated cultural competence elements into their policies, guidelines, contracts and training.

SIGNIFICANCE

Over the last decade, researchers and policymakers have emphasized the central influence of cultural values and cultural/linguistic barriers: health seeking behavior, access to care, and racial and

ethnic disparities. In accordance with these concerns, cultural competence objectives have been: (1) incorporated into the MCHB strategic plan; and (2) in guidance materials related to the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), which is the legislative mandate that health programs supported by MCHB Children with Special Health Care Needs (CSHCN) provide and promote family centered, community-based, coordinated care.

DATA COLLECTION FORM FOR DETAIL SHEET #10

Using a scale of 0-3, please rate the degree to which your grant program has incorporated the following cultural/linguistic competence elements into your policies, guidelines, contracts and training.

Please use the space provided for notes to describe activities related to each element, detail data sources and year of data used to develop score, clarify any reasons for score, and or explain the applicability of elements to program.

0	1	2	3	Element
				1. Strategies for advancing cultural and linguistic competence are integrated into your program's written plan(s) (e.g., grant application, recruiting plan, placement procedures, monitoring and evaluation plan, human resources, formal agreements, etc.).
				2. There are structures, resources, and practices within your program to advance and sustain cultural and linguistic competence.
				3. Cultural and linguistic competence knowledge and skills building are included in training aspects of your program.
				4. Research or program information gathering includes the collection and analysis of data on populations served according to racial, ethnic, and linguistic groupings, where appropriate.
				5. Community and family members from diverse cultural groups are partners in planning your program.
				6. Community and family members from diverse cultural groups are partners in the delivery of your program.
				7. Community and family members from diverse cultural groups are partners in evaluation of your program.
				8. Staff and faculty reflect cultural and linguistic diversity of the significant populations served.
				9. Staff and faculty participate in professional development activities to promote their cultural and linguistic competence.
				10. A process is in place to assess the progress of your program participants in developing cultural and linguistic competence.

- 0 = Not Met
- 1 = Partially Met
- 2 = Mostly Met
- 3 = Completely Met

Total the numbers in the boxes (possible 0-30 score) _____

NOTES/COMMENTS:

59 PERFORMANCE MEASURE

The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs.

GOAL

To assure that a training program has collaborative interactions related to training, technical assistance, continuing education, and other capacity-building services with relevant national, state and local programs, agencies and organizations.

MEASURE

The degree to which a training program collaborates with State Title V agencies, other MCH or MCH-related programs and other professional organizations.

DEFINITION

Attached is a list of the 6 elements that describe activities carried out by training programs for or in collaboration with State Title V and other agencies on a scale of 0 to 1. If a value of '1' is selected, provide the number of activities for the element. The total score for this measure will be determined by the sum of those elements noted as '1.'

HEALTHY PEOPLE 2010 OBJECTIVE

1-7. Increase the proportion of schools of medicine, schools of nursing, and other health professional training schools whose basic curriculum for health care providers includes the core competencies in health promotion and disease prevention.
7-2. Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems...
7-11. Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.
23-8, 23-10. Increase the proportion of Federal, Tribal, State, and local agencies that incorporate specific competencies and provide continuing education to develop competence in the essential public health services.

DATA SOURCES AND ISSUES

The training program completes the attached table which describes the categories of collaborative activity.

SIGNIFICANCE

As a SPRANS, a training program enhances the Title V State block grants that support the MCHB goal to promote comprehensive, coordinated, family-centered, and culturally-sensitive systems of health care that serve the diverse needs of all families within their own communities. Interactive collaboration between a training program and Federal, Tribal, State and local agencies dedicated to improving the health of MCH populations will increase active involvement of many disciplines across public and private sectors and increase the likelihood of success in meeting the goals of relevant stakeholders.

This measure will document a training program's abilities to:

- 1) collaborate with State Title V and other agencies (at a systems level) to support achievement of the MCHB Strategic Goals and CSHCN Healthy People 2010 action plan;
- 2) make the needs of MCH populations more visible to decision-makers and can help states achieve best practice standards for their systems of care;
- 3) reinforce the importance of the value added to LEAH program dollars in supporting faculty leaders to work at all levels of systems change; and
- 4) internally use this data to assure a full scope of these program elements in all regions.

DATA COLLECTION FORM FOR DETAIL SHEET PM #59

Indicate the degree to which your training program collaborates with State Title V (MCH) agencies and other MCH or MCH-related programs using the following values:

- 0= The training program does not collaborate on this element.
- 1=The training program does collaborate on this element.

If your program does collaborate, provide the total number of activities for the element.

Element	0	1	Total Number of Activities
<p><u>Service</u> Examples might include: Clinics run by the training program and/ or in collaboration with other agencies</p>			
<p><u>Training</u> Examples might include: Training in <i>Bright Futures...</i>; Workshops related to a DBP health practice; and Community-based practices. It would not include clinical supervision of long-term trainees.</p>			
<p><u>Continuing Education</u> Examples might include: Conferences; Distance learning; and Computer-based educational experiences. It would not include formal classes or seminars for long-term trainees.</p>			
<p><u>Technical Assistance</u> Examples might include: Conducting needs assessments with State programs; policy development; grant writing assistance; identifying best-practices; and leading collaborative groups. It would not include conducting needs assessments of consumers of the training program services.</p>			
<p><u>Product Development</u> Examples might include: Collaborative development of journal articles and training or informational videos.</p>			
<p><u>Research</u> Examples might include: Collaborative submission of research grants, research teams that include Title V or other MCH-program staff and the training program's faculty.</p>			

Total Score (possible 0-6 score) _____
Total Number of Collaborative Activities _____

84 PERFORMANCE MEASURE

The percent of long-term training graduates who are engaged in work related to MCH populations

Goal 2: Eliminate Health Barriers and Disparities

Level: Grantee

Category: Training

GOAL

To increase the percent of graduates of MCH long-term training programs who are engaged in work related to MCH populations.

