

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

Maternal and Child Health Bureau
Division of Healthy Start and Perinatal Systems

***Healthy Start Initiative: Eliminating Disparities in Perinatal Health
(General Population)***

Announcement Type: New, Competing Continuation
Announcement Number: HRSA-12-016

Catalog of Federal Domestic Assistance (CFDA) No. 93.926

FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 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.*

Application Due Date: January 27, 2012

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Authority: Title III, Part D, Section 330H of the Public Health Service Act (42 U.S.C. 254c-8),
as amended by the Healthy Start Reauthorization Act of 2007 (P.L. 110-339)

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I. Funding Opportunity Description

1. Purpose

This program funding opportunity announcement provides detailed instructions for the development and submission of a competing application for the Healthy Start Initiative: Eliminating Disparities in Perinatal Health (General Population) projects to be funded in June 2012. The Border grant will not be funded through this announcement. Please use HRSA-12-017 to apply for the border grant. The Healthy Start (HS) Program is administratively located in the Health Resources and Services Administration's (HRSA), Maternal and Child Health Bureau (MCHB), Division of Healthy Start and Perinatal Service (DHSPS). As an initiative mandated to reduce the rate of infant mortality and improve Perinatal outcomes through grants for project areas with high annual rates of infant mortality, the Healthy Start program focuses on the contributing factors which research shows influence the Perinatal trends in high-risk communities.

The purpose of this program is to address significant disparities in Perinatal health including disparities experienced by Hispanics, American Indians, African-Americans, Asian/Pacific Islanders, and immigrant populations. Differences in perinatal health indicators may occur by virtue of education, age of mother, income, disability, or living in rural/isolated areas. To address disparities and the factors contributing to them in these indicators, it is anticipated that the proposed scope of project services will cover the pregnancy and interconception phases for women and infants residing in the proposed project area. In order to promote longer interconception periods and prevent relapses of risk behaviors, the woman and infant are to be followed through the infant's second year of life and/or two years following delivery.

In addition, this funding is to be used to enhance the capacity of the community's perinatal and women's health service systems, which will also help meet the goal of reducing ethnic, racial, and other disparities in perinatal health. Funding will be made available to community projects that: 1) meet the eligibility criteria outlined in section III; 2) have an existing or proposed active consortium of stakeholders with the express purpose of addressing issues related to infant mortality reduction and improved perinatal outcomes, including addressing disparities in perinatal health; and 3) have a feasible plan to reduce barriers, improve the comprehensiveness and quality of the local perinatal system of care, and work towards eliminating existing disparities in perinatal health. Successful applicants must have or plan to develop, in a culturally and linguistically sensitive manner, the core service interventions of direct outreach, case management, health education, interconception care, and screening for depression. In addition to the core service interventions, four core system efforts activities are required; development of local health systems action plan, a community-based consortium of individuals and organizations including agencies responsible for administering the State Title V Block Grant Program and other stakeholders (i.e., consumers of project services, public health departments, hospitals, health centers funded under 42 U.S.C. 254b, and other significant sources of health care services) and a sustainability plan. If any of these interventions are already adequately provided in the project area through other funding resources, the applicant should describe in detail why the applicant need not provide them, and also indicate how these strategies are integrated into the project plan.

Projects are required to coordinate their Healthy Start funded services and activities with the state and local agencies that administer MCH block grant programs under Title V of the Social

Security Act. The purpose of this coordination is to promote cooperation, integration, and dissemination of information with state-wide systems and with other community services funded under the Maternal and Child Health Block Grant. In addition, the projects must demonstrate established linkages with key state and local services and resources, such as Title XIX, Title XXI, WIC, Enterprise Communities/Empowerment Zones, section 330 federally funded health centers, and Indian/Tribal Health Services.

The Senate Appropriations Committee report accompanying the 2010 appropriations bill for the Departments of Labor, Health and Human Services, and Education and related agencies for the fiscal year ending September 30, 2010 states, “The healthy start initiative was developed to respond to persistently high rates of infant mortality in this Nation... The Committee urges HRSA to give preference to current and former grantees with expiring or recently expired project periods.” (Senate Report No.111-66, 111th Cong., 1st Sess. 2009, p. 49) HRSA will provide such funding preference as long as similar language is included in the appropriations legislation in effect at the time of the funding award.

2. Background

Healthy Start is authorized under Title III, Part D, Section 330H of Public Health Service Act; (42 U.S.C. 254c-8). Additional information relevant to this funding opportunity includes: 45 CFR Part 74 or 45 CFR Part 92 as applicable, and the Government Performance and Results Act (GPRA), P.L. 103-62.

The Healthy Start program funds local agencies committed to community-driven strategies to attack the causes of infant mortality and other poor perinatal outcomes for women and infants living in high-risk situations. Currently, there are Healthy Start projects across the country in 104 communities with higher-than-average infant mortality rates and/or adverse perinatal health indicators in one or more racial, ethnic, rural or other disparate population groups.

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 2012–2016. Approximately \$4,252,502 is expected to be available annually to fund six (6) grantees. New applicants may apply for a ceiling amount of up to \$750,000 per year. Current Healthy Start grantees (existing competing continuations) may apply for up to \$750,000 or their current funding level, whichever is greater. HRSA reserves the right to adjust current funding levels. All award opportunities are subject to availability of funds. The project period is five (5) years. Funding beyond the first year is dependent on the availability of appropriated funds for the Healthy Start Initiative: Eliminating Disparities in Perinatal Health (General Population) program 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

These competitions are open to new applicants and existing competing continuation* Healthy Start projects. Applicants for funding in these competitions under the Healthy Start Program must be public or non profit entities, including faith-based and community-based organizations, Indian tribes, or tribal organizations (the latter two as defined at 25 U.S.C. 450b). An eligible applicant must have both direct fiduciary and administrative responsibility over the project.

*** For purposes of this funding opportunity, an existing competing continuation is defined as a grantee receiving Healthy Start funds for the project period of June 1, 2008-May 31, 2012. All other applicants, including previously funded Healthy Start projects, whose project period is other than June 1, 2008-May 31, 2012, will be considered new applicants and should check the “new” box on the SF 424 Face page.**

Eligible Project Area

A project area is defined as a geographic community in which the proposed services are to be implemented. A project area must represent a reasonable and logical catchment area, but the defined areas do not have to be contiguous. Communities are broadly defined so that multi-county projects serving racial/ethnic or other disparate groups (e.g., Hmong, Native Americans, etc.) are eligible.

Eligibility Factors Demonstrating Disparities

MCHB may verify submitted data with the appropriate state/local government agency responsible for Vital Statistics. Project data for the eligibility factors for all applicants **must** be included in the application’s transmittal letter and in the community assessment section of the submitted application. The existing racial/ethnic disparities in these or other perinatal indicators should be described in the community assessment section of the application. Any deviation will require prior approval for each budget year.

An applicant’s target population **must** meet the following verifiable criteria:

- Using verifiable three year average data for 2007 through 2009, the proposed target area must have one or more racial/ethnic disparate groups with a three year average infant mortality rate of a least 9.86 deaths/1000 live births which is one-and-a-half times the national infant mortality rate of 6.58/1000 for the period 2007 through 2009.

Transmittal Letter

The required transmittal letter which accompanies the application submission must clearly indicate:

- The target area for which the applicant is applying; and the proposed target population within that project area that confirms eligibility (the target population is the population that you will serve and will determine your eligibility);
- That the infant mortality rate (IMR) for the target population is at least 9.86 deaths/1000 live births (which is one-and-a-half times the national infant mortality rate for the period 2007 through 2009 (6.58)). **No other combination of years and only a three year**

average for the IMR will be accepted to confirm eligibility. (The transmittal letter is submitted as Attachment 1 of the application kit.)

2. Cost Sharing/Matching

Cost sharing/matching is not a requirement 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.

IV. Application and Submission Information

1. Address to Request Application Package

Application Materials and Required Electronic Submission Information

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

Note: Central Contractor Registration (CCR) 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 Central Contractor Registration (CCR) registrations. Although active CCR registration at time of submission is not a new requirement, this systematic enforcement will likely catch some applicants off guard.

According to the CCR Website it can take 24 hours or more for updates to take effect, so ***check for active registration well before your grant deadline.***

An applicant can view their CCR Registration Status by visiting <http://www.bpn.gov/CCRSearch/Search.aspx> and searching by their organization's DUNS. Note

that CCR-registered users may elect not to display their information in the public search.

Applicants that fail to allow ample time to complete registration with CCR 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. The forms contain additional general information and instructions for applications, proposal narratives, and budgets. The forms and instructions may be obtained by:

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

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

2. Content and Form of Application Submission

Application Format Requirements

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

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

Application Format

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

SF-424 Non-Construction – Table of Contents

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

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

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

- 🔔 To ensure that attachments are organized and printed in a consistent manner, follow the order provided below. Note that these instructions may vary across programs.
- 🔔 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 the attachment, ensure that you place a table of contents cover page specific to the attachment. The Table of Contents page will not be counted in the page limit.
- 🔔 Limit the file attachment name to under 50 characters. Do not use any special characters (e.g., %, /, #) or spacing in the file name or word separation. (The exception is the underscore (_) character.) Your attachment will be rejected by Grants.gov if you use special characters or attachment names greater than 50 characters.

| Attachment Number | Attachment Description (Program Guidelines) |
|-------------------|--|
| Attachment 1 | Transmittal Letter – Must include the target area for which the applicant is applying; and the proposed target population within that project area that confirms eligibility. (The target population is the population that you will serve and will determine your eligibility.) That the infant mortality rate (IMR) for the target population is at least 9.86 deaths/1000 live births (which is one and a half times the national infant mortality rate for the period 2007 through 2009 (6.58)). No other combination of years and only a three year average for the Infant Mortality Rate will be accepted to confirm eligibility. |
| Attachment 2 | Section B of the SF-424A – 5 th Year Budget |
| Attachment 3 | Tables, charts, etc. Include personnel allocation worksheet, consortia roster, contractor status report, project area demographics worksheet, and the project implementation plan worksheet. |
| Attachment 4 | Job Descriptions for Key personnel |
| Attachment 5 | Biographical Sketches |
| Attachment 6 | Letters of Agreement and/or Description(s) of Proposed/Existing Contracts (project specific) Provide any documents that describe working relationships between the applicant agency and other agencies and programs cited in the proposal. Documents that confirm actual or pending contractual agreements should clearly describe the roles of the subcontractors and any deliverable. Letters of agreements must be dated. |
| Attachment 7 | Project Organizational Chart - Provide a one-page figure that depicts the organizational structure of the project, including |

| Attachment Number | Attachment Description (Program Guidelines) |
|-------------------|---|
| | subcontractors and other significant collaborators. |
| Attachment 8 | Other Relevant Document - Include here any other documents that are relevant to the application, including letters of supports. Letters of support must be dated. A letter of support from the Title V agency must be included. |
| Attachment 9 | Progress Report on Past Performance - For competing continuations, please include applicant's previous experience and knowledge, including individuals on staff, materials published, and progress on previous project activities. Also, include relative quantitative and qualitative data as it relates to accomplishing project objectives, performance measures, and utilization of services. (<i>This section is limited to 10 pages</i>) |

Application Format

i. Application Face Page

Complete Application Form SF-424 provided with the application package. Prepare according to instructions provided in the form itself. Important note: enter the name of the **Project Director** in 8. f. for the SF-424 “Name and contact information of person to be contacted on matters involving this application.” If, for any reason, the Project Director will be out of the office, please ensure their email Out of Office Assistant is set so HRSA will be aware if any issues arise with the application and a timely response is required. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is 93.926.

DUNS Number

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

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

ii. Table of Contents

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

iii. Budget

Complete Application Form SF-424A Budget Information – Non-Construction Programs provided with the application package. Please complete Sections A, B, E, and F, and then provide a line item budget for each year of the project period. In Section A use rows 1 - 4 to provide the budget amounts for the first four years of the project. Please enter the amounts in the “New or Revised Budget” column- not the “Estimated Unobligated Funds” column. In Section B Object Class Categories of the SF-424A, provide the object class category breakdown for the annual amounts specified in Section A. In Section B, use column (1) to provide category amounts for Year 1 and use columns (2) through (4) for subsequent budget years (up to four years). For year 5, please submit a copy of Sections B of the SF-424A as Attachment 2.

iv. Budget Justification

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for ONE year. However, the applicant **must** submit one-year budgets for each of the subsequent budget periods within the requested project period (usually one to four years) at the time of application. Line item information must be provided to explain the costs entered in the appropriate form, Application Form SF-424. 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 your Progress Report(s) and any other required submissions 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 grantee 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 see Section 5. Funding Restrictions

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

Travel: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops.

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 \$5000 or more and a useful life of one or more years). Also see Section 5. Funding Restrictions

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 the CCR 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.

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. Applicants are requested to submit a copy of their most recent indirect cost rate agreement as **Attachment 8**. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at: <http://rates.psc.gov/> to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

v. *Staffing Plan and Personnel Requirements*

Applicants must present a staffing plan and provide a justification for the plan that includes education and experience qualifications and rationale for the amount of time being requested for each staff position. Position descriptions that include the roles, responsibilities, and qualifications of proposed project staff must be included in **Attachment 4**. Biographical sketches for any key employed personnel that will be assigned to work on the proposed project 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.

vi. *Assurances*

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

vii. *Certifications*

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

viii. *Project Abstract*

Provide a summary of the application. Because the abstract is often distributed to provide

information to the public and Congress, please prepare this so that it is clear, accurate, concise, and without reference to other parts of the application. It must include a brief description of the proposed project including the needs to be addressed, the proposed services, and the population group(s) to be served.

Please place the following at the top of the abstract:

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

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.

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.

Requirements for Healthy Start Projects to be considered when completing section x.
Project Narrative:

Every Healthy Start project funded under this competition is required to provide the core services of outreach and client recruitment, case management, health education, screening for perinatal

depression, and interconceptional continuity of care to all participants. At the community level, the following core system interventions are required: A local health systems action plan for comprehensive perinatal care, a consortium, and collaboration with your State Title V sustainability program and with other agencies. These services can be provided through other resources or through Federal Healthy Start funds. (Additional proposed interventions can be added within the funding limits of the competition, or with supplementary dollars that do not supplant existing services.) If the applicant is **not** requesting funds to support some or all of the core interventions, the section must present evidence documenting how these specific interventions will be provided, that they are comparable in scope to those required of HS projects, linked to proposed project interventions, and monitored to assure the needs of the target population are met. The narrative must demonstrate how the required core interventions will be provided.

Applicants must have or plan to establish a community-based consortium of individuals and organizations including, but not limited to, agencies responsible for administering block grant programs under Title V of the Social Security Act, consumers of project services, providers, local health departments, hospitals and health centers funded under Section 330 of the Public Health Service Act (42 U.S.C. 254b), community-based organizations, and other significant entities appropriate for participation in the project¹.

While you may serve any population that requests assistance from you, at least seventy-five percent (75%) of your services and outreach activities **must** address the needs of the target population who's IMR stated in your application and confirms your eligibility.

1) Core Services:

Every project receiving Healthy Start funds must assure the availability, within the project area, of the following “**core services**”:

- a. Outreach and Client Recruitment**
- b. Case Management**
- c. Health Education**
- d. Interconceptional Care**
- e. Depression Screening and Referral**

The five core services and information required for each is described below:

a. Outreach and Client Recruitment: What Healthy Start Requires

The Healthy Start Program expects projects to find and “reach out” to prospective clients in the community the project serves.

Once clients are identified, the project should have an active system to recruit them into care, and should also have procedures that will enable clients to remain in the care system.

While some clients will learn about the project from friends and through various media, other clients and their families will require substantial effort on the part of outreach workers to engage

¹ Title III, Part D, Section 330H of Public Health Service Act (42 United States Code (U.S.C) 254c-8)

and inform them of the benefits Healthy Start offers, and to enroll them for services. To be successful, outreach strategies need to be varied, friendly to the culture of the people, and very flexible.

Because people living in low-income and high-risk neighborhoods may have had negative and unsatisfying experiences with getting health care and with health care providers, they may be unwilling to trust Healthy Start staff unless the individuals who are reaching out to them are trusted members of their community. These community-based outreach workers usually have the advantage of knowing where women and children in the community tend to get together including places such as playgrounds, laundromats, churches, hair salons, and grocery stores. Also, community outreach workers can go door-to-door in order to find eligible clients, establish eligibility on the spot, and begin building a relationship between the client and Healthy Start.

Since these outreach workers come from the community they serve, they are especially aware of barriers that clients encounter, and ways to get around some of the obstacles. Also, their employment with the Healthy Start project can provide income, self-esteem, and a way to model success for their clients.

Outreach workers are a very important part of the Healthy Start Team. They can provide valuable information back to the team as well as getting needed information and education to clients. Training and supervising outreach workers is essential to having an effective outreach and recruitment system.

There needs to be a plan for accomplishing supervision and providing feedback. There must be ongoing training tailored to the needs of the outreach workers, and case managers must keep outreach workers in the communications network. Because outreach and recruitment is so demanding and requires a very special set of skills, the project leaders should make every effort to assist and encourage outreach workers and to provide formal and informal opportunities for their professional growth and development.

b. Case Management: What Healthy Start Requires

The Healthy Start Program defines case management as a coordinated, culturally sensitive approach to providing services. It uses the techniques of client assessment; referral and follow-up, monitoring, and the use of wrap-around services (e.g., help with transportation, language translation, child care, etc.). Sometimes it is called “care coordination.”

Healthy Start is based on the premise that good case management can make an important impact on birth outcomes, and it continues to help families get the services they need after a baby is born. Often, getting to all the care providers and getting the services families need to support them is a confusing and time-consuming process. Healthy Start families can benefit from the help available to them through their case manager and their case management team.

The team and case manager, working with the family, helps ensure that there is a care plan for each mother and child, and that it is as easy as possible for the family to access the health and social services they need. Because the family is involved in designing the care plan, both the case management team and the family feel invested in the plan.

Case management teams need to have a variety of skills represented. Some of the likely members of a good case management team are outreach workers, social workers, nurses, nutritionists, and the full range of health care providers (nurses, midwives, physicians, physician assistants).

Just as important in facilitating access is the inclusion of translators, child care, transportation and other service providers. In fact, some Healthy Start sites have reported that a great deal of valuable health education can be accomplished while women are being driven to and from appointments. Case management teams have different compositions - some rely more on nurses as case managers; others rely more on social workers. The important concept is that people with different kinds of training and different sets of skills are needed to make up a competent team that works for families. The patients' and families' risk status must be considered in devising the overall make-up of the team and the case management protocol it will use.

In order for case management to work effectively, the various team members need to be in close communication with each other as well as the client. Ongoing case conferences, attended by all team members are important to maintaining good communication. Of course, informal communication is also important, because risk situations can change rapidly, and without respect for scheduled meetings.

For case management to serve clients well there must be enough staff that differing levels of client risk can be adequately addressed; and that services (type, timing, duration and intensity) can be matched to each client family's risk level. It's also crucial to ensure that services are delivered in a format and location that maximizes each client's actual use of them. Along with knowing what each client's environment contains (this includes both the home and the surrounding community); the case manager needs to be able to maintain strong, mutually beneficial relationships with the community partners that provide services to clients. The case management team must be as well-acquainted with the level and scope of services their community partners can provide as they are with the needs of their clients.

Finally, case management is a fluid process that requires good documentation, ongoing monitoring, and excellent communication within the team and with supervisors, as well as with those who provide services in the community.

c. Health Education and Training: What Healthy Start Requires

Health education in the Healthy Start program is more than just individual or group instruction on health topics in a classroom or nurse's office. It employs a variety of strategies, such as taking a field trip to a local supermarket to discuss healthy food choices; setting up a local La Leche League group to understand and promote breast-feeding; or bringing a group of young fathers together to discuss parenting issues.

It can be as multi-faceted as the needs of the community and families that Healthy Start serves. It should be culturally and linguistically appropriate, employ a range of learning strategies that have been proven effective (such as the social ecological framework that targets the multiple levels of influence which promote behavioral change), but most of all it should be appealing to its audience.

Healthy Start believes that good health education comes from good knowledge of the community, its clients, and their needs and desires for health education, and from good planning. Clients should be encouraged to discuss with their case manager and other team members, the health education topics in which they have an interest. Planning should involve as many health care team members as possible, and planning should be done on an annual basis, with enough flexibility that unanticipated cancellations and/or special opportunities can be accommodated. The health education plan that you submit should include your health education activities and their rationale (i.e., you are doing a cooking activity because a lot of women have expressed an interest in learning more about fixing healthy, low-cost meals).

The plan should also indicate the required resources (instructor, materials, transportation, etc.), the intended audience, goals of the activities, timeframe, and a simple plan to evaluate the effectiveness of the activity.

Several recent studies have pointed out that not only is early entry into care important, but that the content of the care is critical to improving outcomes. Based upon the needs assessments findings about risk behaviors, etc., the applicant's project plan must demonstrate that the proposed project's health education and training activities, regardless of funding sources, have an annual plan with time frame, providers/resources and simple evaluation methodologies for health education and training activities to address identified needs of clients, providers and the community at large.

Minimum Health Education Topics for Participants

The health education core service requires that, at a minimum, participants receive information, material, training, support, and/or resources on the following topics:

- Smoking cessation programs, such as Smoke Free Families America;
- Prevention, early identification, testing and treatment for HIV and STDs, especially syphilis;
- Preterm labor;
- Information on back to sleep/safe sleep;
- Substance abuse prevention; and
- Other priority risk behaviors emerging from the assessment.

Minimum Health Education Requirements for Staff and Community Partners/Providers

Part of your annual plan for health education and training must be the continuing education and training of Healthy Start staff and the staff of community partners who are also working with your clients. Continuing education for staff helps raise their awareness of current health issues with which they may have to deal; it provides opportunities for professional growth; and it helps diminish "burnout."

Sensitivity of Health Education Material

Health education messages work best when they are simple, clear, and as easy as possible to understand, so that there is a definite path from the instruction to putting it into practice. All health education activities should have a well-understood goal, so that it's possible to measure whether or not the activity has been successful. In order to establish a health program's goals,

it's necessary to first do a needs assessment to know where the audience is starting from, and what they need to reach the goal that's been set. A needs assessment of what is already available in the community is also important so that the Healthy Start program can try to provide educational resources where they are lacking, rather than duplicate programs that already exist. Audio-visual materials need to be previewed with an eye towards language, graphic or potentially offensive images and cultural or religious sensitivities that might be disturbed by the content of the presentation. Also, it is important that, for whatever education is offered, the individual or group feels safe and comfortable, and the educator feels secure in his/her knowledge of the topic.

d. Interconceptional Care: What Healthy Start Requires

Interconceptional health care is needed to ensure that women are healthy prior to beginning a pregnancy in order to reduce the number of poor pregnancy outcomes. Women of child bearing age and their partners should have access to interconceptional health care.

Many medical conditions, poor personal behaviors, and negative environmental conditions can be identified, treated, and/or eliminated prior to conception, thus decreasing the likelihood of a poor birth outcome. Interconceptional health care offers an important opportunity for practitioners involved in women's health to expand their primary care and prevention roles (ACOG, 1995). Due to the fact that children require well-baby-care through two years of age, pediatricians can play an important role in providing interconceptional counseling to families.

Pediatricians can help to reduce the incidence of low birth weight, congenital anomalies, and infant mortality by counseling mothers in the period between the birth of one child and the conception of another (ACOG).

