

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

Maternal and Child Health Bureau
Division of Child, Adolescent and Family Health

***Affordable Care Act –
Maternal, Infant and Early Childhood Home Visiting Formula Grant Program***

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FUNDING OPPORTUNITY ANNOUNCEMENT

Fiscal Year 2011

Application Due Date: July 21, 2011

*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.*

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I. Funding Opportunity Description

1. Purpose

This announcement solicits applications for the Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) formula grant program to continue the Health Resources and Services Administration's (HRSA) and the Administration for Children and Families' (ACF) commitment to comprehensive family services, coordinated and comprehensive statewide home visiting programs¹, and effective implementation of high-quality evidence-based practices. This is the companion funding opportunity announcement to the competitive MIECHV grant program announcement released on June 1, 2011, as described in section II.2. below.

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

2. Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act or ACA) (P.L. 111-148), historic and transformative legislation designed to make quality, affordable health care available to all Americans, reduce costs, improve health care quality, enhance disease prevention, and strengthen the health care workforce. Through a provision authorizing the creation of the Affordable Care Act MIECHV program², the Act responds to the diverse needs of children and families in communities at risk and provides an unprecedented opportunity for collaboration and partnership at the federal, state, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs. The funds are intended to assure effective coordination and delivery of critical health, development, early learning, child abuse and neglect prevention, and family support services to these children and families through home visiting programs. This new program plays a crucial role in the national effort to build high-quality, comprehensive statewide early childhood systems for pregnant women, parents and caregivers, and children from birth to eight (8) years of age – and, ultimately, to improve health and development outcomes.

HRSA and ACF believe that home visiting should be viewed as one of several service strategies embedded in a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development. This strategy also promotes strong parent-child relationships and effective parenting that supports the physical, emotional, social,

¹ A "state home visiting program" is an overall effort, by the MIECHV grantee, to effectively implement home visiting models (or a single home visiting model) in the state's at-risk community(ies) to promote improvements in the benchmark and participant outcome areas as specified in the legislation.

² See <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>, pages 334-343.

and intellectual development of a child from infancy to adulthood. Together, HRSA and ACF envision high-quality, evidence-based home visiting programs as part of an early childhood system for promoting health and well-being for pregnant women, children through age eight and their families. This system would include a range of other programs such as child care, Head Start, pre-kindergarten, early intervention, special education, and the early elementary grades.

Recognizing that the goal of an effective, comprehensive early childhood system that supports the lifelong health and well-being of children, parents, and caregivers is broader than the scope of any one agency, HRSA and ACF are working in close collaboration and with other Federal agencies and look forward to partnering with states and other stakeholders to foster high-quality, well-coordinated home visiting programs for families in at-risk communities. HRSA and ACF realize that coordination of services with other agencies has been an essential characteristic of state and local programs for many years and will continue to encourage, support, and promote these activities, as close collaboration at all levels will be essential to effective, comprehensive home visiting and early childhood systems.

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

II. Award Information

1. Type of Award

Funding will be provided in the form of a formula grant.

2. Summary of Funding

Of the \$224 million available to support grants to eligible states and jurisdictions under the overall MIECHV program in FY 2011, \$125 million will be awarded on a formula basis to fund the 56 eligible entities (i.e., each state, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa),³ and \$99 million will be available for award to successful applicants among these entities on a competitive basis. **This funding opportunity announcement provides instructions for applications for formula grants only for a one-year project period.** Guidance for application for the competitive grants is provided in HRSA-11-179 that was announced on June 1, 2011. The funding opportunity announcement

³ A separate funding opportunity announcement for funding available to Indian Tribes, consortia of Indian Tribes, Tribal Organizations and Urban Indian Organizations will be announced at another time.

for completing competitive grant applications is available at <https://apply07.grants.gov/apply/UpdateOffer?id=57412>.

FY 2011 formula grant funds will be distributed to states as follows:

- 1) A base allocation of \$1,000,000 for each state;
- 2) An amount based on the number of children under age five (5) in families at or below 100% of the Federal poverty line in the state as compared to the number of such children nationally; in no case will a state or jurisdiction receive less than 120% of the amount received by formula in FY 2010; and
- 3) An amount equal to the funds, if any, currently provided to a state (or entity within that state) to implement one of the projects formerly known as the Supporting Evidence Based Home Visiting (EBHV) Program administered by ACF's Children's Bureau.

A table of the estimated amount of award for each state is included in Appendix G. **Applicants may not apply for more than the designated amount of funding for their state or jurisdiction.**

As required in Section 511(h)(2)(B) of Title V, as amended by the Affordable Care Act (42 U.S.C. §711), if a state has not submitted an approvable application by the beginning of FY 2012, funding may be available for non-profit organizations to compete to implement a statewide evidence-based home visiting program in that state.

III. Eligibility Information

1. Eligible Applicants

Eligibility for funding is limited to a single application from the governor-appointed state lead agency from each state, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

Regardless of the entity or entities designated by the Governor, this application must contain the required memorandum of concurrence signed by the required agencies. Please see the description for Attachment 5: Memorandum of Concurrence, under Section IV.2.xii of this funding opportunity announcement.

2. Cost Sharing/Matching

There is no cost sharing or matching requirements for the MIECHV program.

3. Other

Ceiling Amount for Funding

Applications that exceed the designated ceiling amount for funding (see Appendix G) will be considered non-responsive and will not be considered for funding under this announcement.

Deadline Requirements

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.

Maintenance of Effort/Non-Supplantation

Funds provided to an eligible entity receiving a grant shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives. The grantee must agree to maintain non-Federal funding (State General Funds) for grant activities at a level which is not less than expenditures for such activities as of the date of enactment of this legislation, March 23, 2010.

For purposes of this funding opportunity announcement, home visiting is defined as an evidence-based program, implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting), and is offered on a voluntary basis to pregnant women or children birth to age five (5) targeting the participant outcomes in the legislation which include improved maternal and child health, prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits, improvement in school readiness and achievement, reduction in crime or domestic violence, improvements in family economic self-sufficiency, and improvements in the coordination and referrals for other community resources and supports.

If state general revenue funds for evidence-based home visiting programs have fallen below the amount spent under state law and policies in place on March 23, 2010, the award of federal funds under this program will be **presumed to constitute supplantation**. The state may **rebut this presumption** by demonstrating that any reduction in state funding was unrelated to the receipt or availability of federal Home Visiting program funds. States wishing to provide a rationale which demonstrates compliance with the non-supplantation requirement should submit a justification in writing to HRSA.

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 only 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, including supporting documentation. **HRSA and its Grants Application Center**

(GAC) will only accept paper applications from applicants that received prior written approval. However, the application must still be submitted under the deadline. Suggestion: submit application to Grants.gov at least two days before the deadline to allow for any unforeseen circumstances. 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 from the following site by:

- 1) Downloading from <http://www.grants.gov>, or
- 2) Contacting the HRSA Grants Application Center at:
910 Clopper Road
Suite 155 South
Gaithersburg, MD 20878
Telephone: (877) 477-2123
HRSAGAC@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" 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. This 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.

Applications that exceed the specified limits (approximately 10 MB, or 80 pages when printed by HRSA) will be deemed non-responsive. All application materials must be complete prior to the application deadline. Applications that are modified after the posted

deadline will also be considered non-responsive. Non-responsive applications will not be considered under this funding 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.
-  When providing any electronic attachment with several pages, add a Table of Contents page specific to the attachment. Such pages will not be counted towards the page limit.

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.
Application Checklist Form HHS-5161-1	Form	Pages 1 & 2 of the HHS checklist.	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	Page 1 & 2 to supports 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.

Application Section	Form Type	Instruction	HRSA/Program Guidelines
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 all additional site location(s)	Not counted in the page limit.
Disclosure of Lobbying Activities (SF-LLL)	Form	Supports structured data for lobbying activities.	Not counted in the page limit.
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 pages 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.

Attachment Number	Attachment Description (Program Guidelines)
Attachment 1	Project Logic Model
Attachment 2	Project Timeline
Attachment 3	Project Organizational Chart
Attachment 4	Job Descriptions/ Resume for Key Personnel
Attachment 5	Memorandum of Concurrence
Attachment 6	Description(s) of Proposed/Existing Contracts (subcontracts)/Itemized subcontracts
Attachment 7	References and Citations
Attachment 8	Model Developer Approval Letter(s)

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. For information pertaining to the Catalog of Federal Domestic Assistance, the CFDA Number is 93.505.

DUNS Number

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

Complete the HHS Application Checklist Form HHS 5161-1 provided with the application package.

iv. Budget

Complete Application Form SF-424A Budget Information – Non-Construction Programs provided with the application package. **The budget period is one year.** Please provide a line item budget using the budget categories in the SF-424A for a project and budget period of September 30, 2011 through September 29, 2012.

v. 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. Line item information must be provided to explain the costs entered in the SF-424A. **The budget justification must clearly**

describe each cost element and explain how each cost contributes to meeting the project's objectives/goals. Be very careful about showing how each item in the "other" category is justified. The budget justification **MUST** be concise. Do **NOT** use the justification to expand the project narrative.

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.

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

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

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

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

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

NOTE: Subgranting is not allowed for this grant program.

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

Applicants may include the cost of access accommodations as part of their project's budget, including sign interpreters, plain language and health literate print materials in alternate formats (including Braille, large print, etc.); and cultural/linguistic competence

modifications such as use of cultural brokers, translation or interpretation services at meetings, clinical encounters, and conferences, etc.

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

vi. *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.

vii. *Assurances*

Complete Application Form SF-424B Assurances – Non-Construction

viii. *Certifications*

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

ix. *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 Name
- Address
- Contact Phone Numbers (Voice, Fax)
- E-Mail Address
- Web Site Address, if applicable

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

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 either planned or in process with appropriate national, regional, state and/or local health and public health agencies and/or organizations, communities and appropriate stakeholders in the area(s) served by the project. Organizations may include but need not be limited to local American Academy of Pediatrics chapters, March of Dimes, United Way, Parent-Teacher Associations, School Boards, and Family Support Groups etc.

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.