MEASURE

The percent of long-term training graduates who are engaged in work related to MCH populations.

DEFINITION

Numerator:

Number of trainees reporting they are engaged in work related to MCH populations

Denominator:

The total number of trainees responding to the survey

Units: 100

Text: Percent

Long-term trainees are defined as those who have completed a long-term (greater than or equal to 300 contact hours) leadership training program, including those who received MCH funds and those who did not.

MCH Populations: Includes all of the Nation's women, infants, children, adolescents, and their families, including and children with special health care needs (MCHB Strategic Plan: FYs 2003-2007)

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Goal 1: Improve access to comprehensive, high-quality health care services (Objectives 1.1-1.16).

Related to Goal 7 – Educational and community-based programs: Increase the quality, availability and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life. Specific objectives: 7-7 through 7-11.

Related to Goal 23 – Public Health Infrastructure: Ensure that Federal, Tribal, State, and local health agencies have the infrastructure to provide essential public health services effectively. Specific objectives: 23-8 through 23-10

DATA SOURCE(S) AND ISSUES

A revised trainee follow-up survey that incorporates

the new form for collecting data on the involvement of MCH training program graduates in work related to MCH populations will be used to collect these data.

Data Sources Related to Training and Work
Settings/Populations:

Rittenhouse Diane R, George E. Fryer, Robert L. Phillips et al. Impact of Title Vii Training Programs on Community Health Center Staffing and National Health Service Corps Participation. *Ann Fam Med* 2008;6:397-405. DOI: 10.1370/afm.885.

Karen E. Hauer, Steven J. Durning, Walter N. Kernan, et al. Factors Associated With Medical Students' Career Choices Regarding Internal Medicine *JAMA*. 2008;300(10):1154-1164
(doi:10.1001/jama.300.10.1154)

SIGNIFICANCE

HRSA's MCHB places special emphasis on improving service delivery to women, children and youth from communities with limited access to comprehensive care.

DATA COLLECTION FORM FOR DETAIL SHEET # 84

Long-term training graduates who report working with **the maternal and child health population** (i.e., women, infants, children, adolescents, and their families, including and children with special health care needs) 5 years after completing their training program.

NOTE: If the individual works with more than one of these groups only count them once.

- A. The total number of graduates, 5 years following completion of program _____
- B. The total number of graduates lost to follow-up _____
- C. The total number of respondents (A-B) = denominator _____
- D. Number of respondents who report working with an MCH population _____
- E. Percent of respondents who report working with an MCH population _____

Use the notes field to detail data source used and information that provides significant context for the data.

85 PERFORMANCE MEASURE

Goal 5: Generate, translate, and integrate new knowledge to enhance MCH training, inform policy, and improve health outcomes Level:

Grantee

Category: Training

The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.

GOAL

To increase the number of MCH long-term training programs that actively promote the transfer and utilization of MCH knowledge and research to the policy arena through the work of faculty, trainees, alumni, and collaboration with Title V.

MEASURE

The degree to which MCH long-term training grantees engage in policy development, implementation, and evaluation.

DEFINITION

Attached is a checklist of six elements that demonstrate policy engagement. Please check the degree to which the elements have been implemented. The answer scale is 0-18. Please keep the completed checklist attached.

Policy development, implementation and evaluation in the context of MCH training programs relates to the process of translating research to policy and training for leadership in the core public health function of policy development.

Actively – mutual commitment to policy-related projects or objectives within the past 12 months.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Goal 23: Public Health Infrastructure “Ensure that Federal, tribal, State, and local health agencies have the infrastructure to provide essential public health services effectively.

Related to Objective 23.9: (Developmental)
Increase the proportion of schools for public health workers that integrate into their curricula specific content to develop competence in the essential public health services.

Related to Objective 23.17: (Developmental)
Increase the proportion of Federal, Tribal, State, and local public health agencies that conduct or collaborate on population-based prevention research.

DATA SOURCE(S) AND ISSUES

- Attached data collection form to be completed by grantee.
- Data will be collected from competitive and continuation applications as part of the grant application process and annual reports. The elements of training program engagement in policy development,

implementation, and evaluation need to be operationally defined with progress noted on the attached draft checklist with an example described more fully in the narrative application.

SIGNIFICANCE

Policy development is one of the three core functions of public health as defined in 1988 by the Institute of Medicine in *The Future of Public Health* (National Academy Press, Washington DC).

In this landmark report by the IOM, the committee recommends that “*every public health agency exercise its responsibility to serve the public interest in the development of comprehensive public health policies by promoting use of the scientific knowledge base in decision-making about public health and by leading in developing public health policy.*” Academic institutions such as schools of public health and research universities have the dual responsibility to develop knowledge and to produce well-trained professional practitioners.

This national performance measure relates directly to Goal 5 of the National MCHB Training Strategic Plan to “generate, translate, and integrate new knowledge to enhance MCH training, inform policy, and improve health outcomes”.

DATA COLLECTION FORM FOR DETAIL SHEET #85

Using a scale of 0-3, please rate the degree to which your training program has addressed the following policy development, implementation and evaluation elements.