Identifying women with medical illness or unhealthy behaviors during the interconceptional period creates an opportunity to inform and counsel on the hazards of unhealthy behaviors, appropriate treatment, pregnancy planning, and early entry into prenatal care. Medical, social, and nutritional issues need to be addressed not only during pregnancy but also prior to conception to prevent possible complications.

Impacting maternal behaviors as well as medical issues via interventions that promote healthy women and healthy behaviors work to reduce the risk of poor pregnancy outcomes. Risk assessment, health promotion, and interventions are the main components of interconceptional health care (MCN, 1998).

e. Depression Screening and Referral: What Healthy Start Requires

According to the National Institute of Mental Health (NIMH), it is estimated that 7.9% of U.S. women experience a major depression during their lifetimes. Many others experience dysthymia, a milder and more chronic form of depression. Between 70% and 80% of women experience some type of postpartum depression that tends to start 2-3 days following birth. Of these women, about 10% will have a more severe postpartum depression, marked by intense feelings of sadness, anxiety, or despair that impair the new mother's ability to function.

Depression requires treatment. It is not a sign of weakness and it cannot be wished or "willed" away. Left untreated, the symptoms can last for weeks, months, or even years, and may even

result in suicide. We know that suicide is one of the leading causes of death among women during the reproductive years, and depression is a significant causal factor. With appropriate treatment, however, most people can and will recover. The maternal and fetal complications that sometimes occur along with maternal depression can often be avoided, also.

Effective screening and intervention for depression is a very important part of women's primary health care. When designing this Healthy Start core service, applicants need to ensure that these elements are present in their depression screening and referral strategy:

- A program that identifies ways to fill gaps in screening and assessment services for depression, during and around the time of pregnancy;
- Activities that create and/or enhance community-based intervention services that are both culturally and age appropriate;
- Core activities that screen and refer for depression in place through your state and local MCH programs and mental health programs;
- Strategies to increase the capacity of primary care providers to recognize and treat depression;
- Development/increase in community capacity, to develop infrastructure that integrates depression screening into local health care;
- Formal linkages of your program with area perinatal and mental health providers; and
- The ability to increase community awareness of perinatal depression, its effects, and where the available resources to treat it are located.

There are certain basic considerations that all health education programs have in common. For example, if published material is to be used, it's important that the reading level of the book or pamphlet be as close as possible to the audience's reading level.

2) Core Systems and Efforts

In addition to the Core Services, Healthy Start requires each project to work on activities that will ensure that Healthy Start works collaboratively with others in the community and state; that it provides evidence of being sustainable beyond the time when federal funding is available; that it works within the community to establish and maintain a system of care that makes comprehensive perinatal care understood and available; that it provides sound management of resources, and that it is capable of obtaining and using data to improve care and evaluate impact.

These activities can be grouped as follows:

- a. Local Health Systems Action Plan for Comprehensive Perinatal Care**
- b. Consortium**
- c. Sustainability**
- d. Collaboration and Coordination Linkages with Title V and Others**

These system efforts and the information required about them are described below. In addition, there are questions that relate to three system efforts that you should answer to the best of your ability. Through your answers to the questions that follow, we expect to gain a clear understanding of what your project is planning in respect to these core system efforts. A glossary of commonly used Healthy Start terms can be found in Appendix D of this funding opportunity announcement.

a. Local Health System Action Plan (LHSAP) for Comprehensive Perinatal Care

The importance of a systems approach to enhance services for pregnant and parenting women and their families which incorporates social, emotional, and medical needs is crucial to assure the provision of quality services to the target population. The overall goal of the action plan is to develop an integrated service delivery system to better serve Healthy Start program participants.

The applicant should develop a five-year action plan that describes ongoing collaborative mechanisms and intended efforts to work with existing community services to achieve an integrated system for the target population. This plan should be based on resource and manpower allocations within the scope and budget of this project.

This plan must be linked with the State Title V action plan, but this section does not need to reiterate information in the previous section under Collaboration. The identification of priority areas that will be accomplished each year should be based on the needs assessment.

Intended dates of accomplishment for each activity must be specified, focusing in more detail on the first year of the grant. When discussing the Consortium model, describe the role of the consortia.

The action plan may include, for example, an assessment of additional needs and resources (for example, working with the State Substance Abuse Program to assess the need for substance abuse services to the target population; collecting data to validate anecdotal stories); or it could address initiatives that can be jointly accomplished (for example, coordinating with the State Medicaid program to establish culturally competent outreach programs for prenatal care or working with family day care providers on the Back to Sleep campaign) or it might review the management and administration of ongoing programs and a description of intended methods of improvement (for example, either co-location, patient flow analysis, or appropriate referral and follow up of services such as WIC, well child and women's health (*progress and revisions to the LHSAP are due annually*)).

b. Consortium

It is legislatively mandated that Healthy Start grants establish and maintain for the life of the project, a community-based consortium of individuals and organizations including specified participant organizations. Each applicant must have either an existing consortium or include a plan for the implementation of a consortium. A consortium is an advisory body that is expected to:

- contribute to the development of the application;
- contribute to, review, and recommend approval of the organizational approach for assuring local determination and integration;
- provide advice regarding program direction;
- participate in discussions related to allocation and management of project resources;
- have in place conflict of interest policies governing all activities; and
- be aware of program management and activities such as data collection, monitoring and evaluation, public education, and assuring continuity of care; and share responsibility for the identification and maximization of resources and community ownership to sustain project services beyond the project period.

The consortium must include individuals and organizations including agencies responsible for administering the State Title V Block Grant Program and other stakeholders (i.e., consumers of project services, public health departments, hospitals, and health centers under 42 U.S.C. 254b, and other significant sources of health care services). Its representation must include a partnership of participants (program and community), providers of services, community organizations, and groups, both public and private, with a working interest, skills, or resources that can be brought to bear on the problem of infant mortality and improving perinatal outcome. The individual consortium members also must have sensitivity to and an understanding of the needs of the project area.

The members of the consortium should feel they have a significant advisory role and commitment to the plan for project implementation. This can be facilitated through the participation of participants, community leaders, and service provider representatives in developing the application. Those members of the consortium selected to represent an agency or group should have the authority to make decisions for the entity they represent.

Each member of the consortium should have the necessary expertise to provide sound advice regarding the needs and problems existing in the community and the proposed strategies for the preparation and implementation of the project plan. Consortia should include program participants, i.e., women of childbearing age who will be/are receiving project services and must include, at least one individual representing each of the following groups: local and state agencies responsible for administering block grant programs under Title V of the Social Security Act, public health departments, hospitals, health centers funded under section 330 of the Public Health Service Act(42 U.S.C. 254b), and other significant sources of health care services. It may also include representatives of state agencies that administer Medicaid programs, social service agencies, early intervention programs, local business community; religious organizations or associations; community/civic organizations serving the project area, community participants; and Enterprise Communities/Empowerment Zones, as appropriate.

c. Sustainability

Healthy Start communities include many stakeholders – public and private. In fact, Healthy Start sites have worked to turn community members into stakeholders, and stakeholders into partners. These partners include government agencies, hospitals, universities, Medicaid and other insurers, private foundations, health care providers, local businesses, schools, churches, and many others. It is important that Healthy Start projects use these partnerships to help assure their future achievements.

It is important that either the reduction or end of federal funding does not also mean the end Healthy Start activities. In order to sustain Healthy Start's work, sites need to build bridges to resources, creating a path to permanence. Bridges to resources must have partnerships at their foundation and must be continually built, maintained, and rebuilt as needed.

d. Collaboration and Coordination Linkages with Title V MCH and Other Community State Holders

Within each community, there is a system involving a broad array of providers and public and private agencies at various phases and at varying levels in the delivery of perinatal health care.

Applicants need to receive support from and be linked to appropriate components of their state and local perinatal systems of care to contribute to each system's goal of eliminating racial/ethnic disparities in perinatal health. The purpose of this collaboration is to promote cooperation, integration, and dissemination of information with statewide systems and with other community services funded under the Maternal and Child Health Block Grant.

Of particular importance is close collaboration with the Medicaid and Children's Health Insurance Program (CHIP) agencies. Since many within the target population are Medicaid recipients or will be Medicaid or CHIP eligible, and Medicaid financing of services (including possible development of program waivers) will be essential, projects must maintain early, consistent, and ongoing linkages to and involvement with their state and local Medicaid and Title V MCH agencies in planning and operations.

Other relevant state agencies include those responsible for Title X family planning, CHIP, Administration for Children, Youth and Families (ACYF), Early Head Start, substance abuse, mental health, child welfare, education, early intervention, child care, and job opportunities.

Linkage issues which might be addressed include waivers, Medicaid coordinated care, simplified eligibility applications, collaboration and/or co-location of services.

3) Administration and Management

Applicant organizations are expected to have sound systems, policies, and procedures in place for managing funds, equipment, and personnel to receive grant support. Applicants who propose subcontracting these administrative or fiduciary responsibilities for the project will not be approved for funding. All successful applicants must perform a substantive role in carrying out project activities and not merely serve as a conduit for an award to another party or provide funds to an ineligible party.

The grantee organization will hire key personnel, will be responsible for communication with the consortium organization (if applicant is a consortium, it will be responsible for communication within the consortium and with the community), and will coordinate the preparation and submission of required reports and continuation grant applications for future years. The applicant will have primary responsibility for monitoring the progress of the project toward its objectives, including monitoring contract deliverables.

4) Evaluative Measures

Evaluation is critically important for quality improvement and assessing the value-added contribution of MCHB/HRSA investments. There are currently three types of evaluation of the Healthy Start Program: 1) the National Healthy Start Evaluation; 2) the National Performance Measures (MCHB Block and Discretionary Performance Measures and Financial and Demographic Data Forms); and 3) the project's own local evaluation. All three evaluation measures are discussed below.

All of the data collection activities should be planned and fully implemented by the end of the project's first year. Their scope and tentative time frame for implementation should be included in this section of the application. The proposed tools used for data collection should also be practical and financially feasible for the size and capabilities of project staff and contractors.

By accepting funding, all Healthy Start projects agree to participate in, and cooperate with any national evaluation of the Healthy Start Program.

National Performance Measures

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations. (For additional information see Appendix A of this funding opportunity announcement.)

Project's Local Evaluation

All MCHB discretionary grant 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 should focus on systems, health, and performance indicators. Program tracking is the ongoing monitoring of the project on different aspects of the project's administration, fiscal and contract management, consortium, service delivery, collaboration/partnerships, impact upon both perinatal indicators and on the community, and sustainability.

While the tracking of some program facets and indicators will be required of all projects, each project is free to add/enhance its data collection activities to monitor unique strategies or concerns. The local evaluation and other outputs of program tracking become very beneficial in justifying proposed project modifications, communicating and marketing the project to the community/public as well as to interested funding agencies (e.g., Managed Care), policy making agencies (e.g., State Title V, CHIP and Medicaid) for sustainability and state wide policy development. This section provides a comprehensive framework and description of all aspects of the proposed program.

ix. Project Narrative

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

Use the following section headers for the Narrative:

INTRODUCTION

This section should briefly describe the purpose of the proposed project and the current Perinatal Health Care Delivery System.

Current Perinatal Health Care Delivery System

Please describe: the current number, client capacity, and referral pattern of the perinatal providers and facilities that are known to be actively serving the Medicaid and uninsured populations in the project area: e.g., hospitals, subspecialty/specialty perinatal centers, federally qualified health centers (FQHC); local health departments, birthing centers,

obstetricians, gynecologists, perinatologists, pediatricians; certified nurse midwives, nurse practitioners, family practice physicians.

Provide a legible map(s) of the project area reflecting its boundaries and relation to the city/county and the location of major health providers identified above. These maps can be placed in Attachment 3 as long as they are cross-referenced in the text.

Identify the case management and outreach programs currently in existence including the current number of providers and their educational preparation and skill mix as well as the current client capacity to serve the population targeted under this initiative.

Highlight the status of public and private providers in team building (e.g., the presence, absence, planning for Fetal Infant Mortality Review, and/or other mortality/morbidity reviews, hotline management and referral systems) and in-service training efforts. Describe the current capacities of existing public and private resources providing transportation, child care, and translation services to the project area. Include the current level of utilization and the unmet need for each of these three services in relation to accessing perinatal services.

NEEDS ASSESSMENT

This section outlines the needs of your community and/or organization. The target population and its unmet health needs must be described and documented in this section. Demographic data should be used and cited whenever possible to support the information provided. While services cannot be denied to any eligible member of the community, a Healthy Start project under this competition may focus its efforts and interventions on a particular subpopulation of the community that exhibits disparities in its perinatal, interconceptional health. This section should help reviewers understand the community and/or organization that will be served by the proposed project.

Provide a clear description of the current status, capacity and needs of the proposed geographic project area and the current perinatal system serving that area. Include demographic and health statistics to support the presentation and to demonstrate current prevalent disparities. For comparison to other applications, applicants **must** present data minimally from (three-year average) 2007-2009. If more current data is available, e.g. 2008-2010, it may also be included. Describe (by race/ethnic origin) the perinatal health indicators including, three-year averages (2007-2009) for live births, infant deaths (under one year of age), neonatal and post neonatal mortality rates, as well as the incidence of low birth weight, SIDS, births to teenagers 18 years and younger, trimester of initiation of prenatal care and adequacy of prenatal care. Highlight current trends in morbidity, including such areas as birth defects, infant/child abuse and neglect, accidents, AIDS, other communicable diseases and other prevalent factor(s) affecting the project area.

Briefly describe the size, demographic characteristics, prevalent norms, and health behaviors of the targeted population(s). Please include for women of child bearing age: data on poverty, average education level, employment status, and major industries.

Include information about the primary languages of your proposed target population, including the percentage of the clients who speak each of these languages. List the

population(s) your Healthy Start program will target for its Outreach and Client Recruitment activities (e.g., all pregnant and interconceptional women at risk for a poor perinatal outcome; at risk for developmental delay or special health care needs infants and toddlers; other women of reproductive age; fathers/male partners; etc.).

RESPONSE

Objectives and Indicators

In this section, identify measurable, realistic, time-framed project objectives which are responsive to the goals of this program and the identified need(s) and strengths/resources of the target population. Each objective should be clearly stated, outcome-oriented, and realistic for the resources available. Each project period objective must have associated calendar year objectives for each year of requested Healthy Start funding.

Both project period and calendar period objectives should relate to the needs assessment presented in the previous section of the application. Based upon a performance indicator, objective statements should clearly describe what is to be achieved, when it is to be achieved, the extent of achievement, and target population. Each objective should include **a numerator, a denominator, time frame, and data source including year.**

The initial proposed calendar year objective should include baseline data (utilizing the most current data source available prior to implementation of services using Healthy Start funds) which will be used as a basis for comparison with data from subsequent measurements (as the project period progresses) of the specific health problem(s) to determine whether or not the project is having its intended impact. When utilizing baseline data, applicants must document the date source for both the baseline and the current status. If data sources are older than 2004, please explain why more current data is unavailable.

If percentages are used, the relevant numerator and denominator must be cited. Each project period objective should have a performance indicator which is the statistic or quantitative value that expresses the result of the objective. ***(This section can be reported on the project implementation worksheet, see Appendix C for sample reporting worksheet. If the requested information is reported on a worksheet, just reference the worksheet here, and place it in Attachment 3).***

The following example may assist you in the development of the project objectives, and indicators:

Project Period Objective: By 5/31/16, increase to 75% the number of Pregnant Program Participants that have at least 8 health education sessions during their pregnancy

Calendar Year 1 Objective: By 12/31/11, increase to 45% the number of Pregnant Program Participants that have at least 8 health education sessions during their pregnancy

Calendar Year 2 Objective: By 12/31/12, increase to 55% the number of Pregnant Program Participants that have at least 8 health education sessions during their pregnancy.

Calendar Year 3 Objective: By 12/31/13, increase to 65% the number of Pregnant Program Participants that have at least 8 health education sessions during their pregnancy

Calendar Year 4 Objective: By 12/31/14, increase to 70% the number of Pregnant Program Participants that have at least 8 health education sessions during their pregnancy

Calendar Year 5 Objective: By 12/31/15, increase to 75% the number of Pregnant Program Participants that have at least 8 health education sessions during their pregnancy

Baseline: For calendar year 2010, baseline is (40%) 101/250 (Source: EHB)

Performance Indicator: Number of Pregnant Program Participants who receive eight (8) Health Education Sessions/Number of Pregnant Program Participants

National Performance Measures

Baselines, Objectives, and Indicators for all National Performance Measures (NPM) are to be reported in the section above. (See Appendix A for NPM.) ***All projects must have a plan to meet or exceed the Healthy Start target measures for reducing low birth weight (8.9%) and early entry into prenatal care (75%) by the end of the project period (2013). The 2004 national Healthy Start baselines for these targets were (9.3%) and (70%), respectively.***

METHODOLOGY AND WORK PLAN

In this section, clearly describe the strategies/activities which are proposed to accomplish the goals and objectives stated above including target dates and persons involved for each intervention. ***(This section can be reported on the project implementation worksheet, see Appendix C for sample reporting worksheet. If the requested information is reported on a worksheet, just reference the worksheet here, and place it in Attachment 3.)***

Those strategies described here for which Healthy Start funds will be needed, should reflect the funding requested in the Budget Justification narrative (described in Section IV item v). This narrative should be supported by available/proposed position descriptions, protocols, and/or training curricula, which can be placed and cross referenced in the Appendix section of the application.

In addition to the implementation plan, there are a series of questions that must be answered. Following each question will be two letters and a number in square brackets (e.g., [CS1]). The first two letters indicate the overall topic the question relates to and the number indicates which question it is in the series. Please respond to the questions using the bracketed letter and number. Respond in the order in which the questions are asked. **Applicant may reference a response in a previously answered question.**

Through your answers to the carefully chosen questions we expect to gain a clear understanding of what your project is planning in respect to these core services and systems.

A glossary of commonly used Healthy Start terms can be found in Appendix D.

Forms, tables, documents, and charts may also be referenced in your answers to the questions and included in the Attachment 3 of your application. When answering the questions, keep in mind the two different types of Healthy Start Participants: Program Participants and Community Participants.

A **program participant** is defined as an individual who has direct contact with Healthy Start staff or subcontractors and receives Healthy Start core services on an ongoing systemic basis. A **community participant** is an individual who attends a Healthy Start sponsored event or program, participates in consortium activities, etc. A participant cannot be both a program participant and a community participant.

Core Services:

Please answer the following questions:

How will your program conduct and provide outreach and recruitment to the two levels of Healthy Start participants (e.g., program participant and community participant)? Specifically, tell if these activities will be conducted by staff employed by your Healthy Start program; if they will be conducted by a local provider under subcontract; and/or if they will be conducted by other types of providers. Also, describe your project's proposed intake and enrollment process, including who performs these activities (e.g., conducted directly by staff employed by your Healthy Start program; conducted by a local provider under subcontract, etc.) This should include the strategies you will use to increase awareness and name recognition of your Healthy Start program in the target community. [CS1]

What will be your program's projected number of program participants to be recruited each year? What percentage of your project's anticipated program participants will be enrolled in Healthy Start during their first trimester of pregnancy? Second trimester? Third trimester? When do you anticipate that your project will reach its capacity to enroll new clients and close enrollment? If this was to occur, describe your procedures for dealing with this process. [CS2]

Describe how your project proposes to retain its clients. That is, how does your project plan on keeping its clients in Healthy Start services such as case management, enabling services, health education, etc.? Will these activities be conducted by staff directly employed by the program, by a local provider under subcontract to your Healthy Start program, etc.? [CS3]

Describe your proposed program's linkage and coordination of outreach services with other agencies and organizations within your target community. Describe how your outreach services will be coordinated with your program's other activities. That is, how will your outreach services complement and fit with the other core services provided? [CS4]

What will be the proposed outreach worker's caseload (e.g., number of clients per outreach worker (both unduplicated and duplicated count))? [CS5]

What will be the case managers' schedule of appointments for each of the following type of client: typical pregnant woman; typical postpartum/interconceptional client; and infants and toddlers? That is, will appointments be scheduled at least weekly, at least monthly, at least quarterly, at least once a year, at each visit, etc.? [CS6]

Describe how you will identify, recruit and the projected number of program participants for each group. How often will you assess the risk status of each group (e.g., never, once, at each visit, at important milestones, depends on needs of client, etc.)? [CS7]

Describe your proposed case management program. Specifically, what services will be provided/delivered (e.g., risk assessment, coordination services, home visiting, health education, counseling and guidance, etc.)? If a multi-level system of case management is used (i.e., low risk, medium risk and high risk), please briefly describe the risk assessment system * and staffing for each level (include position title and FTE). Provide the projected number of clients (annually) for each level of risk (i.e., low risk, medium risk and high risk). [CS8]

**If funded, you will be asked to submit all of the proposed risk-assessment forms/protocols for each type of client (e.g., typical pregnant woman, typical postpartum/ interconceptional client, and infants and toddlers) as well as the cadres of services (time, duration, frequency, etc.) for each risk level.*

Describe how the client will be involved in the development of their own service plan (e.g., client is not involved, client is involved, client signs/initials plan, client receives copy of plan, etc.) [CS9]

Case conferences are meetings used to discuss particular clients and their service plans. Do you plan to use case conferences in your program? If so, describe how your Healthy Start program proposes to use case conferences as they relate to supervision, communication, and/or quality improvement. Also include who will be involved in these case conferences. [CS10]

Describe your proposed plan to verify completion of referrals into your program and of clients to other services. What established medical guidelines will your program's case managers use to assure that your clients receive an adequate level of prenatal care (e.g., ACOG, AAP, Kotelchuck, etc.)? [CS11]

How will your program's case management services include HIV testing and counseling? [CS12]

Describe your program's plan to obtain a medical home for all of your clients. What enabling/facilitating services will be offered to ensure client compliance with care (e.g., childcare during medical appointments, transportation assistance, translation services, etc.)? [CS13]

How will your Healthy Start program provide health education to **program participants** for each required health education topic listed below? [CS14]

- Smoking cessation programs, such as Smoke Free Families America,
- Prevention, early identification, testing and treatment for HIV and STDs,

- especially syphilis,
- Preterm labor,
 - Information on back to sleep/safe sleep,
 - Substance abuse prevention, and
 - Other priority risk behaviors emerging from the assessment and that will be provided by our program.