EVALUATION: The legislation does not require states to conduct any evaluation other than to conduct research on promising approaches. The state will provide assurance that they will participate in national evaluation activities. It is the Secretary's intent to fund and carry out the national evaluation described in the legislation. However, HRSA and ACF will not prohibit a state from conducting research and evaluation outside of the national evaluation.

x. *Program Narrative*

In response to the 2nd Supplemental Information Request (SIR) for the FY 2010 MIECHV application, all eligible applicants were required to submit an Updated State Plan. The plans, which were submitted June 8, 2011, included a needs assessment of high-risk communities, selection of targeted communities and models that address the needs of families residing in those communities, a methodology to address the needs of families, a data plan to assess benchmarks and a plan for Continuous Quality Improvement.

The narrative submitted in response to this funding opportunity announcement should build on the applicants' existing plan. Accordingly, applicants may elect to expand on or revise the FY 2010 Updated State Plan already submitted. The narrative provided in response to this funding opportunity announcement should provide a comprehensive framework and description of all aspects of the proposed MIECHV program. It should be succinct, self-explanatory and well organized so that reviewers can understand the proposed project.

Any references used in the Program Narrative may be listed under Attachment 7.

Section 1: Needs Assessment and Identification of the State's Targeted At-Risk Communities

For this section of the narrative, states must justify the selection of the targeted at-risk community or communities for which home visiting services can be supported by FY 2011 funding under the MIECHV program. States adding additional at-risk communities (i.e., at-

risk communities not identified in the previously submitted Updated State Plan) should discuss any other factors contributing to the selection of the additional community(ies).

This section should include as much detailed information as possible regarding specific community risk factors, other characteristics and strengths, the need for a home visiting program, and service systems currently available for families in that community, including information on any home visiting programs currently operating or recently discontinued (since March 23, 2010). Demographic data should be used and cited whenever possible to support the information provided.

For each targeted community proposed, please provide the following information:

- A detailed assessment of needs and existing resources, including:
 - Community strengths and risk factors.
 - Characteristics and needs of participants; to the extent possible, the target population must be described and documented in this section.
 - Any existing home visiting services⁴ in the community, currently operating or discontinued since March 23, 2010, including:
 - the number and types of home visiting programs and initiatives in the community; and
 - the models that are used by identified home visiting programs.
 - Existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community (e.g., centralized intake procedures at the local or state level).
 - Referral resources currently available and needed in the future to support families residing in the community(ies).
- A description of how coordination among existing programs and resources in those communities (including how the program will address existing service gaps) is promoted and implemented;
- Local and state capacity to integrate the proposed home visiting services into an early childhood system, including existing efforts or resources to develop a coordinated early childhood system at the community level, such as a governance structure or coordinated system of planning; and
- A list of communities in the state that were identified as being at risk in the state's initial needs assessment but are not being selected for implementation of the State Home Visiting Program due to limitations on available funding.

⁴ Including state-funded, Federally-funded, locally-funded, and privately-funded programs in the community. Home visiting programs are defined for purposes of this requirement as those with home visiting as the primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents or primary caregivers of children birth to kindergarten entry, targeting the legislatively mandated participant outcome and benchmark areas.

Section 2: Home Visiting Program's Goals and Objectives

The applicant should include clearly articulated goals and objectives for the proposed program, which should build on the goals and objectives submitted for the FY 2010 MIECHV program Updated State Plan.

Applicants are reminded that the program goals should be consistent with, and address, the intent of the MIECHV program. Accordingly, the goals and objectives should reflect the applicant's effort to address the development of a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development and strong parent-child relationships. In addition, strategies for integrating the program with other programs and systems in the state that are related to maternal and child health and early childhood health, development and well-being should be reflected in the goals and objectives as well. An implementation timeline should be provided as Attachment 2.

Applicants must include a logic model for the proposed state home visiting program as a whole. The logic model for the State Home Visiting Program as a whole may build on the model developer's logic model but should not duplicate it. The logic model should identify inputs, outputs and short-term and long-term outcomes. Please include the logic model as Attachment 1. For guidance on creating logic models see:

<http://www.childwelfare.gov/management/effectiveness/models.cfm> or the W.K. Kellogg Foundation tool for developing a logic model at <http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic-Model-Development-Guide.aspx>.

Section 3: Selection of Proposed Home Visiting Model(s) and Explanation of How the Model(s) Meet the Needs of the Targeted Community(ies)

States must justify a program using one or more evidence-based home visiting models (see Appendix A) aimed at addressing the particular risks in the targeted community(ies) and the needs of families residing there. Per the authorizing legislation, at least 75 percent of the funds must be utilized by grantees for evidence-based home visiting models.

States may also propose using up to 25 percent of their grant allocation per year to support a model that is a promising approach. States must explain their selection of the home visiting model(s) by demonstrating how the model(s) will address the needs identified in the targeted at-risk community(ies). In the case of a promising approach, the State must indicate the national organization or institution of higher education that developed or identified the model and how the model will be evaluated through a well-designed and rigorous process. States should also describe how the at-risk community(ies) will be engaged in decision-making regarding the home visiting program.

In some cases, the state may wish to adapt an existing model that has been identified as evidence-based in order to meet the needs of targeted at-risk communities. Adaptations may include broadening the population served, additions, subtractions, or enhancements of the current model. For the purposes of the MIECHV program, an acceptable adaptation of an evidence-based model includes changes to the model that have not been tested with rigorous impact research but are determined by the model developer *not to alter the core components related to program impacts*. Implementing agencies should discuss proposed adaptations with

the program developers prior to implementation to ensure that changes do not alter core components. Changes to an evidence-based model that alter the core elements related to program outcomes could undermine the program's effectiveness. Such changes (otherwise known as "drift") will not be allowed under the funding allocated for evidence-based models. Any proposed adaptations will be reviewed and approved by HHS during the review of the state plans. Adaptations that alter the core components related to program impacts may be funded with funds available for promising approaches, if the state wishes to implement the program as a promising approach instead of as an adaptation of an evidence-based model.

As indicated in the previous guidance for the state's FY 2010 Updated State Plan, any home visiting model proposed in the state's response to this funding opportunity announcement must meet the criteria listed in this document to qualify for funding as an evidence-based home visiting model. For the purposes of this section, states may include the information provided in the previously submitted Updated State Plan.

States proposing additional model(s) must⁵:

- a. Select a model(s) from the list in Appendix A that meets the needs identified in the targeted at-risk community(ies); or
- b. Propose the use of up to 25 percent of the funds for a promising approach to home visiting.

(a) Selection of Approved Evidence-Based Home Visiting Model(s)

This document identifies seven home visiting models that have been determined to meet the evidenced-based criteria established by HRSA and ACF on the basis of a systematic review conducted through the HomVEE study and the public comments received in response to the Federal Register Notice.⁶ The home visiting models known to meet the evidence criteria are listed in Appendix A. In addition, there is detailed information on each model reviewed, including the evidence available for each model and information on other models reviewed that did not meet the criteria. This information is available at: (<http://homvee.acf.hhs.gov/>). Per the authorizing legislation, at least 75 percent of the funds must be utilized by grantees for evidence-based home visiting models. As noted previously, the state may propose, in addition, to expend up to 25 percent of its total grant to implement a model that qualifies as a promising approach (see section (d) "Proposing a Promising Approach," below).

States electing to implement an approved evidence-based model must provide documentation of approval by the developer to implement the model as proposed. The documentation should include verification that the model developer has reviewed and agreed to the plan as

⁵ On an ongoing basis the Home Visiting Evidence of Effectiveness (HomVEE) review will be reviewing the available evidence on home visiting models. States will be informed whenever new models meet the criteria for evidence of effectiveness. States, model developers, or others may make a request for reconsideration of an already-reviewed model for which there is currently insufficient evidence of effectiveness. Please see Appendix J for instructions for making requests for re-review. Please note, however, that there will not be sufficient time for such reviews to be completed prior to consideration or award of applications for FY 2011 formula grants.

⁶ Department of Health and Human Services, Health Resources and Services Administration, Administration for Children and Families, Maternal, Infant, and Early Childhood Home Visiting Program; Request for Public Comment, 75 Federal Register 141 (23 July 2010), pp. 43172-43177.

submitted, including any proposed adaptation, support for participation in the national evaluation, and any other related HHS efforts to coordinate evaluation and programmatic technical assistance. This documentation should include the state's status with regard to any required certification or approval process required by the developer. The approval letter should be submitted as Attachment 8.

In response to this funding opportunity announcement, the state must also include the following information regarding evidence-based model selection:

- Identify the evidence-based home visiting model(s) to be implemented in the state and describe how each model meets the needs of the community(ies) proposed. As required for the FY 2010 Updated State Plan, states are required to engage the targeted community to assess the fit of the model and the community's readiness to implement it. Community involvement is expected to continue on an ongoing basis throughout the duration of this program;
- Provide a description of the state's current and prior experience with implementing the model(s) selected, if any, as well as their current capacity to support the model;
- Submit a plan for ensuring implementation, with fidelity to the model, and include a description of the following: the state's overall approach to home visiting quality assurance; the state's approach to program assessment and support of model fidelity; anticipated challenges and risks to maintaining quality and fidelity, and the proposed response to the issues identified;
- Discuss anticipated challenges and risks of selected program model(s), and the proposed response to the issues identified, and any anticipated technical assistance needs.

For the purposes of this section, the state may include the information provided in the Updated State Plan submitted for MIECHV FY 2010 formula grants.

States that are either (1) selecting evidence-based home visiting models not identified in the MIECHV FY 2010 Updated State Plan or (2) choosing evidence-based models for newly identified at-risk communities must clearly identify these changes when responding to the aforementioned requirements.

(b) Proposing a Promising Approach

States may implement a home visiting model that conforms to a promising approach for achieving the benchmarks and outcomes required by law. A promising approach is one in which there is little to no evidence of effectiveness; one with evidence that does not meet the criteria for an evidence-based model; or a modified version of an evidence-based model that *includes significant alterations to core components*. The promising approach should be grounded in relevant empirical work and have an articulated theory of change. The promising approach must have been developed by or identified with a national organization or institution of higher education, and states must evaluate this approach through a well-designed and rigorous process.

States shall not use more than 25 percent of the amount of the grant paid to the state for promising approaches. In addition, the required evaluation of a promising approach must be

funded from the 25 percent of funds available for promising approaches. A discussion of the expected evaluation activities for promising approaches is included in Appendix B.