0	1	2	3	Element
				Provide multiple didactic opportunities for training on policy development and advocacy to increase understanding of how the policy process works at the federal, state and local levels.
				Provide multiple opportunities within the practicum/field/clinical experience portion of the training curriculum for knowledge and skills building in policy development, implementation and evaluation.
				A process is in place for assessing the policy knowledge and skills of trainees.
				Research findings are disseminated and effectively communicated directly to public health agency leaders and policy officials with attention to how these findings add to the evidence-base for policy decisions and resource allocation.
				Faculty or staff contributes to the development of guidelines, regulations, legislation or other public policy at the local, state, and/or national level.
				Participate in developing and strengthening local, state, and/or national MCH advocacy networks and initiatives. Examples include MCH coalitions, teen pregnancy prevention initiatives, family advocacy groups, or advocacy groups in professional organizations.

0=Not Met
 1=Partially Met
 2=Mostly Met
 3=Completely Met

Total the numbers in the boxes (possible 0-18 score) _____

MCH TRAINING AND EDUCATION PROGRAMS DATA FORM

Faculty and Staff Information

List all personnel (faculty, staff, and others) contributing³ to your training project, including those listed in the budget form and budget narrative and others that your program considers to have a central and ongoing role in the leadership training program whether they are supported or not supported by the grant.

Personnel (Do not list trainees)

Name	Ethnicity (Hispanic or Not Hispanic)	Race (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, More than One Race, Unrecorded)	Gender (Male or Female)	Discipline	Year Hired in MCH Leadership Training Program	Former MCHB Trainee? (Yes/No)
Faculty						
Staff						
Other						

³ A 'central' role refers to those that regularly participate in on-going training activities such as acting as a preceptors; teaching core courses; and participating in other core leadership training activities that would be documented in the progress reports.

Trainee Information (Long-term Trainees Only)

Definition: Long-term trainees (those with greater than or equal to 300 contact hours within the training program) benefiting from the training grant (both supported and non-supported trainees).

Total Number of long-term trainees participating in the training program* _____

Name

Ethnicity

Race

Gender

Address (For supported trainees ONLY)

City

State

Country

Discipline(s) upon Entrance to the Program

Degree(s)

Position at Admission (position title and setting)

Degree Program in which enrolled

Received financial MCH support? [] Yes [] No Amount: \$_____

Type: [] Undergraduate [] Pre-doctoral [] Post-doctoral

[] Part-time student [] Full-time student

Epidemiology training grants ONLY

Length of time receiving support: _____

Research Topic or Title _____

*All trainees participating in the program, whether receiving MCH stipend support or not.

Former Trainee Information (Long-term trainees and former trainees of the Pipeline and Certificate Programs)

The following information is to be provided for each long-term trainee who completed the Training Program 5 years prior to the current reporting year.

Definition of Former Trainee = Grant supported trainees who completed the program 5 years ago

Project does not have any trainees who have completed the Training Program 5 years prior to current reporting year.

Name	Year Graduated	Degree(s) Earned with MCH support (if applicable)	Was University able to contact the trainee?	City of Residence	State of Residence	Country of Residence	Current Employment Setting (<i>see pick list below*</i>)	Working in Public Health organization or agency (including Title V)? (Yes/No)	Working in MCH (Yes/No)

* Employment pick list

- Student
- Schools or school system includes EI programs, elementary and secondary

- Post-secondary setting
- Government agency
- Clinical health care setting (includes hospitals, health centers and clinics)
- Private sector
- Other (specify)

** The term “underserved” refers to “Medically Underserved Areas and Medically Underserved Populations with shortages of primary medical care, dental or mental health providers. Populations may be defined by geographic (a county or service area) or demographic (low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services) factors. The term "vulnerable groups," refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life.

Vulnerable Groups refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. (i.e. Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, etc) *Source: Center for Vulnerable Populations Research. UCLA.*
<http://www.nursing.ucla.edu/orgs/cvpr/who-are-vulnerable.html>

MCH TRAINING PROGRAM GRADUATE FOLLOW-UP QUESTIONS

Contact / Background Information

***Name** (first, middle, last): _____
Previous Name (if used while enrolled in the training program): _____
***Address:** _____

City State Zip
Phone: _____
Primary Email: _____

Permanent Contact Information (someone at a different address who will know how to contact you in the future, e.g., parents)

***Name of Contact:** _____
Relationship: _____
***Address:** _____

City State Zip
Phone: _____

What year did you graduate/complete the MCH Training Program? _____

Degree(s) earned while participating in the MCH Training Program _____ (a pick list will be provided-same as the one provided in the EHB faculty information form)

Ethnicity: (choose one)

Hispanic is an ethnic category for people whose origins are in the Spanish-speaking countries of Latin America or who identify with a Spanish-speaking culture. Individuals who are Hispanic may be of any race.

Hispanic

Not Hispanic

Race: (choose one)

American Indian and Alaskan Native refer to people having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment. Tribe:

Asian refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g. Asian Indian).

Black or African American refers to people having origins in any of the Black racial groups of Africa.

Native Hawaiian and Other Pacific Islander refers to people having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White refers to people having origins in any of the original peoples of Europe, the Middle East, or North Africa.

More than One Race includes individuals who identify with more than one racial designation.

Unrecorded is included for individuals who do not indicate their racial category.

Survey

Please answer all of the following questions as thoroughly as possible. When you have filled out the entire survey, return it to your Center/Program.

1. What best describes your current employment setting:

- Student
- Schools or school system (includes EI programs, elementary and secondary)
- Post-secondary setting
- Government agency
- Community health care setting (includes hospitals, health centers and clinics)
- Private sector
- Other: please specify: _____

2. Do you currently work in a public health organization or agency (including Title V)? Y/N

3. Does your current work relate to Maternal and Child Health (MCH) populations ((i.e. women, infants and children, adolescents, and their families including fathers and children and youth with special health care needs,)?