What method will be used to conduct **program participant health education** (e.g., group instruction, one-on-one instruction, written materials, or referral to another provider)? What is the anticipated number of program participants that will be served by each health education method? What is your proposed staffing, list title and FTE (e.g., staff employed by your Healthy Start program, local provider under subcontract to your Healthy Start program, or other, please explain), and who will supervise this staff? [CS15]

If referring to another provider for health education, how will you track program participants' receipt of that education? [CS16]

How will your Healthy Start program conduct **community participant health education** activities to disseminate health education messages to Healthy Start staff, consortium members, health care providers, and to the general population (e.g., a local provider under contract to your Healthy Start program, directly by staff employed by your Healthy Start program and/or by other, please specify)? What health education topics do you plan to provide to community participants? What is the projected number of participants for each proposed method? [CS17]

How will your Healthy Start program conduct interconceptional services (e.g., by staff employed by your Healthy Start program, by a local provider under contract to your Healthy Start program, by other, please specify)? Describe the services that will be provided to women and infants/toddlers who are program participants through interconceptional care services. How often will your Healthy Start staff have contact with a typical interconceptional program participant during the two years after delivery? Weekly, every two weeks, monthly, other (please specify). [CS18]

What is the projected number of women and their infants that will be served (duplicated and unduplicated) as program participants during the interconceptional period? [CS19]

How will your Healthy Start program track whether a woman made a postpartum visit within six weeks of delivery? How will your Healthy Start program track whether a woman has a medical home for primary care in the interconceptional period? What process will be used to follow up with women who did not have a postpartum visit or a medical home? [CS20]

How will your Healthy Start program ascertain whether a woman has chosen a family planning option? How often will your Healthy Start program follow up with a woman regarding her use of family planning during the interconceptional period (weekly, every two weeks, once a month, etc.)? [CS21]

Describe how your Healthy Start program will enroll infants and toddlers whose mothers were not enrolled in your Healthy Start program while they were pregnant and the criteria

for participation? [CS22]

Will your Healthy Start program provide case management services to coordinate care for infants/toddlers? Will your Healthy Start program offer different levels of case management to coordinate care for infants/toddlers? If so, what are they? [CS23]

Describe how your Healthy Start program will track and ensure the following: a) infant newborn visit within four weeks of hospital discharge; b) infant has or will obtain a medical home for well child care; and c) the immunization status of infants? [CS24]

How will you conduct your perinatal depression screening services (staff employed by your Healthy Start program, local provider under subcontract to your Healthy Start program, other, please specify)? Who will be responsible for the various components of depression services (i.e., screening, treatment, referral, and follow up) (Outreach worker, case manager, etc.)? Include position title and FTE. [CS25]

What types of continuing education and training will be provided to the case management staff? How often will these opportunities be provided? [CS26]

For each group of program participants, i.e., pregnant participants and interconceptional participants: What tool will be used to screen clients for depression, at what intervals will your Healthy Start program typically screen for depression and the projected number of program participants that will be screened (i.e., initial contact with case manager, at each client contact, at first postpartum contact, at regular intervals during each trimester, other)? Please specify for each group. [CS27]

How will your Healthy Start program adapt the screening process to account for cultural diversity among your clients (e.g., screening will be conducted in languages other than English, by workers from the same cultural background as clients, screening tool has been modified to reflect cultural differences, other, please specify)? [CS28]

How will your Healthy Start program educate program participants and community participants about the signs and symptoms of perinatal depression? [CS29]

After a positive screen for depression, who provides further clinical assessment and diagnosis? If a Healthy Start client is diagnosed with perinatal depression, what types of treatment services are available in your community? Please indicate if no treatment is available and your plans to address. [CS30]

How will your Healthy Start program track the status and outcome of referrals made to mental health providers in your community? If so, who will track the status and outcome of referrals? If a woman does not follow through with mental health treatment, describe the proposed process to follow up with the woman to determine why she did not attend her appointment. [CS31]

IMPACT:

Core Systems and Efforts

Please answer the following questions:

Does your community currently have a Local Health System Action Plan (LHSAP)? Please indicate if there is no plan; the plan is currently being drafted or is under review; the plan is in the process of being implemented; the plan has been implemented; at least one of the goals outlined in the plan has been met; and/or the plan is currently being revised.

[CSYS1]

Describe how your program will work with the state and local government funding agencies; partner with community Health Centers and Health Departments; and seek out public/private funding sources. Who will be involved in the development of the LHSAP (i.e., Healthy Start staff, consortium, Title V, key public or private agency partners, key community partners, consumers, etc.)? [CSYS2]

Describe how you will identify the priorities in the LHSAP (i.e., Healthy Start-funded needs assessment; a needs assessment funded by other means; work conducted prior to a Healthy Start grant; findings of a local mortality review board; discussions with provider stakeholders; discussions with community organizations/agencies; discussions with consumers; and/or discussions with consortium). [CSYS3]

Describe how you will use the LHSAP (i.e., set priorities for Healthy Start programming; provide consortium with priorities/direction; provide local MCH agencies with priorities/direction; focus political attention on specific systems priorities/deficiencies; provide a framework for developing collaborative relationships; etc.). [CSYS4]

Who will be responsible for working towards the goals of the LHSAP (i.e., Healthy Start grantee/staff; consortium as a whole; subcommittee of the consortium; etc.)? [CSYS5]

Does the applicant agency/organization have a current consortium in existence? Will it serve as the HS project consortium and address maternal and child health issues? If not, please describe your consortium plans. [CSYS6]

Indicate how many members you anticipate having in your consortium and what will be the anticipated percentage of your consortium members who represent the following categories: [CSYS7]

- state or local government (G)
- program participant (PP)
- community participant (CP)
- community-based health organizations (CBO)
- private agencies or organizations (not community-based)(PAO)
- providers contracting with the Healthy Start program (PC)
- other providers (OP)
- other – please specify

How will the representation within your consortium ensure consideration of and participation by the specific racial/ethnic groups regarding which disparities are sought to be reduced or overcome?” Describe the process your program will use to ensure that the membership on the consortium is culturally representative for both providers and consumers. [CSYS8]

Describe the activities the consortium will implement that are specifically related to the proposed project, including the frequency of consortium meetings, public forums, and training/conferences. [CSYS9]

What percentage of your consortium participants will you keep active? “Active” is defined as attending at least 50 percent of meetings of the full consortium. [CSYS10]

Describe the anticipated role of the consumer in your consortium’s activities. Specifically, what role will the consumers play in the following: strategic planning; budget/finance; personnel recruiting/hiring; developing the scope of services Healthy Start offers; communication/media efforts; data collection/evaluation; and sustainability? Describe the strategies that your Healthy Start program will use to facilitate the participation of consumers on the consortium. [CSYS11]

How will your program work with state and local government funding agencies (e.g., Title V MCH, Title X Family Planning, Title XXI Children’s Health Insurance Program Reauthorization Act (CHIPRA), Early Head Start, EC/EZ, etc.? [CSYS12]

How will your program partner with Federally Qualified Health Centers and Health Departments; and seek out public/private funding sources (e.g., managed care organizations, charities, industry/businesses)? [CSYS13]

Because third party reimbursements (e.g., Medicaid, private insurance, mentoring/training reimbursements from non-HS program funded recipients) are so critical to long term sustainability, please describe your plan to seek reimbursements. [CSYS14]

How and where in the organizational structure will the project/consortium vest major responsibilities for sustainability? [CSYS15]

If you are a Competing Continuation project applicant, please describe previous experience in developing and implementing your LHSAP and consortium. In addition, please describe the ways in which you were able to sustain the project other than through the use of federal funds. [CSYS16]

RESOURCES/CAPABILITIES:

Technical Support Capacity

Please answer the following questions:

Describe any other case management programs serving the same target population in your project area. Please include the number, purpose, and scope of services, in addition to your proposed project’s linkages and communication with those programs. [CSYS17]

Who will provide case management and outreach, and health education services (e.g., case manager; outreach worker; health educator; etc.)? [CSYS18]

List the position title and number of all staff, for each core service, your Healthy Start program plans to employ or will pay for under a subcontract. [CSYS19]

List any additional funding sources that will be used to provide the required core services. [CSYS20]

Briefly describe both the planned and current linkage with your state and local Title V MCH block grant agencies in 1) their 5-year needs assessment, state and local (if applicable) Health Plans, and 2) planning/implementing pertinent federal and state funded perinatal initiatives (e.g., CHIP, Teen Abstinence, Back to Sleep). [CSYS 21]

Describe the current and planned collaboration and service coordination with other entities, service providers, hospitals, health centers, schools/universities, churches, community-based and minority organizations anticipated to implement the proposed project, especially services/activities unique to the competitions. [CSYS22]

For all types of agencies involved, describe planned coordination and information dissemination of lessons that will be learned during this proposed project. Provide summary of signed contracts and/or Memoranda of Agreement with these agencies in **Attachment 3**. [CSYS23]

Organizational Information

Please answer the following questions:

Describe your (applicant) organization, its history, past experiences, and current capacities in MCH, especially in community-based initiatives. Please include relative quantitative and qualitative data as it relates to accomplishing project objectives, performance measures, and utilization of services. This must be included for all competing continuations. [CSYS24]

Provide an organizational chart of the organization, including how the administration and the fiscal management of the proposed project will be integrated into the current administration. Include a brief synopsis of the Project management approach/activities planned for this project. Also, include a chart to show communication and supervision/monitoring pathways with project staff, contractors, and the Consortium. [CSYS25]

Summarize the coordination among key program, fiscal, and evaluation staff. Identify to what extent members of each group will work jointly on monitoring and technical assistance activities; outline the methodologies for soliciting, awarding, and the fiscal and program monitoring of contracts and subcontracts. [CSYS26]

Describe your history of management and oversight involving other grant or contractual funds. If deficiencies have been noted in the most recent internal/external audit, review or reports on the applicant organization's financial management system and management capacity or its implementation of these systems, policies and procedures, identify the

corrective action taken to remedy the deficiency. [CSYS27] **Please note: Once approved for funding, Healthy Start grantees may be required to submit copies of their annual audits with each application for continued funding.**

Briefly describe methodologies that will be used for monitoring utilization and quality assurance (including client satisfaction) of all activities and services. [CSYS28]

Briefly describe the current capacity and potential of the applicant organization and providers and any other entities to assume the provision of any part(s) of the project once the funding period is ended. [CSYS29]

EVALUATIVE MEASURES:

EVALUATION PLAN

Applicants are to provide a description of their local evaluation plan and activities (not to exceed three pages). *(Report of progress on evaluations must be submitted annually in accordance with the schedule set by MCHB and the full evaluation report is due 90 days after the end of the project period.)*

RESOLUTION OF CHALLENGES

Discuss challenges that are likely to be encountered in designing and implementing the activities described in the Work Plan, and approaches that will be used to resolve such challenges.

Please answer the following questions:

What are the anticipated barriers to your program's clients having a medical home?
[CS32]

List the anticipated barriers and challenges to enrolling and retaining clients in your Healthy Start program (e.g., lack of insurance coverage; lack of access to providers who are sensitive to your clients' beliefs and values; lack of transportation; lack of child care; substance abuse; depression or other mental health conditions; domestic violence; unstable housing; language barriers; inconvenient provider office hours; long waits for appointments with provider; etc.). Will the barriers be the same for pregnant clients vs. interconceptional clients? If the barriers are different, please describe the differences. [CS33]

Describe all anticipated barriers to your Healthy Start program's clients receiving the necessary services that may be identified by the case manager (e.g., timely medical appointments; mental health services; substance abuse treatments; etc.). How does your program plan to overcome these barriers? [CS34]

Describe the challenges your organization anticipates in developing the LHSAP (i.e., lack of sufficient staff support or supervision time; lack of resources to perform needs assessment; lack of stakeholder investment in developing the plan; project does not feel the need to develop the plan; political environment will not support goals). How does your organization plan to overcome these challenges? [CSYS30]

List and describe the possible challenges to achieving the goals of the LHSAP (i.e., insufficient Healthy Start resources; insufficient state/local resources; stakeholders do not take responsibility for implementing goals; goals are too large to be realized within the grant period; political climate is not supportive of the efforts; changes in the local health care environment; changes in the national health care environment; necessary groups are not willing to collaborate; categorical funding makes it difficult to combine resources to reach goals). How do you plan on overcoming these challenges? [CSYS31]

Describe the possible challenges to the effectiveness of the consortium. Address the following potential barriers: insufficient staff time dedicated to assisting the consortium in its efforts; lack of other Healthy Start resources; membership lacks critical stakeholders; attendance by key members is irregular; competing agendas of member organizations or unstable relationships among members; no history of collaborative effort; political environment; resources in the state or community are insufficient to support the goals of the consortium. How do you plan on addressing these challenges? [CSYS32]

Formal agreements and letters of understanding with appropriate, actual, or anticipated major agencies or contractors can be referenced here and included in Attachment 6.

ADDITIONAL INFORMATION

Progress Report on Past Performance

For **competing continuations only**, please include applicant's previous experience and knowledge, including individuals on staff, materials published, and progress on previous project activities. Also, include relative quantitative and qualitative data as it relates to accomplishing project objectives, performance measures, and utilization of services.

This section is limited to 10 pages, and should be included as Attachment 9.

Target Area Demographic and Statistics

For the calendar year (CY) 2010, provide census data for each of the three variables in your target area: population by racial distribution (number); number of women of child bearing age (WCBA); and percentage of children under the age of 18 in families with income below the Federal Poverty Level (FPL).

For the years, 2007, 2008, and 2009, provide data for the following variables: number of Live Births, number of Births to teens 17 years and younger, number of Births to Teens 18 and 19, number of Live Births with 1st Trimester entry into prenatal care, number of Live Births with No Prenatal Care, number of Infant Deaths, Infant Mortality Rate (per 1,000 live births), number of Infant Deaths (birth to 28 days), Neonatal Mortality Rate (per 1,000 live births), number of Infant Deaths (29 days to 365 days), Post Neonatal Mortality Rate (per 1,000 live births), number of Moderate Low Birth Weight (LBW) infants (1,501-2,500 grams), Low Birth Weight Rates (percentage), number of Very Low Birth Weight (VLBW) (1,500 grams or less), Very Low Birth Weight Rates (percentage), and Age Appropriate Immunization Rates of Children from Birth to 2 years.

All variables are to be reported for each of the following categories: American Indian/Alaska Native; Asian; Black or African America; Native Hawaiian or other Pacific Islander; and White. For each category you should also identify ethnicity, e.g. Hispanic/Latino. **(This section can be reported on the project demographic worksheet, see Appendix C for sample reporting worksheet. If the requested information is reported on a worksheet, just reference the worksheet here, and place it in Attachment 3.)**

Consortium Roster

Provide a list of consortium members. For each member include their name and agency or organization represented. Also indicate whether they are state or local government (G), program participant (PP), community participant (CP), community-based health organizations (CBO), private agencies or organizations (not community-based), providers contracting with the Healthy Start program, other providers, other – please specify. **(This section can be reported on the Consortium Roster worksheet, see Appendix C for sample reporting worksheet. If the requested information is reported on a worksheet, just reference the worksheet here, and place it in Attachment 3.)**

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 **Healthy Start Initiative: Eliminating Disparities in Perinatal Health "General Population"** and Submission of Administrative Data*

To prepare applicants for reporting requirements, administrative data collection requirements are presented in the appendices of this funding opportunity announcement.

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.**

Attachment 1: Transmittal Letter

Must include:

- The target area for which the applicant is applying; and the proposed target population within that project area that confirms eligibility (The target population is the population that you will serve and will determine your eligibility.);
- That the infant mortality rate (IMR) for the target population is at least 9.86 deaths/1000 live births (which is one-and-a-half times the national infant mortality rate for the period 2007 through 2009 (6.58)). **No other combination of years and only a three year average for the IMR will be accepted to confirm eligibility.**

Attachment 2: For Multi-Year Budgets - Fifth-Year Budgets

If using columns (1) through (4) of the SF-424A Section B for a five-year project period, the applicant will need to submit the budget for year 5 as an attachment. Use the SF-424A Section B.

Attachment 3: Tables, charts, etc.

Include personnel allocation worksheet, consortia roster, contractor status report, project area demographics worksheet, and the project implementation plan worksheet.

Attachment 4: Job Descriptions for Key Personnel

Keep each to one page in length as much as is possible. Item 6 in the Program Narrative section of the SF-424 provides some guidance on items to include in a job description.

Attachment 5: Biographical Sketches of Key Personnel

Include biographical sketches for persons occupying the key positions described in Attachment 4, not to exceed two pages in length. In the event that a biographical sketch is included for an identified individual who is not yet hired, please include a letter of commitment from that person with the biographical sketch.

Attachment 6: Letters of Agreement and/or Description(s) of Proposed/Existing Contracts (project specific)

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

Attachment 7: Project Organizational Chart

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

Attachment 8: Other Relevant Documents

Include here any other documents that are relevant to the application, including letters of support, including letter of support from Title V. Letters of support must be dated.

Attachment 9: Summary Progress Report

For **competing continuations only**, please include applicant's previous experience and knowledge, including individuals on staff, materials published, and progress on previous project activities. Also, include relative quantitative and qualitative data as it relates to accomplishing project objectives, performance measures, and utilization of services.

A well planned accomplishment summary can be of great value by providing a record of accomplishments. It is an important source of material for HRSA in preparing annual reports, planning programs, and communicating program specific accomplishments. The accomplishments of competing continuation applicants are carefully considered during the review process; therefore, applicants are advised to include previously stated goals and objectives in their application and emphasize the progress made in attaining these goals and objectives. Because the Accomplishment Summary is considered when applications are reviewed and scored, **competing continuation applicants who do not include an Accomplishment Summary may not receive as high a score as applicants who do.** The Accomplishment Summary will be evaluated as part of Review Criterion 4: IMPACT.

3. Submission Dates and Times

Application Due Date

The due date for applications under this funding opportunity announcement is **January 27, 2012 at 8:00 P.M. ET.** Applications completed online are considered formally submitted when the application has been successfully transmitted electronically by your organization's Authorized Organization Representative (AOR) through Grants.gov and has been validated by Grants.gov on or before the deadline date and time.

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

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

Late applications:

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

4. Intergovernmental Review

Healthy Start Initiative: Eliminating Disparities in Perinatal Health "General Population" is a program subject to the provisions of Executive Order 12372, as implemented by 45 CFR Part 100.

Executive Order 12372 allows states the option of setting up a system for reviewing applications from within their states for assistance under certain federal programs. Application packages made available under this funding opportunity will contain a listing of states which have chosen to set up such a review system, and will provide a State Single Point of Contact (SPOC) for the review. Information on states affected by this program and State Points of Contact may also be obtained from the Grants Management Specialist listed in the Agency Contact(s) section, as well as from the following Web site: http://www.whitehouse.gov/omb/grants_spoc.

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

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

5. Funding Restrictions

New applicants responding to this announcement may request funding for a project period of up to five (5) years, at no more than \$750,000 per year. Competing Continuations may apply for up to \$750,000 per year or their current funding level, whichever is greater. 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.

Funds under this announcement may not be used for the following purposes:

Shared Staffing: Applicants proposing to utilize the same director or contractual staff across multiple grants/programs (e.g., CISS, SPRANS, HS, State Title V block grant, WIC) should assure that the combined funding for each position does not exceed 100% FTE. If such an irregularity is found, funding will be reduced accordingly.

Shared Equipment: Applicants proposing to purchase equipment which will be used across multiple grants/programs (e.g., CISS, SPRANS, HS, State Title V block grant, WIC) should prorate the costs of the equipment across programs and show the calculation of this pro-ration in their justification. If an irregularity is found where HS equipment is being used by other programs without reimbursement, funding will be reduced accordingly.

Cash Stipends/Incentives: Funds cannot be utilized for cash stipends/monetary incentives given to clients to enroll in project services. However, funds can be used to facilitate participation in project activities (e.g. day care/transportation costs/tokens to attend prenatal/ well child clinic visits), as well as for services rendered to the project (e.g., adolescent peer mentors).

Purchase of Vehicles: Projects should not allocate funds to buy vehicles for the transportation of clients, but rather lease vehicles or contract for these services.

6. Other Submission Requirements

As stated in Section IV.1, except in very rare cases HRSA will no longer accept applications in paper form. Applicants submitting for this funding opportunity are **required** to submit

electronically through Grants.gov. To submit an application electronically, please use the APPLY FOR GRANTS section at <http://www.grants.gov>. When using Grants.gov you will be able to download a copy of the application package, complete it off-line, and then upload and submit the application via the Grants.gov site.

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

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

- Obtain an organizational Data Universal Numbering System (DUNS) number
- Register the organization with Central Contractor Registration (CCR)
- Identify the organization's E-Business Point of Contact (E-Biz POC)
- Confirm the organization's CCR "Marketing Partner ID Number (M-PIN)" password
- Register and approve an Authorized Organization Representative (AOR)
- Obtain a username and password from the Grants.gov Credential Provider

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

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

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

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

V. Application Review Information

1. Review Criteria

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

Review Criteria are used to review and rank applications. The Healthy Start Initiative: Eliminating Disparities in Perinatal Health (General Population) grant program has seven (7) review criteria:

| Review Cross Walk | |
|--|---|
| <u>Narrative Section</u> | <u>Review Criteria</u> |
| Introduction | (1) Need |
| Needs Assessment | (1) Need |
| Objectives and Indicators | (2) Response |
| Methodology and Work plan | (2) Response |
| Core Services | (2) Response |
| Core Systems and Efforts | (4) Impact) |
| Technical Support Capacity | (5) Resources/Capabilities |
| Organizational Information | (5) Resources/Capabilities |
| Evaluation Plan | (3) Evaluative Measures |
| Resolution of Challenges | (5) Resources/Capabilities |
| Budget and Budget Justification Narrative | (6) Support Requested – the budget section should include sufficient justification to allow reviewers to determine the reasonableness of the support requested. |
| Core Systems and Efforts, Technical Support Capacity | (7) Collaboration/Linkage with Title V, Local MCH Agencies and Other community Stakeholders |

Applicants should pay strict attention to addressing all these criteria, as they are the basis upon which the reviewers will evaluate their application:

Criterion 1: Need (20 points): *The extent to which the application describes the problem and associated contributing factors to the problem.*

- 1) Extent to which the proposed plan will enhance or improve Eliminating Disparities activities in the community. The extent to which the proposed plan provides the required core services of outreach and client recruitment, case management, health education, interconceptional care, and depression services.
- 2) Extent to which the demonstrated need(s) of the target population to be served adequately described and supported in the needs assessment and summarized in the problem statement.

- 3) Extent to which the applicant describes the size, demographic characteristics, prevalent norms, health behaviors, and problems associated with the targeted population(s).
- 4) Extent to which the proposed plan addresses the documented need(s) of the targeted population including attention to the cultural and linguistic needs of consumers.
- 5) Extent to which the project is linked to an existing perinatal system of care that enhances the community's infant mortality reduction programs already in operation in the project area.

Criterion 2: Response (15 points): *The extent to which the proposed project responds to the "purpose" included in the program description; and the clarity of the proposed goals and objectives and their relationship to the identified project. The extent to which the activities (scientific or other) described in the application demonstrates capability address the identified problem(s) and attains the project's objectives.*

- 1) Extent to which the project objectives incorporate the specific HS program competition's purpose (i.e., Eliminating Disparities) and are measurable, logical, and appropriate in relation to both the specific problems and interventions identified.
- 2) Extent to which the activities proposed for each service (Outreach, case management, health education, interconceptional care, and depression services) appear feasible and likely to contribute to the achievement of the project's objectives within each budget period.

Criterion 3: Evaluative Measures (10 points): *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.*

- 1) Extent to which the proposed evaluation plan measures program performance, is well organized, adequately described, utilizes sound evaluation methodologies, and complies with MCHB's evaluation protocol for its discretionary grants and national performance measures.
- 2) Extent to which each proposed methodology within the local evaluation is either congruent to or linked with the scopes of the core services (outreach, case management, health education, and training) and components required of all HS community projects.

Criterion 4: Impact (10 points) - Core Systems and Efforts: *The extent and effectiveness of plans for dissemination of project results, and/or the extent to which project results may be national in scope and/or the degree to which a community is impacted by delivery of health services, and/or the degree to which the project activities are replicable, and/or the sustainability of the program beyond federal funding.*

- 1) Extent to which the efforts described in the Local Health System Action Plan develops an integrated service delivery system that better serves Healthy Start program participants, as well as the community as a whole.