If the state would like to propose a promising approach to their home visiting program, their application must:

- Describe the model(s) proposed as a promising approach;
- Identify the national organization or institution of higher learning affiliated with the model(s);
- Specify how the proposed promising approach(es) meets the needs of the at-risk community(ies). It is expected that the state will engage the proposed community to assess the fit of the approach and community readiness to implement it prior to the submission of the plan and on an ongoing basis after implementation begins;
- Provide a description of the state's current and prior experience with implementing the promising approach, as well as its current capacity to support implementation;
- Include an evaluation plan specifying how the proposed promising approach(es) will be evaluated using a well-designed and rigorous process (see Appendix B);
- Submit a plan for ensuring implementation with fidelity to the model, and include a description of the state's overall approach to home visiting quality assurance; the state's approach to program assessment and support of model fidelity; anticipated challenges and risks to maintaining quality and fidelity, and the proposed response to the issues identified; and
- Discuss the anticipated challenges to implementing or evaluating the promising approach, proposed response to issues identified, and any anticipated technical assistance needs.

For purposes of this section, the state may include the information provided in the Updated State Plan submitted for MIECHV FY 2010 formula grants.

States that are either (1) proposing a promising approach not identified in the MIECHV FY 2010 Updated State Plan or (2) choosing a promising approach for serving newly identified at-risk communities must clearly identify these changes when responding to the aforementioned requirements.

Section 4: Implementation Plan for Proposed State Home Visiting Program

States must provide a plan for the implementation of the proposed State Home Visiting Program and for ongoing monitoring of the quality of implementation of chosen model(s) at the community, agency, and participant level. This plan would build on the Updated State Plan submitted for the FY 2010 MIECHV program. The plan must include the following information:

- A description of the process for engaging the at-risk community(ies) around the proposed State Home Visiting Plan, including identifying the organizations, institutions or other groups and individuals consulted;

- A description of the state's approach to the development of home visiting program policy and to setting standards for the State Home Visiting Program;
- A description of how the state will work with the national model developer(s) and a description of the technical assistance and support to be provided through the national model(s). If there is more than one home visiting model selected, this information must be provided for each model;
- A timeline for obtaining the curriculum or other materials needed;
- A description of how and what types of initial and ongoing training and professional development activities will be provided by the state or the implementing local agencies, or obtained from the national model developer;
- A discussion of how recruitment, hiring, and retention of appropriate staff for all positions will be conducted;
- If subcontracts will be used, a plan for recruitment of subcontractor organizations, and a plan for how the subcontractor(s) will recruit, hire, and retain staff of the subcontractor organization(s);
- A description of how the state will ensure that high-quality clinical supervision and reflective practice for all home visitors and supervisors is supported and maintained;
- A description of how the State Home Visiting program identifies and recruits program participants and how attrition rates are minimized. Please include the estimated number of families served and an estimated timeline to reach maximum caseload in each location;
- An operational plan for the coordination between the proposed home visiting program and other existing programs and resources in those communities, especially regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services;
- A description of how data systems will be utilized to ensure collection of data and ongoing continuous quality improvement (CQI);
- An explanation of the state's approach to monitoring, assessing, and supporting implementation with fidelity to the chosen model(s) and maintaining quality assurance;
- A discussion of anticipated challenges to maintaining quality and fidelity, and the proposed response to the issues identified;
- A list of collaborative public and private partners;
- An explanation of how the state will integrate the state's MIECHV program into the broader early childhood system;
- Assurance that the state's home visiting program is designed to result in participant outcomes noted in the legislation;

- Assurance that individualized assessments will be conducted for participant families and that services will be provided in accordance with those individual assessments;
- Assurance that services will be provided on a voluntary basis;
- Assurance that the state will comply with the Maintenance of Effort/Non-Supplantation Requirement; and
- Assurances that priority will be given to serve eligible participants who:
 - Have low incomes;
 - Are pregnant women who have not attained age 21;
 - Have a history of child abuse or neglect or have had interactions with child welfare services;
 - Have a history of substance abuse or need substance abuse treatment;
 - Are users of tobacco products in the home;
 - Have, or have children with, low student achievement;
 - Have children with developmental delays or disabilities;
 - Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

Research and Evaluation

The legislation does not require states to conduct any evaluation other than to conduct research on promising approaches. The state has provided assurances in the application for the FY 2010 MIECHV funding opportunity announcement of participation in any national evaluation activities. It is the Secretary's intent to fund and carry out the national evaluation described in the legislation. However, HRSA and ACF will not prohibit a state from conducting research and evaluation outside of the national evaluation. MIECHV program funds can only be used for conducting research or evaluation activities on programs funded under the MIECHV program. States that choose to conduct research and evaluation activities should describe those activities in the Implementation Plan (see Appendix B for guidance on information necessary to provide for any proposed research and evaluation activities).

Section 5: Meeting Legislatively-Mandated Benchmarks

Plans for the collection of benchmark data were submitted with each state's Updated State Plan for the MEICV FY 2010 program year. To meet the requirements around quantifiable, measurable improvement in benchmark areas,⁷ each state provided a proposal for the initial and ongoing data collection for each of the six benchmark areas. Consequently, for the purposes of this application, the state must reiterate the information provided in the previously submitted plan. **Please identify any additions, deletions, or revisions made to the previously submitted plan.**

⁷ Benchmarks include: Improved maternal and newborn health; Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; Improvement in school readiness and achievement; Reduction in crime or domestic violence; Improvements in family economic self-sufficiency; and, Improvements in the coordination and referrals for other community resources and supports. See Section 511 (d) (1).

As a reminder, the following are parameters for benchmark data collection:

- The grantee must collect data on all benchmark areas.
- The data must be collected for eligible families that have been enrolled⁸ in the program who receive services funded with the MIECHV program funds.
- Each benchmark area includes multiple constructs. States must collect data for all constructs under each benchmark area.
- If the same construct appears in more than one benchmark area, states may utilize the same data for each applicable benchmark area. These instances are noted in the specific discussion of each benchmark area.
- To demonstrate improvements in at least four benchmark areas by the end of three years, the state must show improvement in at least half of the constructs under each benchmark area.
- Standard measures for the constructs within a benchmark area across home visiting models (if more than one home visiting model is implemented within a state) are strongly encouraged.
- We recommend that programs utilize these and other appropriate data for CQI to enhance program operation and decision-making and to individualize services.⁹ Technical assistance will be provided to assist grantees in utilizing data for CQI.
- States may propose either to collect data on each participating family or to use a sampling approach for some or all benchmark areas.
- At a later date, a template will be provided for grantees to report to HHS on benchmark progress at the three-year point.
- The measures and measurement tools proposed by states must be developmentally appropriate for the corresponding constructs and for use with the populations served by the home visiting program.
- For the purposes of the benchmark requirement, it is recommended that data collected across all benchmark areas be coordinated and aligned with other relevant state or local data collection efforts (e.g., link data on children/families served by the state home visiting program to data on the same children/families served by early childhood, child welfare, health care, substance abuse or other programs). In addition to the reporting requirements for each benchmark area, applicants must collect individual-level demographic and service-utilization data on the participants in their program as necessary to analyze and understand the progress children and families are making. Individual-level demographic and service-utilization data may include but are not limited to the following:
 - Family's participation rate in the home visiting program (e.g., number of sessions/number of possible sessions, duration of sessions, attrition rates);

⁸ A family is to be considered enrolled as of the date of the first home visit.

⁹ Section 511 (d)(2)(A).

- Demographic data for the participant child(ren), pregnant woman, expectant father, parent(s), or primary caregiver(s) receiving home visiting services including: child's gender, age of all (including age in month for child) at each data collection point and racial and ethnic background of all participants in the family;
- Participant child's exposure to languages other than English; and
- Family socioeconomic indicators (e.g., family income, employment status).

Technical assistance will be provided to assist a state in selecting or developing benchmark measures.

Benchmark Plan Requirements

States must provide a plan for the continued collection of the benchmark data. It should include information about each construct (e.g., incidence of child injuries) and measure selection (e.g., visits to the emergency department) for each benchmark area, including data collection and analysis. The benchmark plan must include the following information for each benchmark area and its associated constructs:

- Proposed measures:
 - For each construct within each benchmark area (e.g., “general cognitive skills” within the Improvement in School Readiness and Achievement benchmark area), specify the measure proposed. If use of administrative data is proposed, please also include a Memorandum of Understanding (MOU) from the agency with responsibility or oversight of those data.
 - Reliability/validity of measurement tool proposed (demonstrating reliability/validity for the population with which the measurement tool will be used) or justification of appropriateness of proposed measure to capture the construct when not utilizing a measurement tool.
- Proposed definition of improvement for each element of the individual construct (e.g., “improvement will be quantified as a decrease in the number of children identified as at risk by the Ages and Stages Questionnaire-Social Emotional Domain, ASQ-SE, for children's social-emotional development over one year of program enrollment”).
- Proposed data collection and analysis plan, including:
 - The source of the data proposed and justification for why it is the most appropriate for the construct;
 - The population to be assessed by each measure (e.g., parent or child) and the appropriateness of that measure, in terms of such factors as age of children, and in terms of specific population groups such as dual-language-learner children, children with disabilities, etc.;
 - The plan for sampling, if proposed, that includes the sample selection procedures and data to ensure the sampling approach will be representative and produce stable estimates;

- A plan for selection and implementation of a state and local data system;
- A data collection schedule including how often the data will be collected and analyzed (the minimum is specified under each benchmark area in Appendix C, but programs are encouraged to consider more frequent data collection for CQI purposes);
- A plan for ensuring the quality of data collection and analysis. The plan should include minimum qualifications or training requirements for administrators of measures, qualifications of personnel responsible for data management at the state and program level, qualifications of personnel responsible for data analysis at the state and program level, and the time estimated for the data collection-related activities by personnel categories;
- A plan for the identification of scale scores, ratios, or other metrics most appropriate to the measurement proposed;
- A plan for analyzing the data at the local and at the state level. This should include how data will be aggregated and disaggregated to understand the progress made within different communities and for different groups of children and families;
- Plans for gathering and analyzing demographic and service-utilization data on the children and families served in order to better understand the progress children and families are making. This may include data on the degree of participation in services, the child's age in months, the child's race and ethnicity, the child's home language, the child's sex, the parent's education or employment, and other relevant information about the child and family;
- A plan for using benchmark data for CQI at the local program level, community level, and state level; and
- A plan for data safety and monitoring including privacy of data, administration procedures that do not place individuals at risk of harm (e.g., questions related to domestic violence and child maltreatment reporting), and compliance with applicable regulations related to IRB/human subject protections, HIPAA, and FERPA. The plan must include training for all relevant staff on these topics.