- yes
- no

4. Does your current work relate to underserved or vulnerable⁴ populations (i.e, Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, health disparities, etc)

- yes
- no

5. Have you done any of the following activities since completing your training program?

- a. Participated on any of the following as a group leader, initiator, key contributor or in a position of influence/authority: committees of state, national or local organizations; task forces; community boards; advocacy groups; research societies; professional societies; etc.
- b. Served in a clinical position of influence (e.g. director, senior therapist, team leader, etc.)
- c. Provided consultation or technical assistance in MCH areas
- d. Taught/mentored in my discipline or other MCH related field
- e. Conducted research or quality improvement on MCH issues

⁴ The term "underserved" refers to "Medically Underserved Areas and Medically Underserved Populations with shortages of primary medical care, dental or mental health providers. Populations may be defined by geographic (a county or service area) or demographic (low income, Medicaid-eligible populations, cultural and/or linguistic access barriers to primary medical care services) factors. The term "vulnerable groups," refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life.

Vulnerable Groups refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. (i.e, Immigrant Populations Tribal Populations, Migrant Populations, Uninsured Populations, Individuals Who Have Experienced Family Violence, Homeless, Foster Care, HIV/AIDS, etc) *Source: Center for Vulnerable Populations Research. UCLA.*
<http://www.nursing.ucla.edu/orgs/cvpr/who-are-vulnerable.html>

- f. Disseminated information on MCH Issues (e.g., Peer reviewed publications, key presentations, training manuals, issue briefs, best practices documents, standards of care)
- g. Served as a reviewer (e.g., for a journal, conference abstracts, grant, quality assurance process) (ac, c)
- h. Procured grant and other funding in MCH areas
- i. Conducted strategic planning or program evaluation
- j. Participated in public policy development activities (e.g., Participated in community engagement or coalition building efforts, written policy or guidelines, influenced MCH related legislation (provided testimony, educated legislators, etc))
- k. None

6. If you checked any of the activities above, in which of the following settings or capacities would you say these activities occurred? (check all that apply)

- a. Academic
- b. Clinical
- c. Public Health
- d. Public Policy & Advocacy

(end of survey)

Confidentiality Statement

Thank you for agreeing to provide information that will enable your training program to track your training experience and follow up with you after the completion of your training. Your input is critical to our own improvement efforts and our compliance with Federal reporting requirements. Please know that your participation in providing information is entirely voluntary. The information you provide will only be used for monitoring and improvement of the training program. Please also be assured that we take the confidentiality of your personal information very seriously. We very much appreciate your time and assistance in helping to document outcomes of the Training Program. We look forward to learning about your academic and professional development.

Medium Term Trainees

DEFINITION: Medium term trainees are trainees with 40 - 299 contact hours in the current reporting year.

Medium-term Trainees with 40-149 contact hours during the past 12-month grant period

Total Number _____

Disciplines (check all that apply):

- Audiology
- Dentistry-Pediatric
- Dentistry – Other
- Education/Special Education
- Family/Parent/Youth Advocacy
- Genetics/Genetic Counseling
- Health Administration
- Medicine-General
- Medicine-Adolescent Medicine
- Medicine-Developmental-Behavioral Pediatrics
- Medicine-Neurodevelopmental Disabilities
- Medicine-Pediatrics
- Medicine-Pediatric Pulmonology
- Medicine – Other
- Nursing-General
- Nursing-Family/Pediatric Nurse Practitioner
- Nursing-Midwife
- Nursing – Other
- Nutrition
- Occupational Therapy
- Parent
- Physical Therapy
- Psychiatry
- Psychology
- Public Health
- Respiratory Therapy
- Social Work
- Speech-Language Pathology
- Other (Specify)

Medium Term Trainees with 150-299 contact hours

The totals for gender, ethnicity, race and discipline must equal the total number of medium term trainees with 150-299 contact hours

Total Number _____

Gender Male _____ Female _____
(number not percent)

Ethnicity Hispanic: _____ Not Hispanic _____
(number not percent)

Race American Indian or Alaska Native: _____
(number not percent)
 Asian: _____
 Black or African American: _____
 Native Hawaiian or Other Pacific Islander: _____
 White: _____
 More than One Race: _____
 Unrecorded: _____

Discipline

<u>Number</u>	<u>Discipline</u>
_____	Audiology
_____	Dentistry-Pediatric
_____	Dentistry – Other
_____	Education/Special Education
_____	Family/Parent/Youth Advocacy
_____	Genetics/Genetic Counseling
_____	Health Administration
_____	Medicine-General
_____	Medicine-Adolescent Medicine
_____	Medicine-Developmental-Behavioral Pediatrics
_____	Medicine-Neurodevelopmental Disabilities
_____	Medicine-Pediatrics
_____	Medicine-Pediatric Pulmonology
_____	Medicine – Other
_____	Nursing-General
_____	Nursing-Family/Pediatric Nurse Practitioner
_____	Nursing-Midwife
_____	Nursing – Other
_____	Nutrition
_____	Occupational Therapy
_____	Parent
_____	Physical Therapy
_____	Psychiatry
_____	Psychology
_____	Public Health
_____	Respiratory Therapy
_____	Social Work
_____	Speech-Language Pathology
_____	Other (Specify)_____

TOTAL Number of Medium term Trainees: _____

Short Term Trainees

DEFINITION: Short-term trainees are trainees with less than 40 contact hours in the current reporting year.
(Continuing Education participants are not counted in this category)

Total number of short term trainees during the past 12-month grant period _____

Indicate disciplines (check all that apply)