- 2) Extent to which the consortium includes/or will include the appropriate representation of project area consumers, providers, and other key stake holders.
- 3) The structure, role, and plan of action of the consortium in the implementation of the proposed project plan are adequately described.
- 4) The actual or proposed communication pathways between the grantee and the consortium regarding the progress of the project are clearly delineated.
- 5) Extent to which the applicant proposes to sustain the project through new or existing sources and/or acquire additional resources. Extent to which the applicant plans to seek third party reimbursements (e.g. Medicaid, private insurance, mentoring/training reimbursements from non-HS program funded recipients).

Criterion 5: Resources/Capabilities (20 points): *The extent to which project personnel are qualified by training and/or experience to implement and carry out the project. The extent to which project personnel are qualified by training and/or experience to implement and carry out the project. The capabilities of the applicant organization, and quality and availability of facilities and personnel to fulfill the needs and requirements of the proposed project. For competing continuations, past performance will also be considered.*

- 1) Extent to which the proposed approach delineates the interventions included in the plan, and identifies the actual or anticipated agencies and resources which will be used to implement those strategies.
- 2) Extent to which the applicant has the capacity, expertise and past experience to carry out and oversee a complex, integrated, community-driven approach to the proposed Eliminating Disparities activities within the proposed project area.
- 3) Extent to which the applicant has demonstrated an ability to maximize and coordinate existing resources, monitors contracts, and acquire additional resources.
- 4) Extent to which the applicant's fiscal and programmatic contract monitoring system demonstrates their ability to implement and monitor their program.

Criterion 6: Support Requested (15 points): *The reasonableness of the proposed budget in relation to the objectives, the complexity of the activities, and the anticipated results.*

- 1) Extent to which the proposed budget for each year of the five-year project period is realistic, adequately justified, and consistent with the proposed project plan.
- 2) Extent to which the costs of administration and evaluation are reasonable and proportionate to the costs of service provision.
- 3) Degree to which the costs of the proposed project are economical in relation to the proposed service utilization.

Criterion 7: Collaboration/Linkage with Title V, Local MCH Agencies, and Other Community Stake Holders (10 points):

- 1) Extent to which actual or planned involvement of the State Title V, local MCH, and other agencies serving the proposed project area is clearly evident.
- 2) Extent to which the project is consonant with overall state efforts to develop comprehensive community-based systems of services, and focuses on service needs identified in the state's MCH Services Title V- Five Year Comprehensive Needs Assessment and Block Grant Plan.

2. Review and Selection Process

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

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

Funding Preferences

The Senate report accompanying the 2010 appropriations act urges HRSA to afford a funding preference to some applicants. Applicants receiving the preference will be placed in a more competitive position among applications that can be funded.

Applications that do not receive a funding preference will be given full and equitable consideration during the review process. A funding preference will be granted to any qualified applicant that specifically requests the preference and meets the criteria for the preference as follows:

Qualification 1: Preference will be given to current and former Healthy Start grantees with expiring or recently expired project period. A current Healthy Start grantee with neither an expiring nor recently expired project period may apply to serve a new community under the Healthy Start Initiative: Eliminating Disparities in Perinatal Health (General Population) competition (only one applicant per project area will be funded), but will not be eligible for the preference. A current Healthy Start grantee (or existing competing continuation) is defined as a grantee receiving Healthy Start funds for the project period of June 1, 2008–May 31, 2012.

3. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to the start date of June 1, 2012.

VI. AWARD Administration Information

1. Award Notices

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

The Notice of Award sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant's Authorized Organization Representative, and reflects the only authorizing document. It will be sent prior to the start date of June 1, 2012.

2. Administrative and National Policy Requirements

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

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

Trafficking in Persons

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

Smoke-Free Workplace

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

Cultural and Linguistic Competence

HRSA 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? \(AHRO\)](#)

3. Reporting

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

a. Audit Requirements

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

b. Payment Management Requirements

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

c. Status Reports

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

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

3) **Final Report.** 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 Reports. 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.

(2) Performance Reporting

Successful applicants receiving grant funds will be required, within 120 days of the Notice of Award (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 90 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.

d. Transparency Act Reporting Requirements

New (“Type 1”) 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 Notice of Award.

VII. Agency Contacts

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

Tya Renwick
Grants Management Specialist
Government and Special Focus Branch
Office of Federal Assistance Management
Health Resources and Services Administration (HRSA)
Telephone: 301-594-0227
Fax: 301-443-6343
Email: TRenwick@HRSA.GOV

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

Benita Baker
Attn: Division of Healthy Start and Perinatal Services
Maternal and Child Health Bureau, HRSA
Parklawn Building, Room 18-12
5600 Fishers Lane
Rockville, MD 20857
Telephone: 301-443-0543
Fax: 301-594-0186
Email: bbaker@hrsa.gov

Applicants may need assistance when working online to submit their application forms electronically. 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
Phone: 1-800-518-4726
E-mail: support@grants.gov
iPortal: <http://grants.gov/iportal>

VIII. Other Information

To assist applicants in applying for this grant, a technical assistance webcast will be held on **Tuesday, January 10, 2012 from 2pm-4pm ET**. Information on how to register for this webcast can be found at <http://mchb.hrsa.gov/>.

IX. TIPS for Writing a Strong Application

A concise resource offering tips for writing proposals for HHS grants and cooperative agreements can be accessed online at: <http://www.hhs.gov/asrt/og/grantinformation/apptips.html>.

Appendix A: MCHB Administrative Forms and Performance Measures

The following Administrative Forms and Performance Measures are assigned to this MCHB program.

Administrative Forms

- Form 1, Project Budget Details
- Form 2, Project Funding Profile
- Form 3, Budget Details by Types of Individuals Served
- Form 3W, Budget Details by Types of Individuals Served - Worksheet
- Form 4, Project Budget and Expenditures by Type of Services
- Form 5, Number of Individuals Served (Unduplicated) by Type of Individual and source of Primary Insurance Coverage
- Form 5W, Number of Individuals Served (Unduplicated) by Type of Individual - Worksheet
- Form 6, Abstract
- Form 7, Discretionary Grant Project Summary Data (including section 5 & 6)

Performance Measures

- PM07, The degree to which MCHB-funded programs ensure family, youth, and consumer participation in program and policy activities
- PM10, The degree to which MCHB-funded programs have incorporated cultural and linguistic competence elements into their policies, guidelines, contracts and training
- PM14, The degree to which states and communities use “morbidity/mortality” review processes in MCH needs assessment, quality improvement, and/or data capacity building
- PM17, The percentage of children age 0 to 18 participating in MCHB-funded programs who receive coordinated, ongoing, comprehensive care within a medical home
- PM20, The percentage of women participating in MCHB-funded programs who have an ongoing source of primary and preventive care services for women
- PM21, The percentage of women participating in MCHB-funded programs who have a completed referral, among those women who receive a referral
- PM22, The degree to which MCHB-funded programs facilitate health providers' screening of women participants for risk factors
- PM24, The degree to which MCHB-funded initiatives contribute to infrastructure development through core public health assessment, policy development and assurance functions
- PM33, The degree to which MCHB-funded initiatives work to promote sustainability of their programs or initiatives beyond the life of MCHB funding
- PM35, The degree to which states and communities have implemented comprehensive systems for women’s health services
- PM36, The percentage of pregnant participants in MCHB-funded programs receiving prenatal care beginning in the first trimester

- PM38, The percentage of completed referrals among women in MCHB-funded programs
- PM39, The percentage of women participating in MCHB-funded programs who smoke in the last three months of pregnancy
- PM40, The degree to which grantees have facilitated access to medical homes for MCH populations
- PM50, Percent of very low birth weight live births
- PM51, Percent of live singleton births weighing less than 2,500 grams
- PM52, The infant mortality rate per 1,000 live births
- PM53, The neonatal mortality rate per 1,000 live births
- PM54, The post-neonatal mortality rate per 1,000 live births
- PM55, The perinatal mortality rate per 1,000 live births
- PM81, The percent of program participant mothers who breastfeed their infants at 6 months of age

Additional Data Elements

- Perinatal Data Form
 - DHSPS Health Data Sheet
 - Risk Reduction/Prevention Data Sheet
 - Major Services Data
- 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 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 3
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED
For Projects Providing Direct Health Care, Enabling, or Population-based Services

| Target Population(s) | FY | | FY | |
|--|--------------------|--------------------|--------------------|--------------------|
| | \$ Budgeted | \$ Expended | \$ Budgeted | \$ Expended |
| Pregnant Women (All Ages) | | | | |
| Infants (Age 0 to 1 year) | | | | |
| Children and Youth (Age 1 year to 25 years) | | | | |
| CSHCN Infants (Age 0 to 1 year) | | | | |
| CSHCN Children and Youth (Age 1 year to 25 years) | | | | |
| Non-pregnant Women (Age 25 and over) | | | | |
| Other | | | | |
| TOTAL | | | | |

**INSTRUCTIONS FOR COMPLETION OF FORM 3
BUDGET DETAILS BY TYPES OF INDIVIDUALS SERVED**

For Projects Providing Direct Health Care, Enabling, or Population-based Services

If the project provides direct health care 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.

All ages are to be read from x to y, not including y. For example, infants are those from birth to 1, and children and youth are from age 1 to 25.

Enter the budgeted amounts for the appropriate fiscal year, for each targeted population group. Note that the Total for each budgeted column is to be the same as that appearing in the corresponding budgeted column in Form 2, Line 5.

Enter the expended amounts for the appropriate fiscal year that has been completed for each target population group. Note that the Total for the expended column is to be the same as that appearing in the corresponding expended column in Form 2, Line 5.

**FORM 3 WORKSHEET
 BUDGET/EXPENDITURE BREAKDOWN FOR SUBCATEGORIES OF
 INDIVIDUALS SERVED**

For Projects Providing Direct Health Care, Enabling, or Population-based Services

| Target Population | Year 1 | | Year 2 | |
|---|----------|----------|----------|----------|
| | Budgeted | Expended | Budgeted | Expended |
| Pregnant Women (All Ages) <i>(Line 1, Form 3)</i> | | | | |
| Program Participant: Pregnant Women (All Ages) | | | | |
| Community Participant: Pregnant Women (All Ages) | | | | |
| Infants (Age 0 to 1 year) <i>(Line 2, Form 3)</i> | | | | |
| Program Participant: Infants (0 to 1 year) | | | | |
| Community Participant: Infants (0 to 1 year) | | | | |
| Children and Youth (Age 1 year to 25 years) <i>(Line 3, Form 3)</i> | | | | |
| Program Participant: Children Age 12 months through 23 months | | | | |
| Community Participant: Children Age 12 months through 23 months | | | | |
| Program | | | | |

| Target Population | Year 1 | | Year 2 | |
|---|----------|----------|----------|----------|
| | Budgeted | Expended | Budgeted | Expended |
| Participant: Children Age 24 months through 4 years | | | | |
| Community Participant: Children Age 24 months through 4 years | | | | |
| Program Participant: Children and Youth (Non- pregnant) Age 5 years through 24 years | | | | |
| Community Participant: Children and Youth (Non- pregnant) Age 5 years through 24 years | | | | |
| CSHCN Infants (Age 0 to 1 year) (Line 4, Form 3) | | | | |
| Program Participant: CSHCN Infants (0 to 1 year) | | | | |
| Community Participant: CSHCN Infants (0 to 1 year) | | | | |
| CSHCN Children and Youth (Age 1 year to 25 years) (Line 5, Form 3) | | | | |
| Program Participant: CSHCN | | | | |

| Target Population | Year 1 | | Year 2 | |
|---|----------|----------|----------|----------|
| | Budgeted | Expended | Budgeted | Expended |
| Children Age 12 months through 23 months | | | | |
| Community Participant: CSHCN Children Age 12 months through 23 months | | | | |
| Program Participant: CSHCN Children Age 24 months through 4 years | | | | |
| Community Participant: CSHCN Children Age 24 months through 4 years | | | | |
| Program Participant: CSHCN Children and Youth (Non-pregnant) Age 5 years through 24 years | | | | |
| Community Participant: CSHCN Children and Youth (Non-pregnant) Age 5 years through 24 years | | | | |
| Non-Pregnant Women (Age 25 years and over) <i>(Line 6, Form 3)</i> | | | | |
| Program Participant: | | | | |

| Target Population | Year 1 | | Year 2 | |
|---|----------|----------|----------|----------|
| | Budgeted | Expended | Budgeted | Expended |
| Non-pregnant Women (All Ages) | | | | |
| Community Participant: Non-pregnant Women (All Ages) | | | | |
| Other (Line 7, Form 3) | | | | |
| Program Participant: Other | | | | |
| Community Participant: Other | | | | |
| Total | | | | |

**INSTRUCTIONS FOR COMPLETION OF FORM 3 WORKSHEET
BUDGET/EXPENDITURE BREAKDOWN FOR SUBCATEGORIES OF INDIVIDUALS
SERVED**

For Projects Providing Direct Health Care, Enabling, or Population-based Services

This form is intended to provide funding data on the budgeted and expended amounts for the subcategories of individuals served by program and community participants.

Note, the ages are expressed as either x to y, (i.e., 1 to 25, meaning from age 1 up to age 25, but not including 25) or x – y (i.e., 5 years – 24 meaning age 5 through age 24).

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

Enter the budgeted amounts for the appropriate fiscal year, for each subcategory of individuals served by program and community participants. Note, for each fiscal year, the budget total for each category on form 3W is the same as budget total for the corresponding category on Form 3. In addition, the values in the subcategories must add up to the category budget total. For example, if the budget total for Pregnant Women (All Ages) is \$25,000, then the values entered in Program Participant: Pregnant Women (All Ages) and Community Participant: Pregnant Women (All Ages) must equal \$25,000.

Enter the expended amounts for the appropriate fiscal year, for each subcategory of individuals served by program and community participants. Note, the expended total for each category on form 3W is the same as expended total for the corresponding category on Form 3. In addition, the values in the subcategories must add up to the category expended total. For example, if the expended total for Pregnant Women (All Ages) is \$25,000, then the values entered in Program Participant: Pregnant Women (All Ages) and Community Participant: Pregnant Women (All Ages) must equal \$25,000.

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 5
NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED)
By Type of Individual and Source of Primary Insurance Coverage
For Projects Providing Direct Health Care, Enabling or Population-based Services

Reporting Year _____

Table 1

| Pregnant Women Served | (a) Number Served | (b) Total Served | (c) Title XIX % | (d) Title XXI % | (e) Private/Other % | (f) None % | (g) Unknown % |
|------------------------------|------------------------------|-----------------------------|----------------------------|----------------------------|--------------------------------|-----------------------|--------------------------|
| Pregnant Women (All Ages) | | | | | | | |
| 10-14 | | | | | | | |
| 15-19 | | | | | | | |
| 20-24 | | | | | | | |
| 25-34 | | | | | | | |
| 35-44 | | | | | | | |
| 45 + | | | | | | | |

Table 2

| Infants, Children and Youth Served | (a) Number Served | (b) Total Served | (c) Title XIX % | (d) Title XXI % | (e) Private/Other % | (f) None % | (g) Unknown % |
|---|------------------------------|-----------------------------|----------------------------|----------------------------|--------------------------------|-----------------------|--------------------------|
| Infants <1 | | | | | | | |
| Children and Youth 1 to 25 years | | | | | | | |
| 12-24 months | | | | | | | |
| 25 months-4 years | | | | | | | |
| 5-9 | | | | | | | |
| 10-14 | | | | | | | |
| 15-19 | | | | | | | |
| 20-24 | | | | | | | |

Table 3

| CSHCN Infants, Children and Youth Served | (a) Number Served | (b) Total Served | (c) Title XIX % | (d) Title XXI % | (e) Private/Other % | (f) None % | (g) Unknown % |
|---|------------------------------|-----------------------------|----------------------------|----------------------------|--------------------------------|-----------------------|--------------------------|
| Infants <1 yr | | | | | | | |
| Children and Youth 1 to 25 years | | | | | | | |
| 12-24 months | | | | | | | |
| 25 months-4 years | | | | | | | |
| 5-9 | | | | | | | |
| 10-14 | | | | | | | |

| | | | | | | | |
|-------|--|--|--|--|--|--|--|
| 15-19 | | | | | | | |
| 20-24 | | | | | | | |

Table 4

| Women Served | (a) Number Served | (b) Total Served | (c) Title XIX % | (d) Title XXI % | (e) Private/Other % | (f) None % | Unknown % (g) |
|---------------------|------------------------------|-----------------------------|----------------------------|----------------------------|--------------------------------|-----------------------|----------------------|
| Women 25+ | | | | | | | |
| 25-29 | | | | | | | |
| 30-34 | | | | | | | |
| 35-44 | | | | | | | |
| 45-54 | | | | | | | |
| 55-64 | | | | | | | |
| 65+ | | | | | | | |

Table 5

| Other | (a) Number Served | (b) Total Served | (c) Title XIX % | (d) Title XXI % | (e) Private/Other % | (f) None % | Unknown % (g) |
|--------------|------------------------------|-----------------------------|----------------------------|----------------------------|--------------------------------|-----------------------|----------------------|
| Men 25+ | | | | | | | |
| | | | | | | | |

TOTAL SERVED: _____

INSTRUCTIONS FOR THE COMPLETION OF FORM 5

NUMBER OF INDIVIDUALS SERVED (UNDUPLICATED) By Type of Individual and Source of Primary Insurance Coverage For Projects Providing Direct Health Care, Enabling or Population-based Services

Enter data into all required (unshaded) data cells. If an actual number is not available, make an estimate. Please explain all estimates, in a note.

Note that ages are expressed as either x to y, (i.e., 1 to 25, meaning from age 1 up to age 25, but not including 25) or x – y (i.e., 1 – 4 meaning age 1 through age 4). Also, symbols are used to indicate directions. For example, <1 means less than 1, or from birth up to, but not including age 1. On the other hand, 45+ means age 45 and over.

1. At the top of the Form, the Line Reporting Year displays the year for which the data applies.
2. In Column (a), enter the unduplicated count of individuals who received a direct service from the project regardless of the primary source of insurance coverage. These services would generally be included in the top three levels of the MCH pyramid (the fourth, or base level, would generally not contain direct services) and would include individuals served by total dollars reported on Form 3, Line 5.
3. In Column (b), the total number of the individuals served is summed from Column (a).
4. In the remaining columns, report the percentage of those individuals receiving direct health care, enabling or population-based services, who have as their primary source of coverage:
 - Column (c): Title XIX (includes Medicaid expansion under Title XXI)
 - Column (d): Title XXI
 - Column (e): Private or other coverage
 - Column (f): None
 - Column (g): Unknown

These may be estimates. If individuals are covered by more than one source of insurance, they should be listed under the column of their primary source.

FORM 5 WORKSHEET
BREAKDOWN OF INDIVIDUALS SERVED (UNDUPLICATED)
By Type of Individual and Program Participants
 For Projects Providing Direct Health Care, Enabling or Population-based Services

| Table 1 | | |
|---|------------------------------|-------------------------------------|
| Pregnant Women Served | (a) Number Served | (b) Program Participants |
| Pregnant Women (All Ages) | | |
| 10-14 | | |
| 15-19 | | |
| 20-24 | | |
| 25-34 | | |
| 35-44 | | |
| 45 + | | |
| Table 2 | | |
| Infants, Children and Youth Served | (a) Number Served | (b) Program Participants |
| Infants < 1 year | | |
| Children and Youth 1 to 25 years | | |
| 12-24 months | | |
| 25 months-4 years | | |
| 5-9 | | |
| 10-14 | | |
| 15-19 | | |
| 20-24 | | |
| Table 3 | | |
| CSHCN Infants, Children and Youth Served | (a) Number Served | (b) Program Participants |
| Infants < 1 year | | |
| Children and Youth 1 to 25 years | | |
| 12-24 months | | |
| 25 months-4 year | | |
| 5-9 | | |
| 10-14 | | |
| 15-19 | | |
| 20-24 | | |
| Table 4 | | |
| Women Served | (a) Number Served | (b) Program Participants |
| Women 25 + | | |
| 25-29 | | |
| 30-34 | | |
| 35-44 | | |
| 45-54 | | |
| 55-64 | | |
| 65 + | | |
| Table 5 | | |
| Other | (a) Number Served | (b) Program Participants |
| Men (25+) | | |
| Other | | |

**INSTRUCTIONS FOR COMPLETION OF FORM 5 WORKSHEET
BREAKDOWN OF INDIVIDUALS SERVED (UNDUPLICATED)**

By Type of Individual and Program Participants
For Projects Providing Direct Health Care, Enabling or Population-based Services

This form is intended to provide data on the number of program participants by type of individual.

Note, the ages are expressed as either x to y, (i.e., 1 to 25, meaning from age 1 up to age 25, but not including 25) or x – y (i.e., 25 months – 4 meaning age 25months through age 4). Also, symbols are used to indicate directions. For example, <1 means less than 1, or from birth up to, but not including age 1. On the other hand, 45+ means age 45 and over.

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

The values in column (a) Number Served are the same values as those entered on Form 5 for the corresponding type of individual. The values in column (b) Program Participants must be less than or equal to the corresponding value in column (a) Number Served.

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:

- 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 2010 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:

1. Provide a brief description of the major activities and accomplishments over the past year (not to exceed 200 words).
2. 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

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) | | | | | | | ETHNICITY | | | | |
|--|---------------------------------------|-------|---------------------------|---|-------|--------------------|------------|------------------|--------------------|------------------------|------------|-------|
| | American Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Other Pacific Islander | White | More than One Race | Unrecorded | Total | 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+ | | | | | | | | | | | | |
| 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. Infrastructure cannot be selected by itself; it must be selected with another service level. 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 |
|---|---|---|---|---|
| | | | | 1. 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. |
| | | | | 2. Culturally diverse family members/youth/consumers facilitate the program's ability to meet the needs of the populations served. |
| | | | | 3. Family members/youth/consumers are offered training, mentoring, and opportunities to lead advisory committees or task forces. |
| | | | | 4. Family members/youth/consumers who participate in the program are compensated for their time and expenses. |
| | | | | 5. Family members/youth/consumers participate on advisory committees or task forces to guide program activities. |
| | | | | 6. 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. |
| | | | | 7. 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. |
| | | | | 8. 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:

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 10 elements that demonstrate cultural and linguistic competency. Please check the degree to which the elements have been implemented. The answer scale for the entire measure is 0-30. 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 competency 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 competency 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 competency 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 competency 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 competency 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 competency. |
| | | | | 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:

14 PERFORMANCE MEASURE

**Goal 3: Assure Quality of Care
(Build analytic capacity to assess and assure
quality of care)**

Level: State and Local

Category: Data and Evaluation

The degree to which States and communities use “morbidity/mortality” review processes in MCH needs assessment, quality improvement, and/or data capacity building.

GOAL

To increase the number of MCHB programs that incorporate the findings and recommendations from Mortality/Morbidity Review processes in their planning and program development (e.g., needs assessment, quality improvement, and/or capacity building).

MEASURE

The degree to which States and communities use “morbidity/mortality” review processes in MCH needs assessment, quality improvement, and/or data capacity building.

DEFINITION

Attached is a scale to measure 1) the presence of the mortality/morbidity review, 2) coordination with other mortality/morbidity reviews, 3) utilization of the mortality/morbidity review process in MCH planning.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16.1: Reduce fetal and infant deaths.
Related to Objective 16.4: Reduce maternal deaths.