For more details on benchmarks please see Appendix C.

Section 6: State Administration of the State Home Visiting Program

States must include a description of the statewide administrative structure in place to support the State Home Visiting Program. States must also present a plan that indicates how the State Home Visiting Plan will be managed and administered at the state and local levels. This can include updating, and expanding the administration of the home visiting program description submitted with the FY 2010 Updated State Plan. States must describe the existing community and state service and administrative structures available to support the State Home Visiting Program, such as availability of referral services, of management capacity, and other essential structures.

In providing this description, please identify the following:

- The lead agency for the program;
- A list of collaborative partners in the private and public sector;
- An overall management plan for the program at the state and local levels that describes who will be responsible for ensuring the successful implementation of the State Home Visiting Program;
- If the state is supporting more than one home visiting model within a community, a plan for coordination of referrals, assessment, and intake processes across the different models (e.g., a detailed plan for centralized intake, as appropriate);
- Identification of other related state or local evaluation efforts of home visiting programs that are separate from the evaluations of promising approaches;
- Job descriptions for key positions, including resumes; and
- An organization chart.

The narrative must also include a detailed description of how the proposed State Home Visiting Program will meet the legislative requirements, including:

- Well-trained, competent staff;
- High-quality supervision;
- Strong organizational capacity to implement activities involved;
- Referral and service networks available to support the home visiting program and the families it serves in at-risk communities; and
- Monitoring of fidelity of program implementation to ensure services are delivered pursuant to a specified model.

Efforts should be made to ensure that the MIECHV program is coordinated, to the extent possible, with other state early childhood programs including the State Advisory Council and the State Early Childhood Comprehensive Systems program. Accordingly, the narrative should address the following:

- How the state or community(ies) will comply with any model-specific prerequisites for implementation, including those discussed in the implementation profiles available on the HomVEE website (<http://homvee.acf.hhs.gov/>);
- Any strategies for making modifications needed to bolster the state administrative structure in order to establish a home visiting program as a successful component of a comprehensive, integrated early childhood system; and
- Any collaborations established with other state early childhood initiatives as identified earlier in this document.

Section 7: State Plan for Continuous, Quality Improvement

The use of Continuous Quality Improvement (CQI) methods is likely to result in more effective program implementation and improved participant outcomes. Through the collection and regular use of data, home visiting programs can identify and rectify impediments to effective performance as well as document changes and improvements. For these reasons, it is expected that the state will benefit from applying a CQI approach to program implementation.

Accordingly, in the recently submitted Updated State Plan for the FY 2010 MIECHV program, states were asked to provide a plan for CQI with a description of how CQI strategies will be utilized at the local and state levels. For the purposes of this funding opportunity announcement, states may reiterate the CQI plan previously submitted. If possible, the state may update the CQI plan previously provided. States are reminded that technical assistance will be provided as needed on CQI strategies.

Section 8: State Technical Assistance Needs

HHS intends to provide training and technical assistance to states throughout the implementation of the MIECHV program. HHS will use a multi-dimensional and multi-faceted approach for the provision of technical assistance and will provide technical assistance including collaboration and coordination with other federal government agencies, the state administrators, and the national model developers.

HHS recognizes that the national organizations and/or institutes of higher education associated with many home visiting program models that states are likely to implement provide model-specific technical assistance. HHS anticipates providing technical assistance in several areas to complement existing technical assistance efforts, including: conducting ongoing needs assessments; strategic planning; collaboration and partnerships; communication and marketing; fiscal leveraging; implementing and supporting home visiting programs; selecting home visiting model(s) to meet the target populations' needs; data and information systems; special topical issues (e.g., substance abuse, mental health, domestic violence, tribal, and rural issues); continuous quality improvement/quality assurance; workforce issues; developing training systems; participant recruitment and retention; sustainability; and program evaluation. The list of topics is not meant to be exhaustive and HHS intends to tailor technical assistance to meet needs identified by the states.

States should include a list of current technical assistance needs and any anticipated technical assistance needs for the future.

Section 9: Status of Meeting Reporting Requirements

The state should include in the narrative assurances that the state will comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the program. States will be notified in advance of the specific due dates and formatting requirements for submitting this report. This report shall address the following:

State Home Visiting Program Goals and Objectives

- Progress made under each goal and objective during the reporting period, including any barriers to progress that have been encountered and strategies taken to overcome them;
- Any updates or revisions to program goal(s) and objectives;
- To the extent not articulated above, a brief summary regarding the state's efforts to contribute to a comprehensive high-quality early childhood system, using the logic model submitted. Identify updates or changes to logic model, if necessary.

State Home Visiting Promising Approach Update

- Updates on the state's evaluation of any implemented promising approach;
- If applicable, copies of reports developed in the course of the local evaluation of promising approach and any other evaluation of the overall home visiting program undertaken by the state.

Implementation of Home Visiting Program in Targeted At-risk Communities

Updates regarding experience in planning and implementing the home visiting programs selected for each community of need, addressing each of the items listed below. Where applicable, states may discuss any challenges encountered and steps taken to overcome the identified challenges.

- An update on the state's progress for engaging the at-risk community(ies) around the proposed plan;
- Update on work-to-date with national model developer(s) and a description of the technical assistance and support provided to-date through the national model(s);
- Based on the timeline provided, an update on securing curriculum and other materials needed for the home visiting program;
- Update on training and professional development activities obtained from the national model developer, or provided by the state or the implementing local agencies;
- Update on staff recruitment, hiring, and retention for all positions including subcontracts;
- Update on participant recruitment and retention efforts;
- Status of home visiting program caseload within each at-risk community;
- Update on the coordination between home visiting program(s) and other existing programs and resources in those communities (e.g., health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services); and

- A discussion of anticipated challenges to maintaining quality and fidelity of each home visiting program, and the proposed response to the issues identified.

Progress toward Meeting Legislatively Mandated Benchmarks

Update on data collection efforts for each of the six benchmark areas, which would include an update on data collected on all constructs within each benchmark area including definitions of what constitutes improvement, sources of data for each measure utilized, challenges encountered during data collection efforts, and steps taken to overcome them.

Home Visiting Program's CQI Efforts

Update on state's efforts regarding planning and implementing CQI for the home visiting program. If applicable, copies of CQI reports developed addressing opportunities, changes implemented, data collected, and results obtained.

Administration of State Home Visiting Program

- Updated organization chart, if applicable;
- Updates regarding changes to key personnel,¹⁰ if any (include resumes for new staff, if applicable);
- An update on state efforts to meet the following legislative requirements, including a discussion of any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges:
 - Training efforts to ensure well-trained, competent staff;
 - Steps taken to ensure high-quality supervision;
 - Steps taken to ensure referral and services networks to support the home visiting program and the families it serves in at-risk communities; and
- Updates on new policy(ies) created by the state to support home visiting programs.

Technical Assistance Needs

An update on technical assistance needs anticipated for implementing the home visiting program or for developing a statewide early childhood system.

xi. Program Specific Forms

There are no program specific forms required for purposes of this application.

xii. Attachments

Please provide the following items to complete the content of the application. Please note that these are supplementary in nature, and are not intended to be a continuation of the project

¹⁰ Changes in key personnel require prior approval by HHS.

narrative. Unless otherwise noted, attachments count toward the application page limit (80 pages). **Each attachment must be clearly labeled.**

Attachment 1: Project Logic Model

Attachment 2: Project Timeline

Attachment 3: Project Organizational Chart

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

Attachment 4: Job Descriptions for Key Personnel

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

Attachment 5: Memorandum of Concurrence

States must provide a Memorandum of Concurrence signed by the required agencies signifying approval of the proposed plan for a State Home Visiting Program.

For purposes of meeting requirements for this funding opportunity announcement for a State Home Visiting Program, states must provide a Memorandum of Concurrence signed by representatives of the agencies listed below:

- Director of the state's Title V agency;
- Director of the state's agency for Title II of the Child Abuse Prevention and Treatment Act (CAPTA);
- The state's child welfare agency (Title IV-E and IV-B), if this agency is not also administering Title II of CAPTA;
- Director of the state's Single State Agency for Substance Abuse Services;
- The state's Child Care and Development Fund (CCDF) Administrator;
- Director of the state's Head Start State Collaboration Office;
- The State Advisory Council on Early Childhood Education and Care authorized by 642B(b)(1)(A)(i) of the Head Start Act; and
- The state's Elementary and Secondary Education Act Title I or state pre-kindergarten program.

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

- The state's Individuals with Disabilities Education Act (IDEA) Part C and Part B Section 619 lead agency(ies); and
- The state's Medicaid/Children's Health Insurance program (or the person responsible for Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program).

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

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

Attachment 6: Description(s) of Proposed/Existing Contract (subcontracts)

Provide any documents that describe working relationships between the applicant organization and other agencies and programs cited in the proposal. Documents that confirm actual or pending contractual agreements should clearly describe the roles of the subcontractors and any deliverable. Letters of agreement must be dated.

Attachment 7: References and Citations

Attachment 8: Model Developer Letter(s)

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

3. Submission Dates and Times

Application Due Date

The due date for applications under this funding opportunity announcement is July 21, 2011 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.

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

Late applications:

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

4. Intergovernmental Review

The ACA Maternal, Infant, and Early Childhood Home Visiting Program is subject to the provisions of Executive Order 12372, as implemented by 45 CFR 100. Executive Order 12372 allows States the option of setting up a system for reviewing applications from within their States

for assistance under certain Federal programs. Application packages made available under this funding opportunity will contain a listing of States which have chosen to set up such a review system, and will provide a State Single Point of Contact (SPOC) for the review. Information on states affected by this program and State Points of Contact may also be obtained from the Grants Management Officer 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 Tribal Groups should contact their SPOC as early as possible to alert them to the prospective applications and receive any necessary instructions on the State process used under this Executive Order.