- Audiology
- Dentistry-Pediatric
- Dentistry – Other
- Education/Special Education
- Family/Parent/Youth Advocacy
- Genetics/Genetic Counseling
- Health Administration
- Medicine-General
- Medicine-Adolescent Medicine
- Medicine-Developmental-Behavioral Pediatrics
- Medicine-Neurodevelopmental Disabilities
- Medicine-Pediatrics
- Medicine-Pediatric Pulmonology
- Medicine – Other
- Nursing-General
- Nursing-Family/Pediatric Nurse Practitioner
- Nursing-Midwife
- Nursing – Other
- Nutrition
- Occupational Therapy
- Parent
- Physical Therapy
- Psychiatry
- Psychology
- Public Health
- Respiratory Therapy
- Social Work
- Speech-Language Pathology
- Other (Specify)

Technical Assistance/Collaboration Form

DEFINITION: Technical Assistance/Collaboration refers to mutual problem solving and collaboration on a range of issues, which may include program development, clinical services, collaboration, program evaluation, needs assessment, and policy & guidelines formulation. It may include administrative services, site visitation and review/advisory functions. Collaborative partners might include State or local health agencies, and education or social service agencies. Faculty may serve on advisory boards to develop &/or review policies at the local, State, regional, national or international levels. The technical assistance (TA) effort may be a one-time or on-going activity of brief or extended frequency. The intent of the measure is to illustrate the reach of the training program beyond trainees.

Provide the following summary information on the ALL TA provided

Total Number of Technical Assistance/Collaboration Activities	TA Activities by Type of Recipient	Number of TA Activities by Target Audience
_____	<input type="checkbox"/> Other Divisions/ Departments in a University <input type="checkbox"/> Title V (MCH Programs) <input type="checkbox"/> State Health Dept. <input type="checkbox"/> Health Insurance/ Organization <input type="checkbox"/> Education <input type="checkbox"/> Medicaid agency <input type="checkbox"/> Social Service Agency <input type="checkbox"/> Mental Health Agency <input type="checkbox"/> Juvenile Justice or other Legal Entity <input type="checkbox"/> State Adolescent Health <input type="checkbox"/> Developmental Disability Agency <input type="checkbox"/> Early Intervention <input type="checkbox"/> Other Govt. Agencies <input type="checkbox"/> Mixed Agencies <input type="checkbox"/> Professional Organizations/Associations <input type="checkbox"/> Family and/or Consumer Group <input type="checkbox"/> Foundations <input type="checkbox"/> Clinical Programs/ Hospitals <input type="checkbox"/> Other Please Specify	Local _____ Within State _____ Another State _____ Regional _____ National _____ International _____

B. Provide information below on the **5-10 most significant** technical assistance/collaborative activities in the past year. In the notes, briefly state why these were the most significant TA events.

Title	Topic of Technical Assistance/Collaboration <i>Select one from list A and all that apply from List B.</i>		Recipient of TA/Collaborator	Intensity of TA	Primary Target Audience
	List A (select one) A. Clinical care related (including medical home) B. Cultural Competence Related C. Data, Research, Evaluation Methods (Knowledge Translation) D. Family Involvement E. Interdisciplinary Teaming F. Healthcare Workforce Leadership G. Policy H. Prevention Systems Development/Improvement	List B (select all that apply) . Women's/Reproductive/Perinatal Health . Early Childhood Health/Development (birth to school age) . School Age Children . Adolescent CSHCN/Developmental Disabilities . Autism . Emergency Preparedness . Health Information Technology . Mental Health 0. Nutrition 1. Oral Health 2. Patient Safety 3. Respiratory Disease 4. Vulnerable Populations* 5. Racial and Ethnic Diversity or Disparities 6. Other	. Other Divisions/ Departments in a University . Title V (MCH Programs) . State Health Dept. . Health Insurance/ Organization . Education . Medicaid agency . Social Service Agency . Mental Health Agency . Juvenile Justice or other Legal Entity . State Adolescent Health . Developmental Disability Agency . Early Intervention n. Other Govt. Agencies . Mixed Agencies . Professional Organizations/Associations . Family and/or Consumer Group . Foundations . Clinical Programs/Hospitals . Other (specify)	. One time brief (single contact) . One time extended (multi-day contact provided one time) . On-going infrequent (3 or less contacts per year) . On-going frequent (more than 3 contacts per year)	. Local . Within State . Another State . Regional . National . International
1	Example	G- Policy	11- Oral Health	2	2

"Vulnerable groups," refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life.

C. In the past year have you provided technical assistance on emerging issues that are not represented in the topic list above? YES/ NO.

If yes, specify the topic(s): _____

Continuing Education Form

Continuing Education is defined as continuing education programs or trainings that serve to enhance the knowledge and/or maintain the credentials and licensure of professional providers. Training may also serve to enhance the knowledge base of community outreach workers, families, and other members who directly serve the community.