DATA SOURCE(S) AND ISSUES

Attached data collection form to be completed by MCHB Program Directors.

SIGNIFICANCE

Mortality/morbidity reviews are processes aimed at guiding States and communities to identify and solve problems contributing to poor reproductive outcomes and maternal and child health. The ultimate goal is to enhance assessment capacity, policy development, and quality improvement efforts. These processes provide a means to systematically examine the factors that play a role in mortality and morbidity, integrating information about the health of individuals with other information about medical care, community resources, and health and social services systems. This process should lead to system improvements to decrease preventable mortality/morbidity.

DATA COLLECTION FORM FOR DETAIL SHEET #14

Using a scale of 0-1, please rate the degree to which your program utilizes the mortality/morbidity review processes in a coordinated and integrated way in the following categories.

Please use the space provided for notes to describe activities related to each type of review, clarify any reasons for score, and explain the applicability of elements to program.

| Review Processes | In Place | Coordination | Used in State or Local MCH Planning |
|-------------------------------|-----------------|---------------------|--|
| Fetal/Infant Mortality Review | | | |
| Child Fatality Review | | | |
| Maternal Mortality Review | | | |

In Place: 0 = Not in place
 1 = In place

Coordination: 0 = No Coordination
 1 = Coordination between at least 2 mortality/morbidity review processes

Used in State or Local MCH Planning:
 0 = Findings not used in State or Local MCH planning
 1 = Findings used in State or Local MCH planning

NOTES/COMMENTS:

17 PERFORMANCE MEASURE

The percentage of children age 0 to 18 participating in MCHB-funded programs who receive coordinated, ongoing, comprehensive care within a medical home.

**Goal 3: Assure Quality of Care
(Develop and promote health services and systems designed to improve quality of care)**

Level: National

Category: Child Health/Medical Home

GOAL

To increase the number of children in the State who have a medical home.

MEASURE

The percentage of all children age 0 to 18 participating in MCHB-funded programs who receive coordinated, ongoing, comprehensive care within a medical home.

DEFINITION

Numerator:

The number of children participating in MCHB funded projects age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home during the reporting period.

Denominator:

The number of children participating in MCHB funded projects age 0 to 18 during the reporting period.

Units: 100

Text: Percentage

The MCHB uses the American Academy of Pediatrics (AAP) definition of “medical home.” The definition establishes that the medical care of infants, children and adolescents should be accessible, continuous, comprehensive, family centered, coordinated and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them. These characteristics define the “medical home” and describe the care that has traditionally been provided in an office setting by pediatricians. (AAP, Volume 90, No. 5, 11/92).

Please use the space provided for notes to detail the data source and year of data used.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16.22 (Developmental):
Increase the proportion of CSCHN who have access to a medical home.

DATA SOURCE(S) AND ISSUES

Provider and MCHB program patient records.

SIGNIFICANCE

Providing primary care to children in a “medical home” is the standard of practice. Research

indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. Data collected for this measure would help to ensure that children have access to a medical home and help to document the performance of several programs including EPSDT, Immunization, and IDEA in reaching that goal.

20 PERFORMANCE MEASURE

The percentage of women participating in MCHB-funded programs who have an ongoing source of primary and preventive care services for women.

**Goal 3: Assure Quality of Care
(Develop and promote health services and systems designed to improve quality of care)**

Level: Grantee

Category: Women's Health

GOAL

To increase the percentage of women participating in MCHB-funded projects who have an ongoing source of primary and preventive care services for women.

MEASURE

The percentage of women participating in MCHB-funded programs who have an ongoing source of primary and preventive care services for women.

DEFINITION

Numerator:

The number of women participating in MCHB-funded projects who have an ongoing source of primary and preventive care services during the reporting period.

Denominator:

The number of women participating in MCHB-funded projects during the reporting period.

Units: 100

Text: Percentage

“Ongoing source of care” is defined as the provider(s) who deliver ongoing primary and preventive health care. Women commonly use more than one provider for routine care (e.g., internist/FP and obstetrician-gynecologist). Ongoing source of care providers for women should offer services that ideally are accessible, continuous, comprehensive, coordinated and appropriately linked to specialty services, linguistically and culturally relevant and focused on the full context of women's lives.

Please use the space provided for notes to detail the data source and year of data used.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 1.4: Increase the proportion of persons who have a specific source of ongoing care.

DATA SOURCE(S) AND ISSUES

Provider and MCHB program patient records. In the grant application, designated MCHB-funded projects will need to indicate how they will identify and document that program participants have an ongoing relationship with a provider(s) of primary and preventive services.

SIGNIFICANCE

Women across the life span often receive fragmented health care from non-coordinated sources or enter care only for ob/gyn services or to secure services for family dependents. Women

need a comprehensive array of integrated services from an ongoing provider of primary and preventive health care services. Research indicates that women with a stable and continuous source of health care are more likely to receive appropriate preventive care and are less likely to have unmet needs for basic health care.

21 PERFORMANCE MEASURE

The percentage of women participating in MCHB-funded programs who have a completed referral, among those women who receive a referral.

**Goal 3: Assure Quality of Care
(Develop and promote health services and systems that assure appropriate follow-up services)
Level: Grantee
Category: Women's Health**

GOAL

Increase the percentage of completed referrals for women participating in MCHB-funded programs in need of services.

MEASURE

The percentage of women participating in MCHB-funded programs who have a completed referral among those that receive a referral.

DEFINITION

Numerator:
Unduplicated number of MCHB-funded program participants who have at least one completed health or supportive service referral

Denominator:
Unduplicated number of MCHB-funded program participants who receive at least one referral for health and other supportive services
Units: 100 **Text:** Percentage
A "completed service referral" is defined as a client (who received a referral) attending one or more sessions with the provider to whom she was referred. The provider may be within or outside of the MCHB program/agency. The purpose of these referrals can be either treatment-related (e.g., AIDS or substance abuse treatment, domestic violence counseling), preventive (e.g., family planning, WIC, depression screening/ referral, early intervention services), or supportive services (e.g., housing, job training, transportation).

Please use the space provided for notes to detail the data source and year of data used.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16.5 : Reduce maternal illness and complications due to pregnancy

Related to Objective 16.17: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.

Related to Objective 21.3: Increase to at least 95% the proportion of pregnant women and infants who receive risk-appropriate care.

DATA SOURCE(S) AND ISSUES

Provider and MCHB program patient records. Projects will need to have a process to verify a

completed referral.

SIGNIFICANCE

In order to be effective, health services must ensure that a client's risks are identified, and clients receive services that address their identified needs and are referred appropriately. There is no impact if the referral is not completed/services not obtained.

22 PERFORMANCE MEASURE

The degree to which MCHB-funded programs facilitate health providers' screening of women participants for risk factors.

**Goal 3: Assure Quality of Care
(Develop and promote health services and systems that assure appropriate follow-up services)**

Level: Grantee

Category: Women's Health

GOAL

To improve health providers' appropriate screening for risk factors of women participants in MCHB-funded programs.

MEASURE

The degree to which MCHB-funded programs facilitate health providers' screening of women participants for risk factors.

DEFINITION

Attached is a checklist of four activities that demonstrate the degree to which grantees have facilitated the screening of women participants for risk factors. Please indicate the degree to which the activities have been implemented. Please keep the completed checklist attached.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to various objectives related to women's health, including several objectives under the following: Goal 5: Through prevention programs, reduce the disease and economic burden of diabetes, and improve the quality of life for all persons who have or are at risk for diabetes; Goal 9: Improve pregnancy planning and spacing and prevent unintended pregnancy; Goal 12: Improve cardiovascular health and quality of life through the prevention, detection, and treatment of risk factors; early identification and treatment of heart attacks and strokes; and prevention of recurrent cardiovascular events; Goal 13: Prevent HIV infection and its related illness and death; Goal 14: Prevent disease, disability, and death from infectious diseases, including vaccine-preventable diseases; Goal 15: Reduce injuries, disabilities, and deaths due to unintentional injuries and violence; Goal 16: Improve the health and well-being of women, infants, children, and families; Goal 18: Improve mental health and ensure access to appropriate, quality mental health services; Goal 21: Prevent and control oral and craniofacial diseases, conditions, and injuries and improve access to related services; Goal 25: Promote responsible sexual behaviors, strengthen community capacity, and increase access to quality services to prevent sexually transmitted diseases (STDs) and their complications; Goal 26: Reduce substance abuse to protect the health, safety, and quality of life for all, especially children. Goal 27: Reduce illness, disability, and death related to

tobacco use and exposure to secondhand smoke.

DATA SOURCE(S) AND ISSUES

Provider and program patient records

SIGNIFICANCE

Screening of women for behavioral risk factors has proven to be beneficial in improving maternal outcomes, which highlights the importance of women being screened appropriately for risk factors. For example: intimate partner violence during pregnancy has been reported to be as high as 20.1 percent among pregnant women; adverse effects such as spontaneous abortion, LBW, and preterm delivery have been associated with prenatal use of licit and illicit drugs (including alcohol, tobacco, cocaine, and marijuana); screening in the area of mental health can promote early detection and intervention for mental health problems; and while there is insufficient evidence to support a recommendation concerning routine screening of pregnant females for STDs, the benefits of early intervention in HIV and, detection and treatment of asymptomatic Chlamydia have been demonstrated.

DATA COLLECTION FORM FOR DETAIL SHEET #22

Using a scale of 0-2, indicate the degree to which your grant has performed each activity to facilitate screening for each risk factor by health providers in your program.

Please use the space provided for notes to describe activities related to each risk factor, any risk factors included in “other,” and supply performance objectives.

| Risk Factor | Conduct activities that effectively motivate providers to systematically screen for risk factors, e.g., simple chart tools that identify when provider should screen, a sign off for the provider upon screening completion | Develop and/or enhance a system of care that ensures linkages between health care providers and appropriate intervention programs | Provide training to providers on effective and emerging screening tools. |
|-------------------|---|---|--|
| Smoking | | | |
| Alcohol | | | |
| Illicit Drugs | | | |
| Eating Disorders | | | |
| Depression | | | |
| Hypertension | | | |
| Diabetes | | | |
| Domestic Violence | | | |
| Other | | | |

- 0 = Grantee does not provide this function or assure that this function is completed.
- 1 = Grantee sometimes provides or assures the provision of this function but not on a consistent basis.
- 2 = Grantee regularly provides or assures the provision of this function.

NOTES/COMMENTS:

24 PERFORMANCE MEASURE

Goal 4: Improve the Health Infrastructure and Systems of Care
(Assist States and communities to plan and develop comprehensive, integrated health service systems)
Level: State, Community, or Grantee
Category: Infrastructure

The degree to which MCHB-funded initiatives contribute to infrastructure development through core public health assessment, policy development and assurance functions.

GOAL

To develop infrastructure that supports comprehensive and integrated services.

MEASURE

The degree to which MCHB-supported initiatives contribute to the implementation of the 10 MCH Essential Services and Core Public Health Program Functions of assessment, policy development and assurance.

DEFINITION

Attached is a checklist of 10 elements that comprise infrastructure development services for maternal and child health populations. Please score the degree to which each your program contributes to the implementation of each of these elements Each element should be scored 0-2, with a maximum total score of 20 across all elements.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Healthy People Goal 23, Objective 12 (23.12): Increase the proportion of tribes, States, and local health agencies that have implemented a health improvement plan and increase the proportion of local health jurisdictions that have a health improvement plan linked with their State plan.

DATA SOURCE(S) AND ISSUES

Attached data collection form to be completed by grantees based on activities they are directly engaged in or that they contribute to the implementation of by other MCH grantees or programs.

SIGNIFICANCE

Improving the health infrastructure and systems of care is one of the five goals of MCHB. There are five strategies under this goal, all of which are addressed in a number of MCHB initiatives which focus on system-building and infrastructure development. These five strategies follow:

Build analytic capacity for assessment, planning, and evaluation.

Using the best available evidence, develop and promote guidelines and practices that improve services and systems of care.

Assist States and communities to plan and develop comprehensive, integrated health service systems.

Work with States and communities to assure that services and systems of care reach targeted populations.

Work with States and communities to address selected issues within targeted populations.

The ten elements in this measure are comparable to the 10 Essential Public Health Services outlined in Grason H, Guyer B, 1995. *Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America*. Baltimore, MD: The Women's and Children's Health Policy Center, The Johns Hopkins University.

DATA COLLECTION FORM FOR DETAIL SHEET #24

Use the scale below to describe the extent to which your program or initiative has contributed to the implementation of each of the following Public MCH Program core function activities at the local, State, or national level. Please use the space provided for notes to clarify reasons for score

| 0 | 1 | 2 | Element |
|---|---|---|--|
| Assessment Function Activities | | | |
| | | | 1. Assessment and monitoring of maternal and child health status to identify and address problems, including a focus on addressing health disparities [Examples of activities include: developing frameworks, methodologies, and tools for standardized MCH data in public and private sectors; implementing population-specific accountability for MCH components of data systems, and analysis, preparation and reporting on trends of MCH data and health disparities among subgroups.] |
| | | | 2. Diagnosis and investigation health problems and health hazards affecting maternal and child health populations [Examples of activities include conduct of population surveys and reports on risk conditions and behaviors, identification of environmental hazards and preparation of reports on risk conditions and behaviors.] |
| | | | 3. Informing and educating the public and families about MCH issues. |
| Policy Development Function Activities | | | |
| | | | 4. Mobilization of community collaborations and partnerships to identify and solve MCH problems. [Examples of stakeholders to be involved in these partnerships include: policymakers, health care providers, health care insurers and purchasers, families, and other MCH care consumers.] |
| | | | 5. Provision of leadership for priority setting, planning and policy development to support community efforts to assure the health of maternal and child health populations. |
| | | | 6. Promotion and enforcement of legal requirements that protect the health and safety of maternal and child health populations. |
| Assurance Function Activities | | | |
| | | | 7. Linkage of maternal and child health populations to health and other community and family services, and assuring access to comprehensive quality systems of care |
| | | | 8. Assuring the capacity and competency of the public health and personal health workforce to effectively and efficiently address MCH needs. |
| | | | 9. Evaluate the effectiveness, accessibility and quality of direct, enabling and population-based preventive MCH services |
| | | \ | 10. Research and demonstrations to gain new insights and innovative solutions to MCH-related issues and problems |

0 = Grantee does not provide or contribute to the provision of this activity.
 1 = Grantee sometimes provides or contributes to the provision of this activity.
 2 = Grantee regularly provides or contributes to the provision of this activity

Total the numbers in the boxes (possible 0–20 score): _____

NOTES/COMMENTS:

33 PERFORMANCE MEASURE

The degree to which MCHB-funded initiatives work to promote sustainability of their programs or initiatives beyond the life of MCHB funding.

Goal 4: Improve the Health Infrastructure and Systems of Care (Assist States and communities to plan and develop comprehensive, integrated health service systems)

Level: Grantee

Category: Infrastructure

GOAL

To develop infrastructure that supports comprehensive and integrated systems of care for maternal and child health at the local and/or state level.

MEASURE

The degree to which MCHB grantees are planning and implementing strategies to sustain their programs once initial MCHB funding ends.

DEFINITION

Attached is a checklist of nine actions or strategies that build toward program sustainability. Please check the degree to which each of the elements is being planned or carried out by your program, using the three-point scale. The maximum total score for this measure would be 45 across all elements.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Healthy People Goal 23, Objective 12 (23.12): Increase the proportion of Tribes, States, and local health agencies that have implemented a health improvement plan and increase the proportion of local health jurisdictions that have a health improvement plan linked with their State plan.

DATA SOURCE(S) AND ISSUES

Attached is a data collection form to be completed by grantees. Since these actions and their outcomes are necessarily progressive over time from the beginning to the end of a program funding period, grantees' ratings on each element are expected to begin lower in the first year of grant award and increase over time.

SIGNIFICANCE

In recognition of the increasing call for recipients of public funds to sustain their programs after initial funding ends, MCHB encourages grantees to work toward sustainability throughout their grant periods. A number of different terms and explanations have been used as operational

components of sustainability. These components fall into four major categories, each emphasizing a distinct focal point as being at the heart of the sustainability process: (1) adherence to program principles and objectives, (2) organizational integration, (3) maintenance of health benefits, and (4) State or community capacity building. Specific recommended actions that can help grantees build toward each of these four sustainability components are included as the data elements for this PM.

DATA COLLECTION FORM FOR DETAIL SHEET #33

Use the scale below to rate the degree to which your program has taken the following actions to promote sustainability of your program or initiative. Since these actions and their outcomes are necessarily progressive over the funding period, the ratings are expected to begin lower and progress over the grant period. Please use the space provided for notes to clarify reasons for score.

| 0 | 1 | 2 | 3 | Element |
|---|---|---|---|---|
| | | | | 1. A written sustainability plan is in place within two years of the MCHB grant award, with goals, objectives, action steps, and timelines to monitor plan progress. |
| | | | | 2. Staff and leaders in the organization engage and build partnerships with consumers, and other key stakeholders in the community, in the early project planning, and in sustainability planning and implementation processes. |
| | | | | 3. There is support for the MCHB-funded program or initiative within the parent agency or organization, including from individuals with planning and decision making authority. |
| | | | | 4. There is an advisory group or a formal board that includes family, community and state partners, and other stakeholders who can leverage resources or otherwise help to sustain the successful aspects of the program or initiative. |
| | | | | 5. The program's successes and identification of needs are communicated within and outside the organization among partners and the public, using various internal communication, outreach and marketing strategies. |
| | | | | 6. The grantee identified, actively sought, and obtained other funding sources and in-kind resources to sustain the program or initiative. |
| | | | | 7. Policies and procedures developed for the successful aspects of the program or initiative are incorporated into the parent or another organization's system of programs and services. |
| | | | | 8. The responsibilities for carrying out key successful aspects of the program or initiative have begun to be transferred to permanent staff positions in other ongoing programs or organizations. |
| | | | | 9. The grantee has secured financial or in-kind support from within the parent organization or external organizations to sustain the successful aspects of the MCHB-funded program or initiative. |

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

Total the numbers in the boxes (possible 0–27 score): _____

NOTES/COMMENTS:

35 PERFORMANCE MEASURE

The degree to which States and communities have implemented comprehensive systems for women's health services.

Goal 4: Improve the Health Infrastructure and Systems of Care
(Assist States and communities to plan and develop comprehensive, integrated health service systems)
Level: State/Grantee
Category: Women's Health

GOAL

To increase the number of States having comprehensive systems for women's health services.

MEASURE

The degree to which States and communities have implemented comprehensive systems for women's health services.

DEFINITION

Attached is a checklist of 14 elements that contribute to a comprehensive system of care for women. Please indicate the degree to which each of the listed elements has been implemented. Please keep the completed checklist attached.

“Comprehensive system of women's health care” is defined as a system that provides a full array of health services utilizing linkages to all programs serving women. The system must address gaps/barriers in service provision. Services provided must be appropriate to women's age and risk status, emphasizing preventive health care.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 1.2: Increase the proportion of insured persons with coverage for clinical preventive services.

Related to Objective 1.3: Increase the proportion of persons appropriately counseled about health behaviors

Related to Objective 1.4: Increase the proportion of persons who have a specific source of ongoing care.

Related to Objective 1.5: Increase the proportion of persons with a usual primary care provider.

DATA SOURCE(S) AND ISSUES

Attached data collection form is to be completed by State MCH Directors.
MCHB program records

SIGNIFICANCE

Leading authorities including Grason, Hutchins, and Silver, (1999, eds.) “Charting a Course for the Future of Women's and Perinatal Health” recommend the development of models for

delivering health services that are women-centered and incorporate the influences of biological, psychological and social factors on women's health. Such models, otherwise known as "holistic" must also embrace a wellness approach. Also, the NIH "Agenda for Research on Women's Health" States that women's health must include the full biological life cycle of the woman and concomitant physical, mental and emotional changes that occur. In many States, Title V programs already provide an array of services for women beyond pregnancy related care, thus MCH programs are a logical avenue to improve systems of care for women.

DATA COLLECTION FORM FOR DETAIL SHEET #35

Using a scale of 0-2, please rate the degree to which the State or MCHB program has addressed each of the listed elements in a comprehensive system of care for women.

Please use the space provided for notes to describe activities related to each element and clarify any reasons for score.

| 0 | 1 | 2 | Elements of a Comprehensive System of Care for Women |
|---|---|---|--|
| | | | 1. State or program is coordinating services for women through a central organization or entity at the State or community level. |
| | | | 2. State or program has partnerships with community-based agencies. |
| | | | 3. State or program has linkages with family planning programs. |
| | | | 4. State or program has linkages with breast and cervical cancer programs. |
| | | | 5. State or program has linkages with DV/sexual assault programs. |
| | | | 6. State or program has linkages with chronic disease programs. |
| | | | 7. State or program has linkages with perinatal health programs. |
| | | | 8. State or program has linkages with mental health programs. |
| | | | 9. State or program has linkages with nutrition programs. |
| | | | 10. State or program has linkages with substance abuse services programs. |
| | | | 11. State or program has linkages with smoking cessation programs. |
| | | | 12. State or program has linkages with health promotion/disease promotion. |
| | | | 13. State or program includes consumers in advisory groups. |
| | | | 14. State or program has linkages with oral health services programs. |

- 0 = No, the State or MCH program does not provide this function or assure that this function is completed.
 1 = Yes, the State or MCH program sometimes provides or assures the provision of this function but not on a consistent basis.
 2 = Yes, the State or MCH program regularly provides or assures the provision of this function.

Total the numbers in the boxes (possible 0-28 score) _____

36 PERFORMANCE MEASURE

Goal 4: Improve the Health Infrastructure and Systems of Care
(Work with States and communities to assure that services and systems of care reach targeted populations)
Level: Grantee
Category: Women's Health

The percentage of pregnant participants in MCHB-funded programs receiving prenatal care beginning in the first trimester.

GOAL

To increase early entry into prenatal care.

MEASURE

The percentage of pregnant participants in MCHB funded programs receiving prenatal care beginning in the first trimester.

DEFINITION

Numerator:

Number of program participants with reported first prenatal visit during the first trimester.

Denominator:

Number of program participants who are pregnant at any time during the reporting period.

Units: 100

Text: Percentage

Prenatal care visit is defined as a visit to qualified OB health care provider (OB, ARNP, midwife) for physical exam, pregnancy risk assessment, medical/pregnancy history, and determination of gestational age and EDC.

Please use the space provided for notes to clarify type of visits counted as a prenatal care visit in the first trimester of pregnancy and included in the numerator for the purposes of this measure. Please use the space provided for notes to detail the data source and year of data used.

"Program participant" is defined as a pregnant woman receiving MCHB-supported services.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16-6a: Increase the proportion of pregnant women who receive early and adequate perinatal care beginning in the first trimester of pregnancy to 90 percent.

DATA SOURCE(S) AND ISSUES

Provider and program patient records. Vital Records can be used if Birth Certificates can be matched to program participants

SIGNIFICANCE

Early identification of maternal disease and risks for complications of pregnancy or birth are the primary reasons for first trimester entry into prenatal care. Early entry into prenatal care can help assure that women with complex problems

and women with other health risks are seen by specialists and receive the appropriate enhanced support services. This is particularly important for those women in vulnerable racial/ethnic subpopulations experiencing perinatal disparities. Late entry into prenatal care is highly associated with poor pregnancy outcomes, therefore, early and high-quality prenatal care is critical to improving pregnancy outcomes.