Letters from the State Single Point of Contact (SPOC) in response to Executive Order 12372 are due sixty days after the application due date.

5. Funding Restrictions

Applications with budget requests exceeding the state's specified ceiling in Appendix G will be deemed non-responsive and will not be considered for funding. These applications may be returned without further review.

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 Number 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 validated electronic submission prior to the application due date as the final and only acceptable submission of any competing application submitted to Grants.gov.

Tracking your application: It is incumbent on the applicant to track application by using the Grants.gov tracking number (GRANTXXXXXXXX) provided in the confirmation email from Grants.gov. More information about tracking your application can be found at <http://www07.grants.gov/applicants/resources.jsp>. Be sure your application is validated by Grants.gov prior to the application deadline.

V. Application Review Information

1. Review and Selection Process

This is a formula-based grant program. The FY 2010 funds will be distributed to states using a formula determined by:

- 1) A base allocation of \$1,000,000 for each state;
- 2) An amount based on the number of children under age five (5) in families at or below 100% of the Federal poverty line in the state as compared to the number of such children nationally; in no case will a state or jurisdiction receive less than 120% of the amount received by formula in FY 2010; and
- 3) An amount equal to the funds, if any, currently provided to a state (or entity within that state) to implement one of the projects formerly known as the Supporting Evidence Based Home Visiting (EBHV) Program administered by ACF's Children's Bureau of the Administration for Children and Families; and, 3) an amount based on the number of children in families at or below 100% of the Federal poverty level in the state as compared to the number of such children nationally. A table of the estimated amount of award for each state is included as Appendix G.

All applications will be reviewed internally by grants management officials (business and financial review) and program staff (technical review) for eligibility, completeness, accuracy, and compliance with the requirements outlined in this announcement. The program review will include the state's response to items in the Program Narrative section (IV.2.ix through xii) above:

- The organizational capacity and commitment of the entity designated by the Governor to administer an evidence-based home visiting program under the ACA Maternal, Infant, and Early Childhood Home Visiting Program.

- The clarity and feasibility of the state's implementation plan, needs and capacity assessment and the degree to which strategies and methods comply with the specific requirements for an application under this funding opportunity announcement, as outlined above and in accordance with section 511(b) of Title V, as amended by the ACA.
- The clarity of the state's plan for ensuring coordination and collaboration among entities and stakeholders.
- The clarity of the state's plan for the collection of the benchmark data.
- The clarity of the state's plan for continuous quality improvement.
- The clarity of the state's description of anticipated technical assistance needs.

2. Anticipated Announcement and Award Dates

It is anticipated that awards will be announced prior to September 30, 2011.

VI. Award Administration Information

1. Award Notices

Applicants who are selected for funding may be required to respond in a satisfactory manner to Conditions placed on their application before funding can proceed. Letters of notification do not provide authorization to begin performance.

The Notice of Award sets forth the amount of funds granted, the terms and conditions of the award, the effective date of the award, the budget period for which initial support will be given, the non-Federal share to be provided (if applicable), and the total project period for which support is contemplated. Signed by the Grants Management Officer, it is sent to the applicant's Authorized Organization Representative, and reflects the only authorizing document. It will be sent prior to the start date of September 30, 2011.

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).

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://www.omhrc.gov/CLAS>. 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>.

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.

PUBLIC POLICY ISSUANCE

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/nap/nhas>

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.

3. Reporting

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 state should include assurances that the state will comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the program. States will be notified in advance of the specific due dates and formatting requirements for submitting this report. This report shall address the following:

State Home Visiting Program Goals and Objectives

(1) Progress made under each goal and objective during the reporting period, including any barriers to progress that have been encountered and strategies/steps taken to overcome them;

(2) Any updates/revisions to goal(s) and objectives previously identified; and

- (3) To the extent not articulated above, a brief summary regarding the state's efforts to contribute to a comprehensive high-quality early childhood system, using the logic model provided. Identify updates or changes to logic model, if necessary.

State Home Visiting Promising Program Update

- (1) Updates on the grantee's evaluation of any implemented promising programs;
- (2) If applicable, copies of reports developed in the course of the local evaluation of promising programs and any other evaluation of the overall home visiting program undertaken by the grantee.

Implementation of Home Visiting Program in Targeted At-risk Communities

Updates regarding experience in planning and implementing the home visiting programs selected for each community of need, addressing each of the items listed below. Where applicable, states may discuss any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges.

- An update on the state's progress for engaging the at-risk community(ies) around the proposed plan;
- Update on work-to-date with national model developer(s) and a description of the technical assistance and support provided to-date through the national model(s);
- Based on the timeline provided, an update on securing curriculum and other materials needed for the home visiting program;
- Update on training and professional development activities obtained from the national model developer, or provided by the state or the implementing local agencies;
- Update on staff recruitment, hiring, and retention for all positions including subcontracts;
- Update on participant recruitment and retention efforts;
- Status of home visiting program caseload within each at-risk community;
- Update on the coordination between home visiting program(s) and other existing programs and resources in those communities (e.g., health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services); and
- A discussion of anticipated challenges to maintaining quality and fidelity of each home visiting program, and the proposed response to the issues identified.

Progress toward Meeting Legislatively Mandated Benchmarks

Update on data collection efforts for each of the six benchmark areas, which would include an update on data collected on all constructs within each benchmark area including definitions of what constitutes improvement, sources of data for each measure utilized, barriers/challenges encountered during data collection efforts, and steps taken to overcome them.

Home Visiting Program's CQI Efforts

Update on the state's efforts regarding planning and implementing CQI for the home visiting program. If applicable, copies of CQI reports developed addressing opportunities, changes implemented, data collected, and results obtained.

Administration of State Home Visiting Program

- (1) Updated organization chart, if applicable;
- (2) Updates regarding changes to key personnel,¹¹ if any (include resumes for new staff, if applicable);
- (3) An update on the state's efforts to meet the following legislative requirements, including a discussion of any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges:

- Training efforts to ensure well-trained, competent staff;
- Steps taken to ensure high-quality supervision;
- Steps taken to ensure referral and services networks to support the home visiting program and the families it serves in at-risk communities; and
- Updates on new policy(ies) created by the state to support home visiting programs.

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

d. Transparency Act Reporting Requirements

New awards ("Type 1") issued 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

¹¹ Changes in key personnel require prior approval by HHS.

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 grant announcement by contacting:

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

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

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
10-64
Rockville MD 20857
Email: ayowell@hrsa.gov

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

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

VIII. Other Information

For additional information, please refer to Appendices A through J.

PUBLIC BURDEN STATEMENT:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0340. Public reporting burden for this collection of information is estimated to average 96 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, MD 20857.

IX. Tips for Writing a Strong Application

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

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

APPENDIX A: MODELS THAT MEET THE CRITERIA FOR EVIDENCE BASE

This appendix lists the models that meet the criteria for evidence of effectiveness for the MIECHV program. HHS intends to continue to review the available evidence of effectiveness for other home visiting models. In prioritizing models for review, HHS will use the criteria described on the HomVEE website (<http://homvee.acf.hhs.gov/>) and will also take into consideration state requests. HHS will re-review models previously determined not to meet the evidence criteria, if the application of the HHS criteria for evidence of effectiveness included errors, if requested to do so by a state, model developer, researcher, or others.

All states will be notified if any additional models are identified that meet the HHS criteria for evidence of effectiveness.

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

(Note: Models are listed alphabetically)

Early Head Start (EHS) – Home-Based Option

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

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

Family Check-Up

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

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

Healthy Families America (HFA)

Population served: Healthy Families America (HFA) is designed for parents facing challenges such as single parenthood, low income, childhood history of abuse, substance abuse, mental health issues, and/or domestic violence. Individual programs select the specific characteristics of the target population they plan to serve. Families must be enrolled prenatally or within the first

three months after a child's birth. Once enrolled, services are provided to families until the child enters kindergarten.

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

Healthy Steps

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

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

Home Instruction for Parents of Preschool Youngsters (HIPPY)

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

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

Nurse-Family Partnership (NFP)

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

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

Parents as Teachers (PAT)

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

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

APPENDIX B: EXPECTATIONS FOR PROMISING APPROACHES AND OTHER RESEARCH AND EVALUATION ACTIVITIES

HRSA and ACF expect that all evaluation activities funded under the MIECHV program will contribute to developing a knowledge base around successful strategies for the effectiveness, implementation, adoption and sustainability of evidence-based home visiting programs. The legislation does not require that states conduct implementation or impact evaluation other than research on promising approaches.¹²

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

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

Furthermore, HRSA and ACF are especially interested in the use of evaluation strategies that emphasize the use of research to help guide program planning and implementation (e.g., participatory or empowerment evaluation).¹³ To support the state's evaluation efforts around promising programs, states must allocate an appropriate level of funds for a rigorous evaluation in all years of the grant.

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

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

¹² States provided assurances in the initial Funding Opportunity Announcement about participation in any national evaluation activities. It is the Secretary's intent to fund and carry out the national evaluation. However, HRSA and ACF would not prohibit a State from conducting research and evaluation outside of the national evaluation and other ongoing Federal research.

¹³ Participatory evaluation engages stakeholders in the development, implementation, and interpretation of evaluation results to maximize the usefulness of the results for stakeholders. Empowerment evaluation supports stakeholders to learn the tools on conducting effective evaluation to foster inquiry and self-evaluation or installation of continuous quality improvement.

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

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

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

The application should provide a narrative addressing how the evaluation of the promising approach will be conducted. The application should address the proposed evaluation methods, measurement, data collection, sample and sampling (if appropriate), timeline for activities, plan for securing IRB review, and analysis. It should also identify the evaluator, cost of the evaluation, and the source of funds. If the research is measuring the impact of the promising or new home visiting model on participant outcomes, an appropriate comparison condition should be utilized. The plan should also include a logic model or conceptual framework that shows the linkages between the proposed planning and implementation activities and the outcomes that these are designed to achieve. For assistance in developing a logic model, see <http://toolkit.childwelfare.gov/toolkit/>. HHS has already initiated a contract for the provision of technical assistance for evaluation of promising programs and will be providing information about the technical assistance available to states.