A. Provide information related to the total number of CE activities provided through your training program last year.

Total Number of CE Participants _____
Total Number of CE Sessions/Activities _____

Number of CE Sessions/Activities by Primary Target Audience

Number of **Local** CE Activities _____
Number of **State** CE Activities _____
Number of CE Activities in **Another State** _____
Number of **Regional** CE Activities _____
Number of **National** CE Activities _____
Number of **International** CE Activities _____

Number of CE Sessions/Activities for which Credits are Provided _____

For **up to 10** of the most significant CE activities in the past project year, list the title, topics, methods, number of participants, duration and whether CE units were provided. In the field notes, briefly state why these were the most significant CE events (e.g., most participants reached; key topic addressed, new collaboration opportunity, emerging issues, diversity of participants (other than healthcare workers etc))

Title	Topic: List A select one	Topic: List B: <i>select all that apply</i>	Primary Target Audience	Method*	Number of Participants	Continuing Education Credits Provided? (Yes/No)
	A. Clinical Care-Related (including medical home) B. Cultural Competence-Related C. Data, Research, Evaluation Methods (Knowledge Translation) D. Family Involvement E. Interdisciplinary Teaming F. Healthcare Workforce Leadership G. Policy H. Prevention Systems Development/Improvement	. Women's Reproductive/ Perinatal Health . Early Childhood Health/ Development (birth to school age) . School Age Children . Adolescent . CSHCN/Developmental Disabilities . Autism . Emergency Preparedness . Health Information Technology . Mental Health 0. Nutrition 1. Oral Health 2. Patient Safety 3. Respiratory Disease 4. Vulnerable Populations* 5. Racial and Ethnic Diversity or Disparities 6. Other (specify)	. Local . State . Another state . Regional . National . International	A. In-person B. Distance C. Mixed		
1.						
2.						
3.						

* "Vulnerable groups" refers to social groups with increased relative risk (i.e. exposure to risk factors) or susceptibility to health-related problems. This vulnerability is evidenced in higher comparative mortality rates, lower life expectancy, reduced access to care, and diminished quality of life. Center for Vulnerable Populations Research. UCLA. <http://www.nursing.ucla.edu/orgs/cvpr/who-are-vulnerable.html>

C. In the past year have you provided continuing education on emerging issues that are not represented in the topic list above?
YES/ NO. If yes, specify the topic(s): _____

Products, Publications and Submissions Data Collection Form

Part 1

Instructions: Please list the number of products, publications and submissions addressing maternal and child health that have been published or produced by your staff during the reporting period (counting the original completed product or publication developed, not each time it is disseminated or presented). Products and Publications include the following types:

Type	Number
Peer-reviewed publications in scholarly journals – published (including peer-reviewed journal commentaries or supplements)	
Peer-reviewed publications in scholarly journals – submitted	
Books	
Book chapters	
Reports and monographs (including policy briefs and best practices reports)	
Conference presentations and posters presented	
Web-based products (Blogs, podcasts, Web-based video clips, wikis, RSS feeds, news aggregators, social networking sites)	
Electronic products (CD-ROMs, DVDs, audio or videotapes)	
Press communications (TV/Radio interviews, newspaper interviews, public service announcements, and editorial articles)	
Newsletters (electronic or print)	
Pamphlets, brochures, or fact sheets	
Academic course development	
Distance learning modules	
Doctoral dissertations/Master’s theses	
Other	

Part 2

Instructions: For each product, publication and submission listed in Part 1, complete all elements marked with an “*.”

Data collection form: Peer-reviewed publications in scholarly journals – published

*Title: _____
*Author(s): _____
*Publication: _____
*Volume: _____ *Number: _____ Supplement: _____ *Year: _____ *Page(s): _____
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___
*To obtain copies (URL): _____
Key Words (No more than 5): _____
Notes: _____

Data collection form: Peer-reviewed publications in scholarly journals – submitted

*Title: _____
*Author(s): _____
*Publication: _____
*Year Submitted: _____
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___
Key Words (No more than 5): _____
Notes: _____

Data collection form: Books

*Title: _____
*Author(s): _____
*Publisher: _____
*Year Published: _____
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___
Key Words (No more than 5): _____
Notes: _____

Data collection form for: Book chapters

Note: If multiple chapters are developed for the same book, list them separately.

*Chapter Title: _____
*Chapter Author(s): _____
*Book Title: _____
*Book Author(s): _____
*Publisher: _____
*Year Published: _____
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___
Key Words (no more than 5): _____
Notes: _____

Data collection form: Reports and monographs

*Title: _____
*Author(s)/Organization(s): _____
*Year Published: _____
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___
*To obtain copies (URL or email): _____
Key Words (no more than 5): _____
Notes: _____

Data collection form: Conference presentations and posters presented

(This section is not required for MCHB Training grantees.)

*Title: _____
*Author(s)/Organization(s): _____
*Meeting/Conference Name: _____
*Year Presented: _____
*Type: Presentation Poster
*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___
*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Web-based products

*Product: _____

*Year: _____

*Type: blogs podcasts Web-based video clips
 wikis RSS feeds news aggregators
 social networking sites Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___

*To obtain copies (URL): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Electronic Products

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: CD-ROMs DVDs audio tapes
 videotapes Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Press Communications

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: TV interview Radio interview Newspaper interview
 Public service announcement Editorial article Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Newsletters

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: Electronic Print Both

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___

*To obtain copies (URL or email): _____

*Frequency of distribution: weekly monthly quarterly annually Other (Specify)

Number of subscribers: _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Pamphlets, brochures or fact sheets

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Type: Pamphlet Brochure Fact Sheet

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Academic course development

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Distance learning modules

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

- *Media Type: blogs podcasts Web-based video clips
 wikis RSS feeds news aggregators
 social networking sites CD-ROMs DVDs
 audio tapes videotapes Other (Specify)

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Data collection form: Doctoral dissertations/Master's theses

*Title: _____

*Author: _____

*Year Completed: _____

*Type: Doctoral dissertation Master's thesis

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students ___

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Other

(Note, up to 3 may be entered)

*Title: _____

*Author(s)/Organization(s): _____

*Year: _____

*Describe product, publication or submission: _____

*Target Audience: Consumers/Families ___ Professionals ___ Policymakers ___ Students _____

*To obtain copies (URL or email): _____

Key Words (no more than 5): _____

Notes: _____

Appendix B: Trainee/Fellow Guidelines

A. Definitions

1. A **trainee** is an individual whose activities within the training program are directed primarily toward achieving an advanced degree.
2. A **fellow** is an individual who has met at least the minimum standards of education and experience accepted by his/her respective profession and whose activities within the training program are for the primary purpose of obtaining or enhancing particular skills or knowledge.