38 Performance Measure

The percentage of completed referrals among women in MCHB-funded programs.

**Goal 3: Assure Quality of Care
(Develop and promote health services and systems that assure appropriate follow-up services)**

Level: Grantee

Category: Women's Health

GOAL

Increase the percentage of completed referrals for women participating in MCHB-funded programs in need of services.

MEASURE

The percentage of completed referrals among women in MCHB-funded programs.

DEFINITION

Numerator:

Number of referrals to health and other supportive services made by MCHB-funded programs that are completed

Denominator:

Number of referrals to health and other supportive services made by MCHB-funded programs

Units: 100 **Text:** Percentage

A "completed service referral" is defined as a client (who received the referral) attending one or more sessions with the provider to whom she was referred. The provider may be within or outside of the MCHB program/agency. The purpose of these referrals can be either treatment-related (e.g., AIDS or substance abuse treatment, domestic violence counseling), preventive (e.g., family planning, WIC, depression screening/referral, early intervention services) or supportive (e.g., job training, housing, transportation).

Please use the space provided for notes to detail the data source and year of data used.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16.5 : Reduce maternal illness and complications due to pregnancy

Related to Objective 16.17: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women.

Related to Objective 21.3: Increase to at least 95% the proportion of pregnant women and infants who receive risk-appropriate care.

DATA SOURCE(S) AND ISSUES

Provider and MCHB program patient records. Projects will need to have a process to verify a completed referral.

SIGNIFICANCE

In order to be effective, health services must ensure that a client's risks are identified, and clients receive

services that address their identified needs and are referred appropriately. There is no impact if the referral is not completed/services not obtained.

39 PERFORMANCE MEASURE

The percentage of women participating in MCHB-funded programs who smoke in the last three months of pregnancy.

Goal 4: Improve the Health Infrastructure and Systems of Care

(Work with States and communities to address selected issues within targeted populations.)

Level: Grantee

Category: Women's Health

GOAL

Decrease smoking during pregnancy.

MEASURE

The percentage of women participating in MCHB-funded programs who smoke in the last three months of pregnancy.

DEFINITION

Numerator:

Number of MCHB-funded program participants who smoked during the last three months of pregnancy.

Denominator:

Number of MCHB-funded program participants who are pregnant at any time during the reporting period.

Units: 100

Text: Percentage

Please space provided for notes to detail the data source and year of data used.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 27.6 : Increase smoking cessation during pregnancy.

DATA SOURCE(S) AND ISSUES

Provider and MCHB program records. Vital Records can be used if Birth Certificates can be matched to program participants.

SIGNIFICANCE

Birth weight is the single most important determinant of a newborn's survival during the first year. Low birth weight has been associated with maternal smoking during pregnancy.

40 PERFORMANCE MEASURE

The degree to which grantees have facilitated access to medical homes for MCH populations.

**Goal 3: Ensure Quality of Care
(Develop and promote health services and systems designed to improve quality of care)
Level: National
Category: Medical Home**

GOAL

To increase the prevalence of medical homes within the systems that serve MCH populations.

MEASURE

The degree to which grantees have assisted in achieving a medical home for the MCH populations that they serve.

DEFINITION

The family/patient-centered medical home is an approach to providing comprehensive primary care for children, youth, and adults. In 2002 the American Academy of Pediatrics (AAP) described the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The concept was expanded in 2007 and adopted by the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and the American Osteopathic Association as the Joint Principles of the Patient Centered Medical Home.

HEALTHY PEOPLE 2010 OBJECTIVE

Related to Objective 16.22 (Developmental): Increase the proportion of CSCHN who have access to a medical home.

DATA SOURCE(S) AND ISSUES

The family/patient-centered medical home is an approach to providing comprehensive primary care for children, youth, and adults. In 2002 the American Academy of Pediatrics (AAP) described the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The concept was expanded in 2007 and adopted by the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and the American Osteopathic Association as the Joint Principles of the Patient Centered Medical Home.

SIGNIFICANCE

Medical home is the model for 21st century health

care, with a goal of addressing and integrating high quality health promotion, acute care and chronic condition management in a planned, coordinated and family/patient-centered manner. This model is built upon the documented value of primary care and aims to promote the implementation of family/patient-centered care, care coordination and continuous quality improvement. Universal medical home implementation is a key strategy to promote the health and well-being of all children, youth, and adults and to improve the quality of care for patients facing a fragmented health system.

The medical home model has the potential to promote equitable health care and address racial and ethnic disparities in access to care. Reduction in racial and ethnic differences in receiving health care when adults received care within a medical home has been documented. Research also has shown increased preventative screenings, better managed chronic conditions, and better coordination between primary and specialty care providers.

DATA COLLECTION FORM FOR DETAIL SHEET #40

Using the scale below, indicate the degree to which your grant has facilitated access to medical homes for MCH populations. Please use the space provided for notes to describe activities related to each element and clarify reasons for score

Indicate the population focus: pregnant and postpartum women, infants, children, children with special health care needs, adolescents

(While this is a single performance measure, for analytic purposes each of the categories will be scored as an independent measure. Grantees may identify specific categories as not applicable to their grant program by selecting a score of 0 for every item within the category.)

| 0 | 1 | 2 | 3 | Element |
|--|---|---|---|---|
| Category A: Facilitating Access to a Medical Home | | | | |
| | | | | 1. The grantee has disseminated/marketed information about the availability of appropriate medical home sites. |
| | | | | 2. The grantee has facilitated access to sources of financing for medical homes. |
| | | | | 3. The grantee has provided patients and families with direct referral to medical home sites. |
| Category A Subtotal (possible 0-9): | | | | |
| Category B: Screening | | | | |
| | | | | 4. The grantee provides tools for consistent screening for risk factors. |
| | | | | 5. The grantee provides tools for consistent screening for developmental delays or chronic conditions. |
| | | | | 6. The grantee develops and promotes policies that support and facilitate systematic screening by providers. |
| Category B Subtotal (possible 0-9): | | | | |
| Category C: Identification and Referral | | | | |
| | | | | 7. The grantee ensures that MCH populations with special health care needs and those who are at risk of access and health outcome disparities are identified. |
| | | | | 8. The grantee provides appropriate referrals for early intervention services. |
| | | | | 9. The grantee follows up to ensure that referral appointments are kept. |
| Category C Subtotal (possible 0-9): | | | | |
| Category D: Coordination of Services | | | | |

| 0 | 1 | 2 | 3 | Element |
|-------------------------------------|---|---|---|--|
| | | | | 10. The grantee has developed tools to support the coordination of primary and specialty services. |
| | | | | 11. The grantee has provided training in effective coordination of services. |
| | | | | 12. The grantee provides monitoring to assure that services are coordinated. |
| Category D Subtotal (possible 0-9): | | | | |

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

Total the numbers in the boxes (possible 0-36 score)_____

NOTES/COMMENTS:

50 **PERFORMANCE MEASURE** Percent of very low birth weight infants among all live births to program participants.

GOAL To reduce the proportion of all live deliveries with very low birth weight.

DEFINITION **Numerator:** Number of live births with birth weight less than 1,500 grams in the calendar year among program participants.
Denominator: Total number of live births in the calendar year among program participants.
Units: 100 **Text:** Percent

HEALTHY PEOPLE 2010 OBJECTIVE Objective 16-10b: Reduce very low birth weights to 0.9 percent. (Baseline: 1.4 percent in 1997).

DATA SOURCE(S) AND ISSUES Birth certificates are the source for low birth weight.

SIGNIFICANCE Prematurity is the leading cause of infant death. Many risk factors have been identified for low birth weight involving younger and older maternal age, poverty, late prenatal care, smoking and substance abuse.

51 PERFORMANCE MEASURE

The percent of live singleton births weighing less than 2,500 grams among all singleton births to program participants.

GOAL

To reduce the number of all live deliveries with low birth weight.

DEFINITION

Numerator:

Number of live singleton births less than 2,500 grams to program participants.

Denominator:

Live singleton births among program participants.

Units: 1,000 **Text:** Rate per 1,000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-1b: Reduce low birth weights (LBW) to no more than 5 percent of all live births. (Baseline 7.6 in 1998)

DATA SOURCE(S) AND ISSUES

Linked vital records available from the State or the program's own verifiable data systems/sources

SIGNIFICANCE

The general category of low birth weight infants includes pre-term infants and infants with intrauterine growth retardation. Many risk factors have been identified for low birth weight babies including: both young and old maternal age, poverty, late prenatal care, smoking, substance abuse, and multiple births.

| | | |
|--------------------------------------|----------------------------|---|
| 52 | PERFORMANCE MEASURE | The infant mortality rate per 1,000 live births. |
| GOAL | | To reduce the number of infant deaths. |
| DEFINITION | | Numerator: Number of deaths to infants from birth through 364 days of age to program participants. Denominator: Number of live births among program participants. Units: 1,000 Text: Rate per 1,000 |
| HEALTHY PEOPLE 2010 OBJECTIVE | | Objective 16-1c: Reduction of infant deaths (within 1 year) to 4.5 per 1,000 live births. (Baseline: 7.2 in 1998) |
| DATA SOURCE(S) AND ISSUES | | Linked vital records available from the State or the program's own verifiable data systems/sources |
| SIGNIFICANCE | | All countries of the world measure the infant mortality rate as an indicator of general health status. The U.S. has made progress in reducing this rate, but the rate of decline has slowed in the last 10 years. There is still significant racial disparity, as noted in the Healthy People 2000 Mid-course Review. Rates are much higher in the lower social class and in the lowest income groups across all populations. |

| | | |
|--------------------------------------|----------------------------|--|
| 53 | PERFORMANCE MEASURE | The neonatal mortality rate per 1,000 live births. |
| GOAL | | To reduce the number of neonatal deaths |
| DEFINITION | | Numerator: Number of deaths to infants under 28 days born to program participants. Denominator: Number of live births to program participants. Units: 1,000 Text: Rate per 1,000 |
| HEALTHY PEOPLE 2010 OBJECTIVE | | Objective 16-1d: Reduce all neonatal deaths (within the first 28 days of life) to 2.9 per 1,000 live births. (Baseline: 4.8 in 1998) |
| DATA SOURCE(S) AND ISSUES | | Linked vital records available from the State or the program's own verifiable data systems/sources |
| SIGNIFICANCE | | Neonatal mortality is a reflection of the health of the newborn and reflects health status and treatment of the pregnant mother and of the baby after birth. |

54 PERFORMANCE MEASURE

The post-neonatal mortality rate per 1,000 live births.

GOAL

To reduce the number of post-neonatal deaths.

DEFINITION

Numerator:

Number of deaths to infants 28 through 364 days of age born to program participants.

Denominator:

Number of live births to program participants.

Units: 1,000 **Text:** Rate per 1,000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-1e: Reduce all post-neonatal deaths (between 28 days and 1 year) to 1.5 per 1,000 live births. (Baseline: 2.4 in 1998)

DATA SOURCE(S) AND ISSUES

Linked vital records available from the State or the program's own verifiable data systems/sources

SIGNIFICANCE

This period of mortality reflects the environment and the care infants receive. SIDS deaths occur during this period and have been recently reduced due to new infant positioning in the U.S. Poverty and a lack of access to timely care are also related to late infant deaths.

55 PERFORMANCE MEASURE

The perinatal mortality rate per 1,000 live births plus fetal deaths.

GOAL

To reduce the number of perinatal deaths.

DEFINITION

Numerator:

Number of fetal deaths > 28 weeks gestation plus deaths occurring under 7 days to program participants.

Denominator:

Live births plus fetal deaths among program participants.

Units: 1,000 **Text:** Rate per 1,000

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-1b: Reduce the death rate during the perinatal period (28 weeks of gestation to 7 days or less after birth) to 4.5 per 1,000 live births plus fetal deaths. (Baseline 7.5 in 1997)

DATA SOURCE(S) AND ISSUES

Linked vital records available from the State or the program's own verifiable data systems/sources.

SIGNIFICANCE

Perinatal mortality is a reflection of the health of the pregnant woman and newborn and reflects the pregnancy environment and early newborn care.

81 PERFORMANCE MEASURE

The percent of program participant mothers who breastfeed their infants at 6 months of age.

GOAL

To increase the percent of program participant mothers who breastfeed their infants at 6 months of age.

MEASURE

The percent of program participant mothers who breastfeed their infants at 6 months of age.

DEFINITION

Numerator:

Number of program participant mothers who indicate that breast milk is at least one of the types of food their infant is fed at 6 months of age.

Denominator

Number of program participant mothers with infants at 6 months of age.

Units: 100

Text: Percent

Breastfeeding is defined as including any amount of breast milk in the infant's diet, regardless of additional food substances consumed by an infant.

Exclusive breastfeeding is defined as being fed breast milk or water only. Introduction of other substances to an infant, such as formula, cow's milk, juice and solid foods, in addition to breast milk does not qualify as "exclusive" breastfeeding.

A **program participant** is defined as an individual who has direct contact with Healthy Start staff or subcontractors that receives Healthy Start core services on an ongoing systemic basis

HEALTHY PEOPLE 2010 OBJECTIVE

Objective 16-19b: Increase the proportion of mothers who breastfeed their infants at 6 months of age to 50 percent. (Baseline: 29 percent in 1998).

DATA SOURCE(S) AND ISSUES

Provider and MCHB program participant records.

In the grant application, designated MCHB supported projects will need to indicate how they will identify and document that program participants are still breastfeeding at 6months.

SIGNIFICANCE

Human milk is the preferred feeding for all infants, including premature and sick newborns. Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first 6 months after birth. The advantages of breastfeeding are indisputable and include nutritional, immunological and psychological benefits to both mother and infant, as well as economic benefits.

Appendix B: Additional Data Elements

| DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET REVISED- Section A. Characteristics of Program Participants | | | | | | | | | | | | |
|---|---------------------------|-------------------------------|-------------------|--------------|--|--------------|----------------------------------|--|--------------|---------------------------|-------------------|--------------|
| Characteristics of Program Participants | ETHNICITY | | | | RACE | | | | | | | |
| | Hispanic or Latino | Not Hispanic or Latino | Unrecorded | TOTAL | America Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Other Pacific Islander | White | More Than One Race | Unrecorded | Total |
| a. Number of Pregnant Women | | | | | | | | | | | | |
| Under age 15 | | | | | | | | | | | | |
| Aged 15-17 | | | | | | | | | | | | |
| Aged 18-19 | | | | | | | | | | | | |
| Aged 20-24 | | | | | | | | | | | | |
| Aged 25-34 | | | | | | | | | | | | |
| Aged 35-44 | | | | | | | | | | | | |
| 45+ | | | | | | | | | | | | |
| Age Unknown | | | | | | | | | | | | |
| Total Number of Pregnant Women | | | | | | | | | | | | |
| b. Number of Pregnant Women with Incomes: | | | | | | | | | | | | |
| Below 100 Percent of the FPL | | | | | | | | | | | | |
| Between 100-185 Percent of the FPL | | | | | | | | | | | | |
| Income Unknown | | | | | | | | | | | | |

| DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET | | | | | | | | | | | | |
|--|--------------------|------------------------|------------|-------|---------------------------------|-------|---------------------------|---|-------|--------------------|------------|-------|
| REVISED- Section A. Characteristics of Program Participants | | | | | | | | | | | | |
| | ETHNICITY | | | | RACE | | | | | | | |
| | Hispanic or Latino | Not Hispanic or Latino | Unrecorded | TOTAL | America Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Other Pacific Islander | White | More Than One Race | Unrecorded | Total |
| Characteristics of Program Participants | | | | | | | | | | | | |
| Total Number of Pregnant Women with Incomes | | | | | | | | | | | | |
| c. Number of Pregnant Participants by Entry into Prenatal Care: | | | | | | | | | | | | |
| During First Trimester | | | | | | | | | | | | |
| During Second Trimester | | | | | | | | | | | | |
| During Third Trimester | | | | | | | | | | | | |
| Receiving No Prenatal Care | | | | | | | | | | | | |
| Total Number of Pregnant Participants by Entry into Prenatal Care | | | | | | | | | | | | |
| Trimester Unknown | | | | | | | | | | | | |
| Total Number of Pregnant Participants by Entry into Prenatal Care including Trimester Unknown | | | | | | | | | | | | |
| d. Adequate Prenatal Care | | | | | | | | | | | | |

| DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET | | | | | | | | | | | | |
|--|-----------------------|---------------------------|------------|-------|--|-------|---------------------------------|---|-------|--------------------------|------------|-------|
| REVISED- Section A. Characteristics of Program Participants | | | | | | | | | | | | |
| | ETHNICITY | | | | RACE | | | | | | | |
| | Hispanic or Latino | Not Hispanic or Latino | Unrecorded | TOTAL | America Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Other Pacific Islander | White | More Than One Race | Unrecorded | Total |
| Characteristics of Program Participants | | | | | | | | | | | | |
| Total Number of Pregnant Participants Receiving Adequate Prenatal Care (Kotelchuck¹, or similar index) | | | | | | | | | | | | |
| Level of Adequate Prenatal Care Unknown | | | | | | | | | | | | |
| Total number of pregnant participants Receiving Adequate Prenatal Care including unknown Adequacy of Care | | | | | | | | | | | | |
| e. Live Singleton Births to Participants | | | | | | | | | | | | |
| Number of live singleton births greater than or equal to 2500 grams to participants | | | | | | | | | | | | |
| Number of live singleton births between 2499 grams and 1500 grams to participants | | | | | | | | | | | | |

| | DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET | | | | | | | | | | | |
|--|---|-------------------------------|-------------------|--------------|--|--------------|----------------------------------|--|--------------|---------------------------|-------------------|--------------|
| | REVISED- Section A. Characteristics of Program Participants | | | | | | | | | | | |
| | ETHNICITY | | | | RACE | | | | | | | |
| Characteristics of Program Participants | Hispanic or Latino | Not Hispanic or Latino | Unrecorded | TOTAL | America Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Other Pacific Islander | White | More Than One Race | Unrecorded | Total |
| Number of live singleton births less than 1499 grams to participants | | | | | | | | | | | | |
| Number of live singleton births weight unknown | | | | | | | | | | | | |
| Total Number of Live Singleton Births to Participants | | | | | | | | | | | | |
| Total Number of Live Births to Participants including Multiple Births | | | | | | | | | | | | |
| Total Number of program participant maternal deaths defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. | | | | | | | | | | | | |

| DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET | | | | | | | | | | | | |
|---|--------------------|------------------------|------------|-------|---------------------------------|-------|---------------------------|---|-------|--------------------|------------|-------|
| REVISED- Section A. Characteristics of Program Participants | | | | | | | | | | | | |
| | ETHNICITY | | | | RACE | | | | | | | |
| | Hispanic or Latino | Not Hispanic or Latino | Unrecorded | TOTAL | America Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Other Pacific Islander | White | More Than One Race | Unrecorded | Total |
| Characteristics of Program Participants | | | | | | | | | | | | |
| Total Number of program participant late maternal deaths defined as the death of a woman from direct or indirect obstetric causes more than 42 days but less than one year after termination of pregnancy. | | | | | | | | | | | | |
| f. Number of Female Participants in Interconceptional Care/Women's Health Activities | | | | | | | | | | | | |
| Under age 15 | | | | | | | | | | | | |
| Aged 15-17 | | | | | | | | | | | | |
| Aged 18-19 | | | | | | | | | | | | |
| Aged 20-23 | | | | | | | | | | | | |
| Aged 24-34 | | | | | | | | | | | | |
| Aged 35-44 | | | | | | | | | | | | |

| DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET REVISED- Section A. Characteristics of Program Participants | | | | | | | | | | | | |
|---|---------------------------|-------------------------------|-------------------|--------------|--|--------------|----------------------------------|--|--------------|---------------------------|-------------------|--------------|
| Characteristics of Program Participants | ETHNICITY | | | | RACE | | | | | | | |
| | Hispanic or Latino | Not Hispanic or Latino | Unrecorded | TOTAL | America Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Other Pacific Islander | White | More Than One Race | Unrecorded | Total |
| Aged 45 + | | | | | | | | | | | | |
| Age Unknown | | | | | | | | | | | | |
| Total Number of Female Participants in Interconceptional Care/Women's Health Activities | | | | | | | | | | | | |
| g. Infant/Child Health Participants | | | | | | | | | | | | |
| Number of Infant Participants Aged 0 to 11 months | | | | | | | | | | | | |
| Number of Child Participants aged 12 to 23 months | | | | | | | | | | | | |
| Number of Infant/Child Participants Age Unknown | | | | | | | | | | | | |
| Total Number of Infant/Child Health Participants | | | | | | | | | | | | |
| h. Male Support Services Participants | | | | | | | | | | | | |

| DIVISION OF HEALTHY START AND PERINATAL SERVICES HEALTH DATA SHEET | | | | | | | | | | | | |
|---|---------------------------|-------------------------------|-------------------|--------------|--|--------------|----------------------------------|--|--------------|---------------------------|-------------------|--------------|
| REVISED- Section A. Characteristics of Program Participants | | | | | | | | | | | | |
| | ETHNICITY | | | | RACE | | | | | | | |
| | Hispanic or Latino | Not Hispanic or Latino | Unrecorded | TOTAL | America Indian or Alaska Native | Asian | Black or African American | Native Hawaiian or Other Pacific Islander | White | More Than One Race | Unrecorded | Total |
| Characteristics of Program Participants | | | | | | | | | | | | |
| Number of Male Participants 17 years and under | | | | | | | | | | | | |
| Number of Male Participants 18 years and older | | | | | | | | | | | | |
| Number of Male Participants Age Unknown | | | | | | | | | | | | |
| Total Number of Male Support Services Participants | | | | | | | | | | | | |

| B. RISK REDUCTION/PREVENTION SERVICES (For Program Participants) | | | | |
|---|------------------------|---|---|--|
| RISK FACTORS | Number Screened | Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling | Number whose Treatment is Supported by Grant | Number Referred for Further Assessment and/or Treatment |
| a. PRENATAL PROGRAM PARTICIPANTS | | | | |
| Group B Strep or Bacterial Vaginosis | | | | |
| HIV/AIDS | | | | |
| Other STDs | | | | |
| Smoking | | | | |
| Alcohol | | | | |
| Illicit Drugs | | | | |
| Depression | | | | |
| Other Mental Health Problem | | | | |
| Domestic Violence | | | | |
| Homelessness | | | | |
| Overweight & Obesity | | | | |
| Underweight | | | | |
| Hypertension | | | | |
| Gestational Diabetes | | | | |
| Family History of Breast Cancer | | | | |
| Asthma | | | | |
| Peridontal Infection | | | | |

| | B. RISK REDUCTION/PREVENTION SERVICES | | | |
|--|--|---|---|--|
| | (For Program Participants) | | | |
| RISK FACTORS | Number Screened | Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling | Number whose Treatment is Supported by Grant | Number Referred for Further Assessment and/or Treatment |
| b. INTERCONCEPTIONAL WOMEN PARTICIPANTS | | | | |
| Group B Strep or Bacterial Vaginosis | | | | |
| HIV/AIDS | | | | |
| Other STDs | | | | |
| Smoking | | | | |
| Alcohol | | | | |
| Illicit Drugs | | | | |
| Depression | | | | |
| Other Mental Health Problem | | | | |
| Domestic Violence | | | | |
| Homelessness | | | | |
| Overweight & Obesity | | | | |
| Underweight | | | | |
| Lack of Physical Activity | | | | |
| Hypertension | | | | |
| Cholesterol | | | | |
| Diabetes | | | | |
| Family History of Breast Cancer | | | | |

| | | | | |
|--|--|---|---|--|
| Fecal Occult Blood Test | | | | |
| Asthma | | | | |
| Peridontal Infection | | | | |
| | B. RISK REDUCTION/PREVENTION SERVICES | | | |
| | (For Program Participants) | | | |
| RISK FACTORS | Number Screened | Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling | Number whose Treatment is Supported by Grant | Number Referred for Further Assessment and/or Treatment |
| c. INFANT CHILD (0-23 months) | | | | |
| Prenatal Drug Exposure | | | | |
| Prenatal Alcohol Exposure | | | | |
| Mental Health Problems | | | | |
| Family Violence/Intentional Injury | | | | |
| Homelessness | | | | |
| Not Attaining Appropriate Height or Length for Age | | | | |
| Developmental Delays | | | | |
| Asthma | | | | |
| HIV/AIDS | | | | |
| Other Special Health Care Needs | | | | |
| Failure to Thrive | | | | |