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

Additional assistance may be found in a document titled "Program Manager's Guide to Evaluation." A copy of this document can be accessed at: http://www.acf.hhs.gov/programs/opre/other_resrch/pm_guide_eval/reports/pmguide/pmguide_toc.html.

APPENDIX C: SPECIFIC GUIDANCE REGARDING INDIVIDUAL BENCHMARK AREAS

States will be required to report to the Secretary data on all benchmark areas in a format to be specified at a later date. At this time states are required to collect data on all constructs listed below each benchmark area. It should be noted that one benchmark requires collection of data for “reduction in crime or domestic violence.” Given this language, states are not required to report on both domains, but may elect one or the other. For all other benchmark areas, the states must collect data for all benchmark areas and for all constructs listed under each benchmark area. States may choose to collect data for additional constructs within a benchmark area or in additional areas in which the state is interested. In order to capture quantifiable, measurable improvement, grantees must collect, at a minimum, data for each benchmark area and construct when the family is enrolled in the program and at one year post-program enrollment.

Technical assistance related to the benchmark requirement will be available to the state during the process of preparing for and submitting the plan as well as during the implementation of the program. Requests for technical assistance should be made to the state’s Project Officer, identified in Appendix D.

I. Improved Maternal and Newborn Health

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

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

B. Definition of quantifiable, measurable improvement:

- For prenatal care, preconception care, inter-birth intervals, screening of maternal depression, breastfeeding, adequacy of well-child visits, and health insurance coverage, improvement is defined as changes over time for mothers and infants;
- For pre- and post-natal parental use of alcohol, tobacco, or illicit drugs improvement is defined as rate decreases over time.

C. Sources of data:

- Data can be collected from interviews and surveys with families or through administrative data, if available, at the individual and family level.
- Maternal and Child Health Bureau National Performance Measures-
<https://perfdata.hrsa.gov/MCHB/TVISReports/MeasurementData/MeasurementDataMenu.aspx>
- For more information, see *Healthy People 2020* at <http://www.healthypeople.gov/hp2020>.

D. Format to report data

- Depending on the measure used and the grantee's plan for data utilization, the format of the data should include rates for each relevant construct. For example, the percentage of children birth to age five in families participating in the program who receive the recommended schedule of well-child visits; the percentage of mothers enrolled in the program prenatally who breastfeed their infants at six months of age.

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

A. Constructs that must be reported for this benchmark area (all constructs must be measured):

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

B. Definition of quantifiable, measurable improvement:

- Decreases over time for identified constructs other than information provided or training on preventing child injuries, for which increases are considered improvement.

C. Specifying source of data:

- For reductions in emergency department visits and child injury prevention: Data can be collected through participant report, medical records, emergency department patient records or hospital discharge systems. Injury-related medical treatment includes ambulatory care, emergency department visits, and hospitalizations due to injury or ingestions.
- For child abuse, neglect and maltreatment: It is preferred that data be collected through administrative data provided by the state and local child welfare agencies. Grantees may propose collecting the data through self-report or direct measurement if it utilizes a valid and reliable tool.

For more information see:

- List of the state contacts for National Child Abuse and Neglect Data System collection are available at: <http://www.acf.hhs.gov/programs/cb/pubs/cm09/cm09.pdf#page=150>
- Child Maltreatment: <http://www.acf.hhs.gov/programs/cb/pubs/cm09/>
- National Data Archive on Child Abuse and Neglect (NDACAN): <http://www.ndacan.cornell.edu>.
- Centers for Disease Control Injury Prevention: http://apps.nccd.cdc.gov/NCIPC_SII/Default/Default.aspx?pid=2
- National Health Survey: <http://www.cdc.gov/nchs/nhis.htm>
- Children's Safety Network and Child Death Review Resource Center's Best Practices website: <http://www.childinjuryprevention.org>
- State Injury Prevention Profiles; <http://www.childrenssafetynetwork.org/stateprofiles/state.asp>

D. Format to report data:

- For reductions in emergency department visits: The data format should include emergency department visits divided by the number of children or mothers enrolled in the program.
- For child injuries training or information: The construct can be reported as the percentage of participants who receive information or training on injury prevention by the total number of families participating in the program.
- For reduction of incidence of child injuries: The construct should be reported as the rate of child injuries requiring medical treatment (i.e., ambulatory care, emergency department visits or hospitalizations) for children participating in the program.
- For child abuse, neglect and maltreatment: Each construct can be reported as a rate for children prior to kindergarten entry participating in the program.

- The rate for **suspected maltreatment** is the number of cases of suspected maltreatment of children in the program, divided by the number of children in the program.
- The rate for **substantiated maltreatment** would be calculated by counting the number of cases of substantiated maltreatment of children in the program and dividing by the number of children in the program.
- To calculate the rate of **first-time victims**: Count the number of children in the program who are first-time victims divided by the number of children in the program. A first time victim is defined as a child who:
 - had a maltreatment disposition of “victim” and
 - never had a prior disposition of victim
- Data should be reported overall for a program and also should be broken down for each construct by:
 - Age category (0-12 months, 13-36 months, and 37-84 months, as appropriate given population served by the home visiting program)
 - For child abuse, neglect or maltreatment only: maltreatment type (i.e., neglect, physical abuse, sexual abuse, emotional maltreatment, other)

III. Improvements in School Readiness and Achievement.

A. Constructs that must be reported for this benchmark area (all constructs must be measured):

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

For more information see:

- http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/index.html

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

B. Definition of quantifiable, measurable improvement:

- Increases over time in the developmental progress of children between entry to the program and one year after enrollment.

C. Specifying source of data:

- Data can be collected from a variety of sources including observation (e.g., teacher or other independent observer), direct assessment, administrative data or health records (e.g. program-specific clinical information systems), parent-report, teacher-report or samples of children's work. The grantee must collect and report data from the source appropriate to the method and measurement of the construct proposed.

D. Format to report data:

- Depending on the measure used and the grantee plan for using the data, the data reported should be either one or both of the following:
 - Scale scores. When they are available, scores should be the calculated score for individual scales in the measure. Individual item-level data should not be reported. The scale scores should be calculated as instructed in the manual or other documentation provided by the measure developer; and,
 - Rates of children in a particular risk category (e.g., rates of children at risk for language delay).

The following are some suggested ideas or sources for measures within the area of "Improvements in School Readiness and Achievement:"

- http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_title.html
- Maternal and Child Health Bureau National Performance Measures-
<https://perfdata.hrsa.gov/MCHB/TVISReports/MeasurementData/MeasurementDataMenu.aspx>
- <http://casel.org/publications/compendium-of-sel-assessment-tools/>
- <http://journal.naeyc.org/btj/200401/Maxwell.pdf>
- <http://www.earlylearning.ubc.ca/research/initiatives/early-development-instrument/>

IV. Crime or Domestic Violence

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

Crime

A. If the grantee chooses to report crime, constructs that must be reported for this benchmark area (all constructs must be measured) for caregivers served by the home visiting program:

- Arrests
- Convictions

B. Definition of quantifiable, measurable improvement:

- For family-level crime rates, improvement shall be defined as rate decreases over time in the identified constructs.

C. Sources of data:

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

D. Format to report data:

- Data can be reported as annual aggregate rates for parents participating in the program. Data should be reported broken down by reason for the arrest or conviction.

Domestic Violence

A. If the grantee chooses to report on domestic violence, constructs that must be reported for this benchmark area (all constructs must be measured) include:

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

B. Definition of quantifiable, measurable improvement:

- For screenings, improvement shall be defined as increases in the rate compared to the population served completed over time.
- For referrals and completion of safety plans related to domestic violence, improvement shall be defined as an increase over time.

C. Sources of data:

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

For more information see:

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

D. Format to report data:

- Depending on the measure used for each construct and the grantee plan for using the data, the data reported should be either one or both of the following:
 - Percentage of screenings for domestic violence of program participants.
 - Referrals and safety plans should be reported as a rate of appropriate services identified and referrals and safety plans made by the total number of identified participants in need of these services.

V. Family Economic Self-Sufficiency.

A. Constructs that must be reported for this benchmark area (all constructs must be measured):

- Household income and benefits
 - Household shall be defined as all those living in a home (who stay there at least 4 nights a week on average) who contribute to the support of the child or pregnant woman linked to the HV program. Tenants/boarders shall not be counted as members of the household
 - Income and benefits shall be defined as earnings from work, plus other sources of cash support. These sources may be private (i.e., rent from tenants/boarders, cash assistance from friends or relatives), or they may be linked to public systems (i.e. child support payments, TANF, Social Security (SSI/SSDI/OAI), and Unemployment Insurance).
- Employment or Education of adult members of the household
- Health insurance status

B. Definition of quantifiable, measurable improvement:

- For household income, improvement shall be defined as an increase in total household income and benefits over time.
- Note that the second construct above refers to employment *or* education. We recognize that there can be an inverse relationship between the two in the short-run, i.e., while

people are pursuing education, they may reduce their participation in the labor force, and vice versa. Therefore, while sites should measure both constructs, improvement in one or the other shall be considered sufficient to show positive results for this construct.

- For employment, improvement shall be defined as an increase in the number of paid hours worked plus unpaid hours devoted to care of an infant by all adults in participating households over time.
- For education, improvement shall be defined as an increase in the educational attainment of adults in participating households over time. Educational attainment shall be defined by the completion not only of academic degrees, but also of training and certification programs.
- For health insurance status, improvement shall be defined as an increase in the number of household members who have health insurance over time.

C. Specifying source of data:

- Data can come from interviews or surveys with families. Data on child support and public benefit receipt may be able to be gathered or verified from the relevant agencies, if data-sharing agreements can be developed. For employment, family-level data may also be gathered or verified using Unemployment Insurance data.

D. Format to report data:

- For the purposes of Federal reporting, family economic self-sufficiency data should be collected for the month of enrollment and the month one-year post enrollment.
 - a. Household income and benefits, specifying each source of income or benefits and the amount gathered from each source;
 - b. Number of adult household members employed during the month, and average hours per month worked by each adult household member
 - c. Educational benchmarks achieved (e.g., program completion, degree attainment) by each adult household member, number of adult household members participating in educational activities since the previous survey, and hours per month spent by each adult household member in educational programs; and,
 - d. Health insurance status of all household members.