B. Qualifications

1. A **trainee** must have at least a baccalaureate degree and be enrolled in a graduate program.
2. A **fellow** must have achieved the academic degree and completed requisite training which constitutes the basic professional level training for his/her field.
3. A **postdoctoral** fellow must have an earned doctorate and must have completed any required internship.
4. A **special fellow** may be approved, upon request to the MCHB, only in those unusual circumstances where particular needs cannot be met within the categories described above.
5. **Citizenship** – A fellow or trainee must be a United States citizen, or, as an alien, must have been admitted to the United States with a permanent resident visa.
6. **Licensure** – For any profession for which licensure is a prerequisite, the applicant must also be licensed by one of the states, or, in the case of foreign graduates, meet other requirements which legally qualify him/her to practice his/her profession in the United States.

C. Restrictions

1. Concurrent Income

It is expected that most trainees/fellows will be full time. In most instances stipends may not be granted to persons receiving a concurrent salary, fellowship or traineeship stipend, or other financial support related to his/her training or employment. In the case of part-time trainees/fellows, exceptions may be requested and will be considered on an individual basis. Tuition support may be provided to full-time or part-time trainees.

2. Non-related Duties

The training institution shall not require trainees or fellows to perform any duties which are not directly related to the purpose of the training for which the grant was awarded.

3. **Field Training**

Training institutions may not utilize grant funds to support field training, except when such training is part of the specified requirements of a degree program, or is authorized in the approved application.

4. **Other**

Grant funds may **not** be used: (a) for the support of any trainee who would not, in the judgment of the institution, be able to use the training or meet the minimum qualifications specified in the approved plan for the training; (b) to continue the support of a trainee who has failed to demonstrate satisfactory participation; or (c) for support of candidates for undergraduate or pre-professional degrees, or the basic professional degree.

D. Trainee Costs

1. **Allowable Costs**

- a. Stipends
- b. Tuition and fees, including medical insurance
- c. Travel related to training and field placements
- d. For a few institutions it is beneficial to support trainees through tuition remission and wages. Tuition remission and other forms of compensation paid as, or in lieu of, wages to students (including fellows and trainees) performing necessary work are allowable provided that there is a bona fide employer-employee relationship between the student and the institution for the work performed, the tuition or other payments are reasonable compensation for the work performed and are conditioned explicitly upon the performance of necessary work, and it is the institution's practice to similarly compensate students in non-sponsored as well as sponsored activities.

2. **Non-Allowable Costs**

- a. Dependency allowances
- b. Travel between home and training site, unless specifically authorized
- c. Fringe benefits or deductions which normally apply only to persons with the status of an employee

3. **Stipend Levels**

All stipends indicated are for a full calendar year, and must be prorated for an academic year or other training period of less than twelve months. The stipend levels may, for the Maternal and Child Health Training Program, be treated as ceilings rather than mandatory amounts, i.e., **stipends may be less than but may not exceed the amounts indicated.** However, where lesser amounts are awarded the awarding institution must have established, written policy which identifies the basis or bases for such variation and which ensures equitable treatment for all eligible trainees/fellows. These stipend levels apply to the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Health Resources and Services Administration training grantees and were updated on January 20, 2012, see <http://grants.nih.gov/grants/guide/notice-files/NOT-OD-12-033.html>.

The stipend levels are as follows:

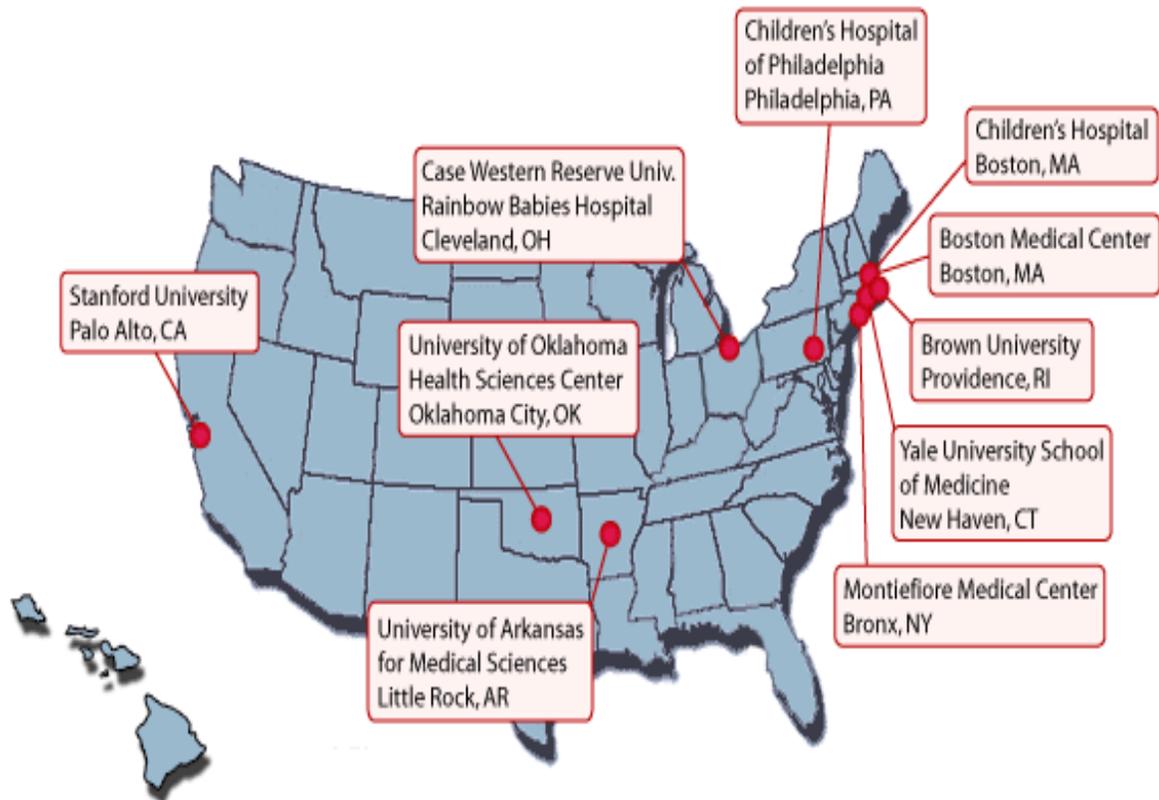
Career Level		Stipend for FY 2012
Undergraduates in the MARC and COR Programs:		
Freshmen/Sophomores		\$8,304
Juniors/Seniors		\$11,628
Pre-doctoral		\$22,032
Postdoctoral		
Years of Experience:		
	0	\$39,264
	1	\$41,364
	2	\$44,340
	3	\$46,092
	4	\$47,820
	5	\$49,884
	6	\$51,582
	7 or more	\$54,180