C. HEALTHY START MAJOR SERVICE TABLE

| a. DIRECT HEALTH CARE SERVICES | |
|---|--|
| Prenatal Clinic Visits: | |
| Number of Medical Visits by All Prenatal Participants | |
| Postpartum Clinic Visits | |
| Number of Medical Visits by All Postpartum Participants | |
| Well Baby/ Pediatric Clinic Visits | |
| Number of Any Provider Visits by All Infant/Child Participants | |
| Adolescent Health Services | |
| Number of any Provider Visits by Participants age 17 and under | |
| Family Planning | |
| Number of Participants Receiving Family Planning Services | |
| Women's Health | |
| Number of Participants Receiving Women's Health Services | |

| b. ENABLING SERVICES | |
|---|--|
| Total Number of Families Served | |
| Number of Families in the Prenatal Period Assisted by Case Management | |
| Number of Families in the Interconceptional Period Assisted by Case Management | |
| Number of Families in the Prenatal Period Assisted by Outreach | |
| Number of Families in the Interconceptional | |

| | |
|---|----------------------|
| Period Assisted by Outreach | <input type="text"/> |
| Number of Families in the Prenatal Period Receiving Home Visiting | <input type="text"/> |
| Number of Families in the Interconceptional Period Receiving Home Visiting | <input type="text"/> |
| Number of Participants Age 17 and Under who participated in Adolescent Pregnancy Prevention Activities | <input type="text"/> |
| Number of Families who participated in Pregnancy/Childbirth Education Activities | <input type="text"/> |
| Number of Families who participated in Parenting Skill Building/Education | <input type="text"/> |
| Number of Participants in Youth Empowerment/Peer Education/ Self-Esteem/Mentor Programs | <input type="text"/> |
| Number of Families Who Received Transportation Services Includes Tokens, Taxis and Vans | <input type="text"/> |
| Number of Families Who Receive Translation Services | <input type="text"/> |
| Number of Families Receiving Child Care Services | <input type="text"/> |
| Number of Participants Who Received Breastfeeding Education , Counseling and Support | <input type="text"/> |
| Number of Participants Who Received Nutrition Education and Counseling Services including WIC Services | <input type="text"/> |

Number of Participants in
Male Support Services:

Number of Participants Referred for
Housing Assistance

Total Participants assisted with
Jobs/Job Training

Total Participants served in
Prison/Jail Initiatives

c. POPULATION

Number Of **Immunizations**
Provided

Public Information/Education:
Number of Individuals Reached

d. INFRASTRUCTURE BUILDING

Consortia Training
Number of Individual Members Trained

Provider Training
Number of Individual Providers Trained

Instructions for Additional Data Elements
Division of Healthy Start and Perinatal Services Health Data Sheet

Description:

The Division of Healthy Start and Perinatal Services has an additional data element form. This form is divided into three sections:

Section A. Characteristics of Participants;

- Section B. Risk Reduction/Prevention Services; and
- Section C. Healthy Start Major Service Table.

The following contains information on how to complete each section of the form.

Section A. Characteristics of Program Participants

- The three pages contains columns noting ethnicity and race.
- Ethnicity is broken down into three columns: Hispanic or Latino, Not Hispanic or Latino, and unrecorded.
- Race is broken down into seven columns: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White, and more than one, and unrecorded.

a. Number of Pregnant Women

- Enter the unduplicated count of all pregnant program participants by age group and ethnicity/race. The response should reflect what the person considers herself to be and is not based on percentages of ancestry.
- Enter the count of all pregnant program participants during whose age is unknown by ethnicity/race. Participant's age and appropriate age groups should be determined at time of enrollment into any Healthy Start activity

NOTE: The number pre-populated in the total columns for Hispanic or Latino or not Hispanic or Latino should be identical to the race total column.

b. Income Level of Program Participants

Income level of the program participant refers to the annual income for the client's family, compared to the Federal Poverty Level, recorded at enrollment as percentage of level for a family of the same size. Annual income data can be estimated from monthly data, if necessary (Monthly income x 12). Grantees may wish to record information on income and family size and calculate poverty levels separately, or enter only the computed poverty level for the client. The Federal poverty level is updated annually in February and published in the Federal Register.

- Enter the unduplicated count of all pregnant program participants with incomes below 100% of the FPL by race/ethnicity served by your grant.
- Enter the unduplicated count of all pregnant program participants with incomes between 100-185 % of the FPL by race/ethnicity served by your grant.
- Enter the unduplicated count of all pregnant program participants with income level unknown by race/ethnicity served by your grant.

NOTE: The number pre-populated in the total columns for Hispanic or Latino or not Hispanic or Latino should be identical to the race total column.

c. Number of Pregnant Participants who Enter Prenatal Care

Healthy Start Prenatal Care Definition

A visit made for the medical supervision of a pregnancy by a physician or other health care provider during the pregnancy, **and/or** other ancillary services occurring during the antenatal period (e.g., nutrition, health assessments and education, lab test, and psychosocial services).

Trimester of entry into prenatal care is defined as:

| Number of Pregnant Women who Enter Prenatal Care: | Number of participants with reported first prenatal visit: |
|---|--|
| During First Trimester | before 13 weeks gestation. |
| During Second Trimester | between 13 week and 25 week |
| During Third Trimester | between 26 and delivery |
| Receiving No Prenatal Care | Participants who report no prenatal care |

- Enter the number of pregnant participants who enter prenatal care by ethnicity/race during First Trimester.
- Enter the number of pregnant participants who enter prenatal care by ethnicity/race during second Trimester.
- Enter the number of pregnant participants who enter prenatal care by ethnicity/race during third Trimester.
- Enter the number of pregnant participants who enter prenatal care by ethnicity/race receiving no prenatal care.
- Enter the number of pregnant participants whose entry into prenatal care is unknown.

The total number of pregnant participants who enter prenatal care by ethnicity and race is the sum of the following four rows of data for each respective column: During First Trimester, During Second Trimester, During Third Trimester, and Receiving No Prenatal Care. The number entered in the total columns for Hispanic or Latino or not Hispanic or Latino should be identical to the race total column. The number entered in the total columns should be identical to the number entered for the denominator on form 9, performance measure number 36.

NOTE: *The number pre-populated in the total columns for Hispanic or Latino or not Hispanic or Latino should be identical to the race total column..*

d. Adequate Prenatal Care

Adequate prenatal care is defined as the number of participants who receive adequate prenatal care as measured by the Kotelchuck Scale, Kessner Index or similar index.

Kotelchuck Scale: percent of women whose ratio of observed to expected prenatal visits is greater than or equal to 80% defined in the Adequacy of Prenatal Care Units (APNCU) as the lower

boundary of “adequate care” (expected visits are adjusted for gestational age and month prenatal care began).

Kessner Index: This index takes into account three factors: month in which prenatal care began number of prenatal care visits, and length of gestation. “Not adequate” prenatal care includes intermediate, inadequate, and unknown adequacy of care.

- Enter the number of pregnant participants receiving adequate prenatal care by ethnicity/race (Kotelchuck, Kessner or similar index). Specify the index when you enter data for this item.
- Enter the number of pregnant participants whose adequacy of prenatal care is unknown by ethnicity/race.

NOTE: *The number pre-populated in the total columns for Hispanic or Latino or not Hispanic or Latino should be identical to the race total column.*

e. Live Singleton Births to Participants

Report the birth outcomes on all live singleton births to program participants.

- Enter the number of live singleton births to program participants 2500 grams or greater by ethnicity/race. The number entered in the total column should be identical to the number entered for the numerator on form 9, performance measures numbers 50-54.
- Enter the number of live singleton births between 1500 and 2499 (Low Birth Weight or LBW) grams to participants by ethnicity/race served. The number entered in the total column should be identical to the number entered for the denominator on form 9, performance measure number 51.
- Enter the number of live singleton births less than 1499 grams (Very Low Birth Weight or VLBW) to program participants by ethnicity/race served by your grant. The number entered in the total column should be identical to the number entered for the denominator on form 9, performance measure number 50.
- Enter the number of live singleton births to program participants whose weight is unknown by ethnicity/race served.
- Enter the total number of live singleton births including multiple births to program participants by ethnicity/race.
- Enter the total number of program participant maternal deaths defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.
- Enter the total number of program participant late maternal deaths defined as the death of a woman from direct or indirect obstetric causes more than 42 days but less than one year after termination of pregnancy
-

NOTE: *The number pre-populated in the total columns for Hispanic or Latino or not Hispanic or Latino should be identical to the race total column.*

f. Interconceptional Care Services

Interconceptional care services are defined as services to participants who both enrolled and received services in the period from the delivery to two year’s following delivery. Participant’s age and appropriate age groups should be determined at time of enrollment into any Healthy Start activity or in the case of women enrolled prenatally, the initiation of inter-conceptional services.

- Enter the number of program participants receiving interconceptional care/women’s health care during the reporting period to program participants by ethnicity/race.

- Enter the number of program participants receiving interconceptional care/women's health care during the reporting period whose age is unknown to program participants by ethnicity/race.

g. Infant/Child Health Participants

- Enter the number of infant participants aged 0 to 11 months by race/ethnicity.
- Enter the number of child participants aged 12 to 23 months by race/ethnicity.
- Enter the number of child participants whose age is unknown by race/ethnicity.

h. Male Support Services Participants

Male participants are defined as the parenting male who has received a Healthy Start service, directly or indirectly, such as involvement in the HS supported fatherhood or male support group or case management/case coordination services.

- Enter the number of male participants 17 years and under by race/ethnicity.
- Enter the number of male participants 18 years and over by race/ethnicity
- Enter the number of male participants whose age is unknown by race/ethnicity.

Section B. Risk Reduction/Prevention Services

- This three page document contains tables with the first column noting prenatal participants, interconceptional women participants, and infant/child (0-23 months) and their respective risk factors.
- The prevention services for this table are broken down into five columns: Risk Factors, Number Screened, Number Receiving Risk Prevention Counseling and/or Risk Reduction Counseling, Number whose Treatment is Supported by Grant, Number Referred for Further Assessment and/or Treatment.
- All entry fields in this table are numeric; no commas or text are permitted.

a. Prenatal Program Participants

Enter numbers of prenatal program participants that have received prevention services for the risk factors listed.

- The risk factors for prenatal participants are: Group B Strep or Bacterial Vaginosis, HIV/AIDS, Other STDs, Smoking, Alcohol, Illicit Drugs, Depression, Other Mental Health Problems, Domestic Violence, Homelessness, Overweight & Obesity, Underweight, Hypertension, Gestational Diabetes, Family History of Breast Cancer, Periodontal Infection, and Asthma.

b. Interconceptional Women Participants

Enter numbers of interconceptional women participants that have received prevention services for the risk factors listed.

- The risk factors for interconceptional women participants are: Group B Strep or Bacterial Vaginosis, HIV/AIDS, Other STDs, Smoking, Alcohol, Illicit Drugs, Depression, Other Mental Health Problems, Domestic Violence, Homelessness, Overweight & Obesity, Underweight, Lack of Physical Activity, Hypertension, Cholesterol, Diabetes, Family History of Breast Cancer, Fecal Occult Blood Test, Periodontal Infection, and Asthma.

c. Infant/Child Health Participants

Enter numbers of infant or child participants (0-23 months) that have received prevention services for the risk factors listed.

- The risk factors for infant or child participants are: Prenatal Drug Exposure, Prenatal Alcohol Exposure, Mental Health Problems, Family Violence/Intentional Injury, Homelessness, Not Attaining Height or Length for Age, Developmental Delays, Asthma, HIV/AIDS, and Other Special Health Care Needs and Failure to thrive.

Perinatal Data Form Section C. Major Services Data Table

This document consists of four sub-sections:

- a. Direct Health Care Services,
 - b. Enabling Services,
 - c. Population, and
 - d. Infrastructure Building.
- Healthy Start major services for each of these subsection are listed.
 - All entry fields in this table are numeric; no commas or text are permitted. Enter data for those services provided either directly or indirectly, by the Healthy Start grant.
 - Unless otherwise noted data entered is for program participants only. Data for Community Participants that receive Direct Health Care Services and/or Enabling Services should be detailed in the notes section.

a. Direct Health Care Services

Enter data for the direct health care services listed.

- The direct health care services listed are: Prenatal Clinic Visits, Postpartum Clinic Visits, Well Baby/Pediatric Clinic Visits, Adolescent Health Services, Family Planning, and Women's Health.
- Data is entered for only those services that your grant provided or that is a documented completed referral.

b. Enabling Services

Enter data for the enabling services listed.

- The enabling services listed are: Families Served, Case Management, Outreach, Home Visiting, Adolescent Pregnancy Prevention Activities, Pregnancy/Childbirth Education Activities, Parenting Skill Building/Education, Youth Empowerment/Peer Education/Self-Esteem/Mentor Programs, Transportation Services, Translation Services, Child Care Services, Breastfeeding Education, Counseling and Support, Nutrition Education and Counseling Services, Male Support Services, Housing Assistance, Jobs/Job Training, and Prison/Jail Initiatives.
- Data is entered for only those services that your grant provided or that is a documented completed referral.

c. Population Based Services

Enter data for the population-based services listed, if applicable.

- The population-based services listed are: Immunizations and Public Information/Education.

Note: Data entered for Public Information/Education are for community participants only.

d. Infrastructure Building Services

Note: Data entered here are for community participants only.

Enter data for the infrastructure building services listed, if necessary.

- The infrastructure building services listed are: Consortia Training and Provider Training.
- Data is entered for only those services that your grant provided.

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 C: Sample Worksheets

Healthy Start Project Implementation Plan
Project Area Demographic and Statistical Data Table
Key Personnel Roster
Contractor Status Report
Consortium Roster

Grantee Organization:

Project Name:

Project Grant No:

City

State

Healthy Start Project IMPLEMENTATION PLAN

| Project Period Objective | Calendar Year Objective | Plan | Strategy and Activities | Progress |
|---------------------------|----------------------------|------|-------------------------|----------|
| Project Period Objective: | Calendar Year 1 Objective: | | | |
| Baseline: | | | | |
| Performance Indicator : | Calendar Year 2 Objective: | | | |
| | Calendar Year 3 Objective: | | | |
| | Calendar Year 4 Objective: | | | |

PROJECT AREA DEMOGRAPHIC AND STATISTICAL DATA TABLE

| VARIABLE | WHITE | BLACK | OTHER | (N)1 TOTAL | HISPANIC ORIGIN | TOTAL |
|---|-------|-------|-------|---------------|--------------------|-------|
| Year XXXX Census Data: | | | | | | |
| Population by Racial Distribution (number) | | | | | | |
| # Women of Child-bearing Age (WCBA) | | | | | | |
| % Children under 18 in families with incomes below Federal Poverty Level (FPL) | | | | | | |
| Year XXXX : | | | | | | |
| # Live Births | | | | | | |
| # Births to Teens 17 years and younger | | | | | | |
| # Births to Teens 18 and 19 | | | | | | |
| # Live Births with 1st Trimester entry | | | | | | |
| # Live Births with No Prenatal Care | | | | | | |
| # Infant Deaths | | | | | | |
| Infant Mortality Rate (per 1,000 live births) | | | | | | |
| # Infant deaths (birth to 28 days) | | | | | | |
| Neonatal Mortality Rate (per 1,000 live births) | | | | | | |
| # Infant Deaths (29 days to 365 days) | | | | | | |
| Post-Neonatal Mortality Rate (per 1,000 live births) | | | | | | |
| # Moderate Low Birth Weight (LBW) infants born with birth weight of 1501 to 2500 grams) | | | | | | |
| Moderate Low Birth Weight Rates, % (birth weight 1501 to 2500 grams) | | | | | | |
| # Very Low Birth Weight (VLBW) Infants born with birth weight of 1500 grams or less | | | | | | |
| Very Low Birth Weight Rates, % (birth weight of 1500 grams or less) | | | | | | |
| Age Appropriate Immunization Rates of Children From Birth to 2 years | | | | | | |
| Year XXXX : | | | | | | |
| # Live Births | | | | | | |
| # Births to Teens 17 years and younger | | | | | | |
| # Births to Teens 18 and 19 | | | | | | |
| # Live Births with 1st Trimester entry | | | | | | |
| # Live Births with No Prenatal Care | | | | | | |
| # Infant Deaths | | | | | | |
| Infant Mortality Rate (per 1,000 live births) | | | | | | |
| # Infant deaths (birth to 28 days) | | | | | | |
| Neonatal Mortality Rate (per 1,000 live births) | | | | | | |
| # Infant Deaths (29 days to 365 days) | | | | | | |
| Post-Neonatal Mortality Rate (per 1,000 live births) | | | | | | |
| # Moderate Low Birth Weight (LBW) infants born with birth weight of 1501 to 2500 grams) | | | | | | |
| Moderate Low Birth Weight Rates, % (birth weight 1501 to 2500 grams) | | | | | | |
| # Very Low Birth Weight (VLBW) Infants born with birth weight of 1500 grams or less | | | | | | |
| Very Low Birth Weight Rates, % (birth weight of 1500 grams or less) | | | | | | |
| Age Appropriate Immunization Rates of Children From Birth to 2 years | | | | | | |

PROJECT AREA DEMOGRAPHIC AND STATISTICAL DATA TABLE

Page 2

| VARIABLE | WHITE | BLACK | OTHER | (N)1 TOTAL | HISPANIC ORIGIN |
|---|-------|-------|-------|------------|-----------------|
| Year XXXX: | | | | | |
| # Live Births | | | | | |
| # Births to Teens 17 years and younger | | | | | |
| # Births to Teens 18 and 19 | | | | | |
| # Live Births with 1st Trimester entry | | | | | |
| # Live Births with No Prenatal Care | | | | | |
| # Infant Deaths | | | | | |
| Infant Mortality Rate (per 1,000 live births) | | | | | |
| # Infant deaths (birth to 28 days) | | | | | |
| Neonatal Mortality Rate (per 1,000 live births) | | | | | |
| # Infant Deaths (29 days to 365 days) | | | | | |
| Post-Neonatal Mortality Rate (per 1,000 live births) | | | | | |
| # Moderate Low Birth Weight (LBW) infants born with birth weight of 1501 to 2500 grams) | | | | | |
| Moderate Low Birth Weight Rates, % (birth weight 1501 to 2500 grams) | | | | | |
| # Very Low Birth Weight (VLBW) Infants born with birth weight of 1500 grams or less | | | | | |
| Very Low Birth Weight Rates, % (birth weight of 1500 grams or less) | | | | | |
| Age Appropriate Immunization Rates of Children From Birth to 2 years | | | | | |
| Year XXXX: | | | | | |
| # Live Births | | | | | |
| # Births to Teens 17 years and younger | | | | | |
| # Births to Teens 18 and 19 | | | | | |
| # Live Births with 1st Trimester entry | | | | | |
| # Live Births with No Prenatal Care | | | | | |
| # Infant Deaths | | | | | |
| Infant Mortality Rate (per 1,000 live births) | | | | | |
| # Infant deaths (birth to 28 days) | | | | | |
| Neonatal Mortality Rate (per 1,000 live births) | | | | | |
| # Infant Deaths (29 days to 365 days) | | | | | |
| Post-Neonatal Mortality Rate (per 1,000 live births) | | | | | |
| # Moderate Low Birth Weight (LBW) infants born with birth weight of 1501 to 2500 grams) | | | | | |
| Moderate Low Birth Weight Rates, % (birth weight 1501 to 2500 grams) | | | | | |
| # Very Low Birth Weight (VLBW) Infants born with birth weight of 1500 grams or less | | | | | |
| Very Low Birth Weight Rates, % (birth weight of 1500 grams or less) | | | | | |
| Age Appropriate Immunization Rates of Children From Birth to 2 years | | | | | |

KEY PERSONNEL & ALL FUNDED POSITIONS

| 1. NAME AND POSITION TITLE | 2. ANNUAL SALARY | 3. NO. MONTHS BUDGET | 4. % TIME | 5. TOTAL \$ AMOUNT REQUESTED |
|--------------------------------|------------------|----------------------|-----------|------------------------------|
| | (1) | (2) | (3) | (4) |
| | \$ | | % | \$ |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| FRINGE BENEFIT (Rate _____) | TOTAL | | | \$ |

1. Enter Name of Employee and Position Title
2. Enter Annual Salary
3. Enter Number of Months in Budget
4. Enter the percent time on Grant
5. Enter Total Amount Requested

Contractor Status Report

| CONTRACTOR1 | CONTRACT PERIOD2 | DATE CONTRACT WAS SIGNED3 | SERVICE4 | DATE SERVICE BEGAN5 | CONTRACT AMOUNT6 |
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| TOTAL AMOUNT | | | | | |

1. Name of contractor
2. Indicate the date the contract begins and the date the contract ends.
3. Indicate the date the contract became legally binding.
4. Identify the service that is being contracted.
5. Indicate the date on which service provision began
6. Identify the amount of the contract.

HEALTHY START PROJECT AREA CONSORTIUM ROSTER

| NAME | AGENCY/ORGANIZATION. REPRESENTED | State/Local Government | Program Participant | Community Participant | Community –based Organization | Private Agencies (Organizations | Contract Providers | Other (Specify) |
|------|-------------------------------------|---------------------------|---------------------|-----------------------|----------------------------------|------------------------------------|--------------------|-----------------|
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APPENDIX D: Glossary of Terms

Adolescent Health Services: Number of non-pregnant/non-parenting teens receiving services from a medical or other health provider funded by Healthy Start.

Adolescent Pregnancy Prevention: Number of adolescents receiving services from a Healthy Start affiliated program oriented towards pregnancy prevention.

Annual Performance Indicator: For each Healthy Start performance measure, the percentage or rate resulting from dividing the numerator by the denominator as specifically defined in the measure. This indicator should show how the project is progressing towards achieving one of their Project Period objectives.

Below 100 Percent of the Federal Poverty Level: Annual income for the client's family, compared to the Federal Poverty Level. Record at enrollment as Percentage of level for a family of the same size. Annual income data can be estimated from monthly data, if necessary (Monthly income x 12). Grantees may wish to record information on income and family size and calculate poverty levels separately, or enter only the computed poverty level for the client. The Federal poverty level is updated annually in February and published in the Federal Register.

Births which are Preterm: Live births that occur at 17 through 36 weeks of gestation.