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

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

- Evaluation Data Coordination Project
http://www.acf.hhs.gov/programs/opre/other_resrch/eval_data/index.html
- Maternal and Child Health Bureau National Performance Measures-
<https://perfdata.hrsa.gov/MCHB/TVISReports/MeasurementData/MeasurementDataMenu.aspx>

VI. Coordination and Referrals for Other Community Resources and Supports

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

A. Constructs that must be reported for this benchmark area (all constructs must be measured):

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

B. Definition of quantifiable, measurable improvement:

- Increase in the proportion of families screened for needs, particularly those relevant for affecting participant outcomes.
- Increase in the proportion of families identified with a need who receive an appropriate referral, when there are services available in the communities.
- MOU: Increase in the number of formal agreements with other social service agencies.
- Information sharing: Increase in the number of social service agencies that engage in regular communication with the home visiting provider.
- Number of completed referrals: Increase in the percentage of families with referrals for which receipt of services can be confirmed.

C. Specifying source of data:

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

The Secretary of HHS will provide technical assistance specifically around measuring this domain.

D. Format to report data:

- Number of screenings and number of referrals provided divided by the total number of participating families.
- Total number of social service agencies with an MOU and/or regular communication.
- Proportion of referrals of participating families with identified needs whose receipt of service was verified divided by the total number of participating families with identified needs.

APPENDIX D: MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM - REGIONAL PROJECT OFFICERS

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APPENDIX E: GLOSSARY

Adaptation	In some cases, the state may wish to adapt an existing model that has been identified as evidence-based in order to meet the needs of targeted at-risk communities. For the purposes of the MIECHV, an acceptable adaptation of an evidence-based model includes changes to the model that have not been tested with rigorous impact research but are determined by the model developer <i>not to alter the core components related to program impacts</i> . Literature around adaptation of evidence-based programs consistently recommends that implementing agencies should discuss proposed adaptations with the program developers prior to implementation to ensure that changes do not alter core components. Changes to an evidence-based model that alter the core elements related to program outcomes undermine the program’s effectiveness. Such changes (otherwise known as “drift”) will not be allowed under the funding allocated for evidence-based models.
Administration for Children and Families	The Administration for Children and Families (ACF), within the Department of Health and Human Services (HHS) is responsible for Federal programs that promote the economic and social well-being of families, children, individuals, and communities.
Aggregate Data	Data combined from multiple measures and/or across multiple subjects.
At-Risk Community	A community with concentrations of: premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school dropouts; substance abuse; unemployment; or child maltreatment. <i>See Section 511 (b)(1)(A).</i>
Baseline Data	Basic information collected to establish and understand the existing conditions. It is used later to provide a comparison for assessing program impact
Benchmark Data	Data collected for the purposes of measuring progress towards an intended goal.
Community Involvement	A state’s effort to establish two-way communication with the public to create understanding of the MIECHV program and related actions, to ensure public input into decision-making processes related to affected communities, and to make certain that the state is aware of and responsive to public concerns. Adapted from the Environmental Protection Agency’s definition of ‘community involvement.’ http://www.epa.gov/waste/hazard/correctiveaction/training/key_terms.htm .

Continuous Quality Improvement (CQI)	A systematic approach to improving processes and outcomes through regular data collection, examination of performance relative to pre-determined targets, review of practices that promote or impede improvement, and application of changes in practices that may lead to improvements in performance.
Early Childhood System	An integrated early childhood service system that address the critical components of access to comprehensive health services and medical homes, social-emotional development and mental health of young children, early care and education, parenting education, and family support. http://eccs.hrsa.gov/About/index.htm
Enrollment	A family is to be considered enrolled in a home visiting program as of the date of the first home visit.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	A program for Medicaid beneficiaries under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf)
Federal Education Rights and Privacy Act (FERPA)	A Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. See http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html .
Health Resources and Services Administration (HRSA)	An agency of the U.S. Department of Health and Human Services, the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.
High- or Moderate-Quality Study Design	In order to meet criteria for evidence of effectiveness, a home visiting model must have been (1) evaluated using rigorous methodology and (2) shown to have a positive impact on outcomes. With respect to determining the quality of the methodology of a research study, there are a number of variables that should be considered in order to ensure the highest probability that the study will produce unbiased estimates of program impacts. These variables include study design (i.e., randomized controlled trial [RCT] or quasi-experimental design [QED]), level of attrition, baseline equivalence, reassignment of participants from one condition to another in the trial, and confounding factors. Two types of impact study designs have the potential to be both well designed and rigorous: randomized controlled trials and quasi-experimental designs. A randomized controlled trial is defined as a study design in which sample members are assigned to the program and comparison groups by chance. A quasi-experimental design is defined as a study design in which sample members are

selected for the program and comparison groups in a nonrandom way.

An impact study is considered high-, moderate- or low-quality depending on the study's capacity to provide unbiased estimates of program impact. Studies that are rated "high" and "moderate", therefore, meet requirements to be considered "well-designed, rigorous impact research." In brief, the high rating is reserved for random assignment studies with low attrition of sample members and no reassignment of sample members after the original random assignment or regression discontinuity or single case designs that meet WWC design standards (http://ies.ed.gov/ncee/wwc/pdf/wwc_rd.pdf). The moderate rating applies to random assignment studies that, due to flaws in the study design or execution (for example, high sample attrition), do not meet all the criteria for the high rating; and to studies that use a matched comparison group design; or a regression discontinuity design or a single case design that meets the WWC design standards with reservations. Studies that do not meet all the criteria for either high or moderate quality are considered low quality studies. More detailed information about study design quality is available at: <http://homvee.acf.hhs.gov/>.

**Health Insurance
Portability and
Accountability Act
(HIPAA), Privacy
Rule**

The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.
<http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html>

**Home Visiting
Evidence of
Effectiveness Review
(HomVEE) Study**

The Office of Planning, Research and Evaluation, Administration for Child and Families (OPRE/ACF) launched Home Visiting Evidence of Effectiveness (HomVEE) to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting programs that target families with pregnant women and children ages birth to five. To carry out the HomVEE review, Mathematica Policy Research conducted a thorough search of the research literature on home visiting, issued a call for studies to identify additional research, reviewed the literature, assessed the quality of research studies, and evaluated the strength of evidence for specific home visiting program models.

Home Visiting Models

For the purposes of the MIECHV, *home visiting models* are defined as programs or initiatives in which home visiting is a primary service

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

Infants

Children less than one year of age not included in any other class of individuals. (Title V glossary
<ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf>)

Institutional Review Board

An *institutional review board (IRB)* is “a specially constituted review body established or designated by an entity to protect the welfare of human subjects recruited to participate in biomedical or behavioral research.” See http://www.hhs.gov/ohrp/archive/irb/irb_glossary.htm

Key Positions

Any position that is vital to the planning, implementation, administration, and evaluation of the home visiting program.

Legislatively Mandated Benchmarks

The *Legislatively Mandated Benchmarks* for the MIECHV program include: improved maternal and newborn health; prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports. See *Section 511 (d) (1)(A)*.

Legislatively Mandated Outcomes

The *Legislatively Mandated Outcomes* refer to the “improvements in outcomes for individual families.” These outcomes include: (i) improvements in prenatal, maternal, and new born health, including improved pregnancy outcomes; (ii) improvements in child health and development, including the prevention of child injuries and maltreatment and improvements in cognitive, language, social-emotional, and physical developmental indicators; (iii) improvement in parenting skills; (iv) improvements in school readiness and child academic achievement; (v) reduction in crime or domestic violence; (vi) improvements in family economic self-sufficiency; (vii) improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with state child welfare agency training. See *Section 511 (d) (2)(B)*.

Life Course Development

Life course development points to broad social, economic, and environmental factors as contributors to poor and favorable health and

development outcomes for children, as well as to persistent inequalities in the health and well-being of children and families.

Logic Model

A map or simple illustration of what you do, why you do it, what you hope to achieve, and how you will measure achievement. It includes the anticipated outcomes of your services, indicators of those outcomes, and measurement tools to evaluate the outcomes.

<http://toolkit.childwelfare.gov/toolkit/> and

<http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic-Model-Development-Guide.aspx>

Low Income

An individual or family with an income determined to be below the official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [Title V, Sec. 501 (b)(2)]

Memorandum of Concurrence

This requirement is made to ensure agreement among state agencies on the proposed plan for a State Home Visiting Program. The purpose is to demonstrate that these agencies are committed to collaboration and are in agreement with implementation of the program, as well as to ensure that home visiting is part of a continuum of early childhood services within the state.

Patient Protection and Affordable Care Act of 2010

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

Performance Management

The systematic process by which an agency involves its employees, as individuals and members of a group, in improving organizational effectiveness in the accomplishment of agency mission and goals.

http://www.opm.gov/hcaaf_resource_center/assets/Ropc_tool3.pdf

A performance management system continuously uses: 1) performance standards, 2) performance measures, 3) documents and reports to show the progress in meeting standards and targets while providing feedback, and 4) maintains a program of quality improvement to manage change.

http://www.turningpointprogram.org/toolkit/pdf/Silos_to_Systems.pdf

Perinatal	Period from gestation of 28 weeks or more to seven days or less after birth. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf)
Reflective Practice	Reflective practice is “the process of continuous learning through thoughtful examination of one’s work.” From Mentoring, Coaching, and Reflective Practice: An Annotated Resource List http://nitcci.nccic.acf.hhs.gov/resources/final_resources_for_mentorin_g.pdf .
Reliability of Measurement	Consistency of a measure to capture the intended construct (e.g., a person answering the questionnaire will most likely answer in a similar way both today and tomorrow). It is most frequently quantified through inter-rater reliability, test-retest reliability or internal consistency.
Risk Factors	Scientifically established direct causes of, and contributors to, negative outcomes for a specific population, such as maltreatment, juvenile delinquency, morbidity and/or mortality. Changes in behavior or physiological conditions are the indicators of achievement of risk factor targets. Risk factor reduction tends to be considered an intermediate, rather than a final, outcome.
Sampling	Selecting a group of participants that are representative of the population to which the data is intended to generalize. Sampling is used in instances where it is not feasible or appropriate to measure every single member of a specific population.
Socio-Ecological Perspective	Emphasizes that children develop within families, families exist within a community, and the community is surrounded by the larger society. This perspective reflects the understanding that development is a process involving transactions between the growing child and the social environment or ecology in which development takes place and considers the complex interplay between individual, family, community, and societal factors.