*Determination of the “years of relevant experience” shall be made in accordance with program guidelines and will give credit to experience gained prior to entry into the grant-supported program as well as to prior years of participation in the grant-supported program. The appropriate number of “years” (of relevant experience) at the time of entry into the program will be determined as of the date on which the individual trainee begins his/her training rather than on the budget period beginning date of the training grant. Stipends for subsequent years of support are at the next level on the stipend chart.

b. Supplements to Stipends

Stipends specified above may be supplemented by an institution from non-federal funds. No Federal funds may be used for stipend supplementation unless specifically authorized under the terms of the program from which the supplemental funds are derived.

APPENDIX C: MCH DBP Training Grants by State, 2011



- Boston Medical Center
- Brown University
- Children's Hospital Boston
- Case Western Reserve University
- Children's Hospital of Philadelphia
- Montefiore Medical Center
- Stanford University
- University of Arkansas
- University of Oklahoma
- Yale University School of Medicine

Appendix D: Key Elements of Collaborative Office Rounds (COR)

Collaborative Office Rounds (COR): COR utilizes a study group approach that emphasizes the practical challenges confronted by community-based practitioners. The approach is directed primarily to fellows and practitioners and emphasizes material linked to clinical situations. Other characteristics of the COR approach include: a small group experience, an atmosphere promoting the free exchange of ideas, and a continuing relationship with resource faculty and other group members.

Projects can cosponsor, with child psychiatry, an ongoing COR group designed to be a training experience for fellows and a continuing education experience for community providers. This is in addition to any COR groups supported by separate COR grants to some departments of pediatrics.

Specific objectives must include, but are not limited to, the following:

- Enhance understanding of psychosocial aspects of pediatrics and increase ability to help children and families deal with these issues;
- Expand power to discriminate between transient disturbances and more serious psychiatric disorders;
- Heighten awareness of the scope of participants' competencies and strengthen orientation to consult with or refer to other professionals as appropriate;
- Promote collaboration between pediatricians and child psychiatrists; and
- Facilitate a more comprehensive approach to health supervision, such as envisaged in Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.

COR Program Features

Faculty Composition and Qualifications—Faculty must include at least one pediatrician and one child psychiatrist as moderators. Substitute moderators should be designated so that both a pediatrician and a child psychiatrist are present consistently in moderator roles. Visiting faculty may be brought in as consultants or speakers.

Members—Members of the group should ideally be limited to ten or twelve, including the two moderators. Developmental-Behavioral Pediatrics Program COR groups are expected to include their fellows as well as others, such as primary care pediatricians, fellows in child psychiatry, and community child psychiatrists. Regular attendance should be the norm. Visitors/auditors might attend for education or training purposes as long as their numbers and pattern of attendance are not disruptive.

Meetings—Meetings should be at regular intervals, e.g., monthly, and for set periods of time. Meetings must be at least one hour long.

Format—Format should be a case-oriented approach to pursue the COR group's objectives. In addition to case material, the focus may also be on consultative activities to community agencies,

including activities that deal with systems and facilities. Case material may be supplemented with didactic material

Location and Timing—Location and timing of the meetings need to be sufficiently convenient to facilitate sustained participation. COR groups that are primarily concerned with issues that arise in a particular area, e.g., the inner city, are encouraged to meet in the area if it meets the test of convenience.

Evaluation— Evaluation of all COR groups is expected to include monitoring of process and assessment of impact in relation to goals. In addition, they must cooperate with efforts to evaluate the programs on a national basis.

Confidentiality—All COR group participants must adhere fully to the highest professional standards with regard to confidentiality.

Exclusively Educational Activity—Grant funds awarded for a COR group program may be used only for expenses clearly related to and necessary for the educational activity. COR funds may be used for continuing medical education (CME) credit required of practitioners. Funds may not be used to support service delivery and research. It is hoped that those brought together will be inspired in the direction of collaborative research.

Application—The program description should include the following information about the COR component in their application:

The proposed group composition in terms of level and specialization;

Objectives, such as those suggested above, to illustrate the goals of the COR group;

Explanation of each of the requirements outlined above, with appropriate description and/or assurance provided for each; and

Amplifying information that might assist in getting a picture of how the COR group could be expected to function and what educational accomplishments could be anticipated.