Births with Evidence of Prenatal Exposure to Alcohol: Evidence, at time of delivery, of alcoholic beverages (wine, beer, mixed drinks, e.g., coolers or distilled liquor) consumed during pregnancy.

Births with Evidence of Prenatal Exposure to Drugs: Evidence, at time of delivery, of any drug – other than over the counter or prescription drug – used inappropriately.

Births with Evidence of Prenatal Exposure to HIV/AIDS: Births with exposure to, or presence of, HIV.

Births with Evidence of Prenatal Exposure to STD/STI: Presence, at time of delivery, of Sexually Transmitted Disease/Infection (Syphilis, Gonorrhea, Herpes, Chlamydia, Hepatitis B, etc.)

Budget Period: The interval of time (usually 12 months) into which the project period is divided for budgetary and funding purposes.

Capacity: Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity measures the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcomes, and risk factors. Program capacity results should answer the question, "What does the Project Area need to achieve the desired results?"

Case Management Services: Provision of services in a coordinated, culturally competent approach through client assessment, referral, monitoring, facilitation, and follow-up on utilization of needed services. Case management is also known as care coordination. For pregnant women, these services include those that assure access and utilization of quality prenatal care, delivery, and postpartum care. For infants up to two years of age, these services assure access and utilization of appropriate quality preventive and primary care services.

Childbirth Education (Number of Participants Who Received): Number of participants who received child-birth information per a pre-designed schedule/curriculum as an ongoing part of their prenatal care or participated in a formal Childbirth Education program. Childbirth education information may have been provided in classes, support groups, or in one-on-one sessions. Information may have been offered either directly or through an outside referral source.

Client Satisfaction: The number of unduplicated MCHB supported projects that report being satisfied with the responsiveness of services provided to them by MCHB in a determined time period as measured by customer satisfaction surveys.

Common Performance Measures: A means of assessing progress on a select group of outcomes and activities which are common to all Healthy Start projects.

Completed Service Referral: A referral is considered completed, when the client received the services from provider(s) to whom she was referred either within or outside of the MCHB program/agency. The purpose of these referrals can be either treatment-related or preventive.

Comprehensive System of Women's Health Care: A system that provides a full array of health services utilizing linkages to all programs serving women. The system must address gaps/barriers in service provision. Services provided must be appropriate to women's age and risk status, emphasizing preventive health care. It must include the full biological life cycle of the woman and concomitant physical, mental, and emotional changes that occur.

Community-based Consortium: An existing, formally organized partnership, advisory board or coalition of organizations and individuals representing consumers, appropriate agencies at the State, Tribal, county, city government levels, public and private providers, churches, local civic/community action groups, and local businesses which identify themselves with the project's target project area, and who unite in an effort to collectively apply their resources to the implementation of one or more common strategies for the achievement of a common goal within that project area. The Consortium must have current approved by-laws, which include policies regarding conflict of interest, to serve the needs as identified by its mission and/or functional statement. If the project area lies either in a federally designated Empowerment Zone/Enterprise Community, at least one member of that collaborative should also be on the Healthy Start Consortium.

Community Participant: is an individual who attends a Healthy Start sponsored event or participates in consortium activities, etc.

Consortia Training (Number of Individual Members Trained): Number of individual consortium members participating in formalized Healthy Start funded consortium training.

Contractor: An entity/individual with whom the grantee organization enters a binding agreement to perform one or more of the proposed services for the project according to the proposed plan, and fiscal and data reporting requirements established (and monitored) by the grantee organization. The scope of one contractor's proposed services cannot constitute the bulk of services for the proposed Healthy Start project; such sub-granting is not allowed under HRSA.

Cultural Competence: A set of values, behaviors, attitudes, and practices within a system, organization, program or among individuals which enables them to work effective cross culturally. Further, it refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time.

Direct Health Care Services: 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.

Domestic Violence (Number of Participants Served): Number of participants who have received Healthy Start services directed at the prevention or treatment/reduction of domestic violence. This may include formal presentations, support groups, or one-on-one counseling sessions related to domestic violence.

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 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.

Family-Centered Care: A system or philosophy of care that incorporates the family as an integral component of the health care system.

Family Planning: Number of participants receiving individualized family planning counseling and/or services with a medical provider or other health provider. The primary purpose is to provide services related to contraception, infertility, or sterilization.

Government Performance and Results Act (GPRA): Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance objectives, and report annually on actual performance.

Hispanic: Persons of any race who report/identify themselves as Mexican-American, Chicano, Mexican, Puerto Rican, Cuban, Central or South American (Spanish countries) or other Hispanic origin.

HIV/AIDS Education Only (Number of Participants Who Received): Number of participants who have received individual and/or group education on HIV/AIDS without lab testing. This includes teaching clients on how to get tested, but where the testing was not included in the Healthy Start service.

HIV/AIDS Counseling and Treatment (Number of Participants Served): Number of participants who have received Healthy Start funded individual and/or group counseling which includes (blood) testing, and/or treatment services related to HIV/AIDS, including psycho-social, care giver support, other medical and/or support activities.

Housing Assistance Referrals (Number of Participants Referred): Number of Healthy Start participants who have received assistance and/or a referral pertaining to locating, repairing, or paying for permanent or temporary housing.

Hypertension: Under new, stricter national blood pressure guidelines issued in May 2003, a resting blood pressure reading below 120/80 millimeters of mercury (mm Hg) is normal. Hypertension, or high blood pressure, is defined as a resting blood pressure consistently at 140/90 mm Hg or higher. A reading in between these levels defines a new pre-hypertensive category. Furthermore, under the new guidelines, a reading of 115/75 is the level above which the risk of cardiovascular complications starts to increase. (Mayo Clinic, 2003)

Immunizations: Number of age-appropriate immunizations provided (e.g., MMR, OPV, DPT, H. influenza, and Hepatitis B) according to AAP/PCIP established standards) during Healthy Start funded activities/services.

Infant Deaths Within 28 Days of Birth: Number of deaths reported by vital records, program records, care giver from birth to 28 days. Also known as neonatal mortality.

Infant Deaths After 28 Days of Birth: Number of deaths reported by vital records, program records, care giver from 29 days to 364 days after birth. Also known as post-neonatal mortality.

Infant Mortality Rate: The number of deaths to infants from birth through 364 days of age. This measure is reported per 1,000 live births.

Infants within Acceptable Standards for Growth And Development by Age One: Presence of appropriate growth norms and developmental skills.

Infrastructure Building Services: 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.

Integrated Service System: An integrated health care service system is an organization that, through ownership or formal agreements, vertically and horizontally aligns health care facilities, programs, or services in order to offer a continuum of health care to a defined geographic population and is willing to be held responsible clinically (i.e., improving quality) and fiscally (i.e., reducing costs) for the health status of that population.

Jobs/Jobs Training (Total Participants Served): Number of Healthy Start participants who have attended programs designed to assist participants in improving, in obtaining and maintaining employment or furthering their formal education including job skills classes, training programs in specific skills, academic mentoring/tutoring programs, GED training, literacy, and English as a Second Language.

Local Health System Action Plan: A four year action plan that describes ongoing collaborative mechanisms and intended efforts to work with existing community services to make improvements toward an integrated system for perinatal care for the target population.

Low Birthweight: The number of live births less than 2,500 grams. This measure is usually reported as a percentage of total live births.

Male Support Services (Total Males Served): Number of men who have attended or been involved in the Healthy Start funded fatherhood or male support group activities.

Medical Home: MCHB uses the AAP definition of medical home. The definition establishes that the medical care of infants, children, and adolescents should be accessible, continuous, comprehensive, family-centered, coordinated, and compassionate. It should be delivered or directed by well-trained physicians who are able to manage or facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a relationship of mutual responsibility and trust with them.

Mental Health Services (Number of Participants Served): Number of participants in Healthy Start funded mental health activities (i.e., support groups, individual, and group therapy).

Mental Health Services (Number of Participants Referred): Number of Healthy Start participants referred for residential or outpatient mental health services.

Model: A category of organizational or service interventions which were derived during the demonstration phase of the Healthy Start to reduce infant mortality and improve perinatal outcomes.

Model-Specific Performance Measures: A means of assessing progress on a select group of outcomes and basic interventions relevant to one of the nine Healthy Start models/categories of intervention.

Moderate Low Birth Weight: Live births with birth weight greater than or equal to 1500 and less than 2,500 grams (i.e., 1500-2499 grams). This measure is usually reported as a percentage of the total number of live births.

Needs Assessment: A study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining: 1) what are prevalent and otherwise unmet needs of

the target population; 2) what is essential in terms of the provision of health services to address those prevalent or unmet needs; 3) what is available; and, 4) what is missing.

Number of Women Assisted by Case Management: Number of Healthy Start women/program participants who participated in activities which assisted them in gaining and coordinating access to necessary care and services appropriate to their needs. Case management can encompass various types of activities e.g., facilitation/coordination of services (assessment of family's health and social service needs) development of a care plan; arrangements to assist family in accessing services; follow up on either referrals or 'no shows'; tracking family's changing service needs and/or progress

Number of Women Assisted through Home Visiting: Number of women/ program participants who were visited in their homes by Healthy Start affiliated health, social, or educational professionals, or by workers with special training including indigenous workers, community perinatal outreach workers, neighborhood health advocates, resource mothers/fathers, 'nannans', 'parrains', etc.

Number of Women Assisted by Outreach: Number of women/ program participants for which there is documentation that they met with a Healthy Start community outreach worker and received services (e.g., Outreach worker logs, assignment sheets, client records).

Number of Mothers of Infants Showing Evidence of Alcohol Use: Binge or excessive consumption of alcoholic beverages (wine, beer, mixed drinks, e.g., coolers or distilled liquor).

Number of Mothers of Infants Showing Evidence of Behavior Risk Factors: Behavioral risk factors may be documented, and recorded, through 1) self-reporting by the women/ program participants, or 2) other clinical observations.

Number of Mothers of Infants Showing Evidence of Diabetes: Presence by the woman/ program participants of diabetes mellitus (receiving medication to manage blood sugar, insulin dependent) or gestational diabetes

Number of Mothers of Infants Showing Evidence of Domestic Violence: Physical, sexual and/or emotional abuse of a woman/ program participants by her partner, companion or another family member

Number of Mothers of Infants Showing Evidence of Drug Use: Any drug including over the counter or prescription drug used inappropriately.

Number of Mothers of Infants Showing Evidence of Inadequate Housing: Presence of environmental hazards in housing conditions, (i.e., accident hazards, plumbing, electrical, water, heat, ventilation, facilities for cooking, privacy, access barriers)

Number of Mothers of Infants Showing Evidence of Lack of Family Support: Family system of the woman/ program participants unable to meet emotional and/or physical needs of participant.

Number of Mothers of Infants Showing Evidence of Problems with Bonding with Infant: Inattention to infant needs, presence of verbalization of negative characteristics of infant, resentment of infant, etc.

Number of Mothers of Infants Showing Evidence of Smoking Use: Presence of tobacco use by the mother.

Number of Mothers Who Received Child Care Services for Their Infant(s): Number of Healthy Start women/ program participants for which intermittent child care has been arranged and/or financed by Healthy Start. Includes care provided either on and/or off clinic sites, and other child care provider sites.

Number of Mothers Who Received Translation Services: Number of women/ program participants who received translation services funded in whole, or in part, by Healthy Start.

Number of Mothers Who Received Transportation Services Includes Tokens, Taxis, Vans: Number of Healthy Start women/ program participants who received transportation services either directly or by a completed referral to a Healthy Start funded transportation provider.

Number of Participants Directly Served: Number of Healthy Start participants who received substance abuse treatment through a residential, outpatient, or other day treatment program funded by Healthy Start.

Number of Participants Referred: Number of Healthy Start participants who have a completed service referral for substance abuse treatment. (i.e., received services from provider to whom s/he was referred by project).

Number of Postpartum Women Influenced By Healthy Start Outreach Activities Prior to Becoming a Participant: Number of clients who enrolled in the Healthy Start program and received clinical services as a result of a session with or personal contact from a community outreach worker, or a local public education and/or media campaign.

Number of Postpartum Women Participating During Reporting Period: Number of participants who both enrolled and received services after delivery.

Number of Pregnant Participants During Reporting Period: Unduplicated count of all current pregnant participants during reporting period. Participant's age and appropriate age groups should be determined at time of enrollment into any Healthy Start activity.

Number of Pregnant Women Influenced By Healthy Start Outreach Activities Prior to Becoming a Participant: Number of clients who enrolled in the Healthy Start program and received clinical services as a result of a session with or personal contact from a community outreach worker, or a local public education and/or media campaign.

Number of Pregnant Women Showing Evidence Of: Recorded at assessment, updated as necessary. Behavioral risk factors may be documented, and recorded, through 1) positive toxicity screen other medical tests indicating use; 2) self-reporting by the participant, or 3) other clinical observations, judgments.

Number of Pregnant Women Showing Evidence Of Drug Use: Any drug including over the counter or prescription drug used inappropriately

Number of Pregnant Women Showing Evidence Of Alcohol Use: Any alcoholic beverages (wine, beer, mixed drinks, e.g., coolers or distilled liquor) consumed during pregnancy

Number of Pregnant Women Showing Evidence Of Smoking: Any tobacco smoked, chewed, or snuffed at any time during pregnancy

Number of Pregnant Women Showing Evidence Of HIV/AIDS: Presence of HIV

Number of Pregnant Women Showing Evidence Of STDs: Presence of Sexually Transmitted Disease (Syphilis, Gonorrhea, Herpes, Chlamydia, and Hepatitis B)

Number of Pregnant Women Showing Evidence Of Bacterial Vaginosis: Presence of diagnosis of bacterial vaginosis

Number of Pregnant Women Showing Evidence Of Diabetes: Presence of diabetes mellitus (diet controlled receiving medication to manage blood sugar, insulin dependent) or gestational diabetes

Number of Pregnant Women Showing Evidence Of Hypertension: Presence of a higher blood pressure than is judged to be normal (usually a diastolic pressure of at least 90 mm Hg or a systolic greater than 140 mm Hg or a 15 mm Hg rise in diastolic or at 30 mm Hg in systolic over base line).

Number of Pregnant Women Showing Evidence Of Inadequate Housing: Presence of environmental hazards in housing conditions, (i.e., structural/accident hazards; plumbing, electrical, water, heat, ventilation, facilities for cooking, privacy, access barriers)

Number of Pregnant Women Showing Evidence Of Domestic Violence: Physical, sexual, and/or emotional abuse of a woman by her partner, companion, or another family member

Number of Pregnant Women Showing Evidence Of Lack of Family Support: Presence of isolation; family system unable to provide necessary psycho social, emotional, and/or physical support.

Number of Pregnant Women Who Are Medicaid Recipients: Recorded at assessment, updated as necessary.

Number of Pregnant Women Receiving Prenatal Care: Participants who report no prenatal care

Number of Pregnant Women Receiving Adequate Prenatal Care (Kotelchuck, Kessner or similar index): Number of participants who receive adequate prenatal care as measured by the Kotelchuck Scale or Kessner Index

Number of Pregnant Women Who Enter Prenatal Care During First Trimester: Number of participants with reported first prenatal visit before 13 weeks gestation

Number of Pregnant Women who Enter Prenatal Care During Second Trimester: Number of participants with reported first prenatal visit between 13 week and 25 week gestation

Number of Pregnant Women who Enter Prenatal Care During Third Trimester: Number of participants with reported first prenatal visit between 26 week and delivery

Number of Women Making Postpartum Visit within Eight Weeks of End of Pregnancy: Number of participants within eight weeks of delivery who made at least one visit to a health care provider for a health assessment and/interconception counseling (including postpartum tubal ligation).

Nutrition Education and Counseling including WIC Coordination (Number of Participants Who Received): Number of participating, pregnant women or parents of infants, who have received on a regular or on-going basis, information that is case specific and identifies particular nutritional risks or nutrition related medical conditions that are pertinent to the perinatal period. Services may have been provided and/or coordinated with the local WIC program; or may have been offered by Healthy Start funded professionals.

Objectives: Descriptions of what is to be achieved in measurable, time framed terms. Based upon a performance indicator, objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of achievement, and target population. Each objective should include a numerator, a denominator, time frame, and a baseline with data source including year. Projects are expected to monitor their progress in accomplishing their approved project period objectives through the measurement of their budget period objectives.

On-Going Source of Care: Defined as the provider(s) who deliver ongoing primary and preventive health care. Women commonly use more than one provider for routine care (e.g., internist/FP and OB/GYN) Ongoing source of care providers for women should offer services that ideally are accessible, continuous, comprehensive, coordinated, and appropriately linked to specialty services, culturally relevant, and focused on the full context of women's lives.

Parenting Education (Number of Participants Who Received): Number of participants who attended classes, support groups, or one-on-one education sessions which were provided to parents about infant/child care and development. To qualify as parenting education, these sessions need to be on-going (not sporadic) and have objectives. Parenting tips provided during routine baby exams and sick child care to trips to the emergency room do not constitute parenting education.

Perinatal Period: The period occurring from preconception through the first year of life (for the infant and its family).

Perinatal System of Care: A component of a community's overall primary health care system which connects and offers a linked array of medical and other services to address the comprehensive needs of women and their families throughout the childbearing process (including counseling and services related to: prenatal, delivery, and postpartum periods, newborn/well baby care through the infant's first year of life, and, inter-conceptual care including family planning).

Performance Indicator: A measurable variable developed by the grantee to measure the result or the impact which the model is having on the target population. Example: Number of pregnant participants who report decreased

smoking at a given time over the total number of pregnant participants who report that they smoke during their initial assessment.

Performance Measure: A narrative statement that describes a specific maternal and child health need, or requirement, that when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or project area and generally within a specific time frame. (Example: The rate of women in [Target Area] who received early prenatal care in 2002.)

Performance Objective: A statement of intention against which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, and the extent of the achievement, and target populations.

Phase I: Demonstration Phase of the Healthy Start Infant Mortality Initiative (1991-1997) which developed and implemented a broad range of community-driven interventions to improve maternal and infant health in communities experiencing high rates of infant mortality.

Phase II: Replication Phase of Healthy Start is (1997 to 2000) designed to disseminate, replicate and adapt various effective models of intervention through funding and mentoring new projects that will implement such models in their communities.

Population Based Services: 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.

Pregnant Woman: A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Prenatal Clinic Visits: All known medical prenatal care visits made by Healthy Start pregnant clients residing in the project area during the reporting period. The prenatal care visit is made for medical supervision of the pregnancy by a physician or other health care provider during the pregnancy.

Prison/Jail Initiatives (Total Participants Served): Number of pregnant women participating in Healthy Start activities at local correctional facilities.

Program Participant: is an individual having direct contact with Health Start staff or subcontractors and receiving Healthy Start services on an ongoing systematic basis.

Project Area: A geographic area for which improvements have been planned and are being implemented with the Healthy Start principles of: innovation, community commitment and involvement, increased access, service integration, and personal responsibility. A project area must represent a reasonable and logical catchment area. The proposed project area is identified and approved through the initial Healthy Start funding application process. Healthy Start services can only be provided to residents of the approved project area. Changes to this project area cannot be made without prior approval of HRSA/MCHB.

Project Period: The total time for which Healthy Start funding has been programmatically approved for a project (e.g. four years, two years). A project period may consist of one or more 'budget periods' (defined above). The total project period comprises the original project period and any extensions.

Provider Training (Number of Individual Providers Trained): Number of individual providers (professional and paraprofessional workers) participating in Healthy Start funded formalized training activities.

Public Information/Education (Number of Individuals Reached): Number of individuals informed on perinatal issues by Healthy Start media campaigns, health fairs, hotlines, or other Healthy Start funded media activities. Includes persons residing outside the PA who often hear, observe, or respond to Healthy Start media messages via television, radio, bus and/or theater advertisements which by design are directed at the PA community.

Race: Racial and ethnic categories reflect Federal Register Announcement “Office of Management and Budget: Revisions to Standards for Classification of Federal Data on Race and Ethnicity; Notices” issued October 30, 1997.

The response should reflect what the person considers herself to be and is not based on percentages of ancestry. Hispanic' refers to those people whose origins are from Spain, Mexico, or the Spanish speaking countries of Central and South America- Origin can be viewed as the ancestry, nationality, lineage, or country in which the person or his or her ancestors were born before their arrival in the United States.

Recommended Number of Well-Child Visits During the First Year of Life: Number of infants at age 12 months or older who received the recommended number of well-child visits for their age

Services Specific to Pregnant Teens: Number of adolescents receiving services from a Healthy Start affiliated program designed for pregnant teens.

Services Specific to Parenting Teens: Number of adolescents receiving services from a Healthy Start affiliated program designed for parenting teens.

Smoking Cessation (Number of Participants Who Received): Number of participants who have attended support groups, or one-on-one counseling sessions providing information to pregnant women, their partners, or parents of infants on a regular basis about the risks to the fetus and infant of smoking parents; and provided support and information on how to quit.

Substance Abuse Treatment and Counseling: Number of Healthy Start participants who received substance abuse treatment, counseling and/or referrals. Services may include an array of medical services, including testing and treatment for concurrent HIV/AIDS and/or STD's, and psychiatric, psychological or social services which are either provided by a single site or case managed across multiple sites, family and collateral/partner counseling and rehabilitation.

Sustainability: Projects should foster community partnerships and build capacity and/or program resources that continue as needed in that community after federal funds discontinue. A sustained project is one that demonstrates the continuation of key elements of program/service components started under the MCHB supported project.

Sustainability Plan: A set of administrative actions designed to identify and negotiate the continued financing and/or transition of project components to other entities to continue the provision of successful project services in the project area beyond the Federal Healthy Start funded project period.

Technical Assistance: The process of providing recipients with expert assistance of specific health related or administrative services that include: systems review planning, policy options analysis, coordination coalition building/training, data systems development, needs assessment, service cost analysis, and performance indicators.

Total # of Deliveries/Births During the Reporting Period: All live births during the reporting period to Healthy Start participants.

Urban and Rural Delineations: “According to the 1990 census definition, the urban population comprises all persons living in: (a) places of 2,500 or more inhabitants incorporated as cities, villages, boroughs (except in Alaska and New York) and towns (except in the New England states, New York and Wisconsin), but excluding the persons living in the rural portions of extended cities (places with low population density in one or more large parts of their area); (b) census designated places (previously termed unincorporated) of 2,500 or more inhabitants, and (c) other territory, incorporated or unincorporated, included in urbanized areas. An urbanized area comprises one or more places and the adjacent densely populated settled surrounding territory that together have a minimum population of 50,000 persons. In all definitions, the population not classified as urban constitutes the rural population. (Source: US Dept. Of Commerce, Statistical Abstract of the United States - 1995, The National Data Book, p.4).

Very Low Birth Weight: Live births with birth weight less than 1,500 grams. This measure is usually reported as a percentage of all live births.

Well Baby/Pediatric Care Clinic: All ambulatory pediatric care visits made by Healthy Start infant clients residing in the project area, excluding ER visits during the reporting period.

Well Child Visit 2-4 Weeks After Birth: Number of infants whose care giver reports having a well child visit during this time period.

Youth Empowerment/Peer Education/Self-Esteem Mentor Programs: Number of non-pregnant/non-parenting teens who are served by these specified Healthy Start programs. This may include group activities (e.g. Family Life Center activities, Teen Life Center activities, Male Mentoring Programs, Self-Esteem Programs, etc.)