Statewide Needs Assessment

In completing the FY 2010 Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program application, states were required to complete three steps, the second of which was submission of a statewide needs assessment as a condition for receiving FY 2011 Title V Block Grant allotments. The needs assessment included an identification of communities with concentrations of premature birth, low-birth-weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health, poverty, crime, domestic violence, high rates of high-school drop-outs, substance abuse, unemployment, or child maltreatment, identification of the quality and capacity of existing programs or initiatives for early childhood home visiting in the state, and a discussion of the state's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

Technical Assistance

The process of providing grant recipients with expert assistance to build their capacity to fully meet the requirements of and successfully implement the program. Technical assistance may be provided by federal staff or contract providers and may include training, research, peer learning, and consultation on the federal requirements which include a broad range of topics regarding health and human services and program administration and evaluation.

Title V

The authorizing legislation for the Maternal and Child Health Block Grant to states, which is found in Title V of the Social Security Act. (Title V glossary
<ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf>)

Updated State Plan

In completing the FY 2010 Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program application, states were required to complete three steps, the third of which is submission of an Updated State Plan for a State Home Visiting Program. The Updated State Plan includes identification of the at-risk community(ies) where home visiting services are to be provided, a detailed assessment of the particular needs of that community(ies) in terms of risk factors and existing services, identification of home visiting services proposed to be implemented to meet identified needs in that community(ies), a description of the state and local infrastructure available to support the program, specification of any additional infrastructure support necessary to achieve program success, and a plan for collecting benchmark data, conducting continuous quality improvement, and performing any required research or evaluation.

APPENDIX F: AUDITS

Section 2951 of the Affordable Care Act amends Title V of the Social Security Act by adding Section 511: the Maternal, Infant, and Early Childhood Home Visiting Program ('the Home Visiting program'). Several existing provisions of Title V are made applicable to grants made under the Home Visiting program, including Section 506, which authorizes the Secretary to require states to submit reports and audits. As stated in Section 511(i)(2)(D), Section 506 is applicable to grants made under the Home Visiting program, "to the extent determined by the Secretary to be appropriate...."

Accordingly, as authorized by Section 506(b)(1):

Each state shall, not less often than once every two years, audit its expenditures from amounts received under this title. Such state audits shall be conducted by an entity independent of the state agency administering a program funded under this title in accordance with the Comptroller General's standards for auditing governmental organizations, programs, activities, and functions and generally accepted auditing standards. Within 30 days following the completion of each audit report, the state shall submit a copy of that audit report to the Secretary.

For the purposes of the Home Visiting program, ***the audit shall include the amount of the state's Maintenance of Effort amount (baseline established as of March 23, 2010)***. If an audit reveals that a state has not adhered to the maintenance of effort requirement, the following penalties under Section 506(b)(2)-(3) shall apply:

- (2) Each state shall repay to the United States amounts found by the Secretary, after notice and opportunity for a hearing to the state, not to have been expended in accordance with this title and, if such repayment is not made, the Secretary may offset such amounts against the amount of any allotment to which the state is or may become entitled under this title or may otherwise recover such amounts.
- (3) The Secretary may, after notice and opportunity for a hearing, withhold payment of funds to any state which is not using its allotment under this title in accordance with this title. The Secretary may withhold such funds until the Secretary finds that the reason for the withholding has been removed and there is reasonable assurance that it will not recur.

APPENDIX G: TABLE OF THE ESTIMATED AMOUNT OF FORMULA-BASED AWARDS

Alabama	\$1,976,665	Nevada	\$1,136,889
Alaska	\$1,000,000	New Hampshire	\$1,000,000
Arizona	\$2,631,887	New Jersey ²	\$2,574,098
Arkansas	\$1,534,677	New Mexico	\$1,228,531
California ³	\$11,510,679	New York ²	\$5,604,010
Colorado ²	\$2,290,650	North Carolina	\$3,209,123
Connecticut	\$1,026,087	North Dakota	\$1,000,000
Delaware ³	\$1,673,000	Ohio ²	\$4,252,919
District of Columbia	\$1,000,000	Oklahoma ²	\$2,340,796
Florida	\$4,964,887	Oregon	\$1,407,493
Georgia	\$3,635,264	Pennsylvania	\$3,010,846
Hawaii ²	\$1,673,000	Rhode Island ²	\$1,673,000
Idaho	\$1,000,000	South Carolina ²	\$2,589,218
Illinois ²	\$4,296,218	South Dakota	\$1,000,000
Indiana	\$2,218,380	Tennessee ³	\$3,812,421
Iowa	\$1,140,642	Texas ²	\$10,483,330
Kansas	\$1,172,802	Utah ²	\$1,770,713
Kentucky	\$1,905,970	Vermont	\$1,000,000
Louisiana	\$2,082,723	Virginia	\$1,940,266
Maine	\$1,000,000	Washington	\$1,819,698
Maryland	\$1,336,085	West Virginia	\$1,060,259
Massachusetts	\$1,463,681	Wisconsin	\$1,600,310
Michigan	\$3,013,935	Wyoming	\$1,000,000
Minnesota ²	\$2,049,101	American Samoa	\$1,000,000
Mississippi	\$1,769,606	Guam	\$1,000,000
Missouri	\$2,120,142	No. Mariana Islands	\$1,000,000
Montana	\$1,000,000	Puerto Rico	\$1,000,000
Nebraska	\$1,000,000	Virgin Islands	\$1,000,000
		Total Awards	\$125,000,000

¹ U. S. Census Bureau, Small Area Income and Poverty Estimates, Estimates for The United States 2008, 2009, Under age 5 in poverty, 2008, 2009 <http://www.census.gov/cgi-bin/saie/national.cgi?year=2009&ascii=>

² Includes \$673,000 for one EBHV Program grantee site

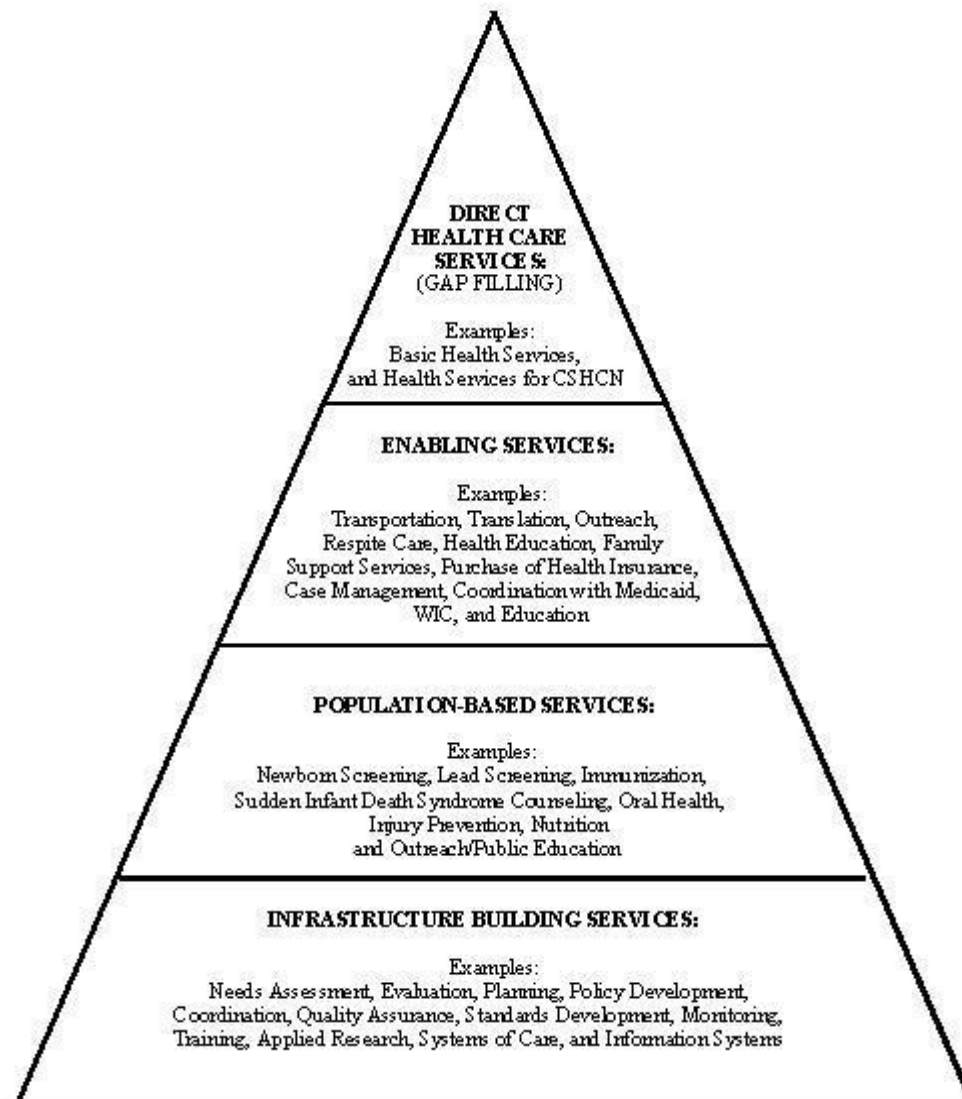
³ Includes \$1,346,000 for two EBHV Program grantee sites

APPENDIX H: DESIGN OPTIONS FOR HOME VISITING EVALUATION (DOHVE) COMPENDIUM OF MEASURES

The Design Options for Home Visiting Evaluation (DOHVE) Compendium of Measures for MIECHV Grantees is available for review and use and can be found at the MDRC website at the following link: http://www.mdrc.org/project_12_104.html. The 53-page compendium was generated by conducting a scan of the literature on home visiting and compiling a list of measures commonly used to assess maternal, child and family outcomes in home visiting models. A list of domains, sub-domains, the respective measures and their description as derived from eight compendia are presented in table format. While measures are listed according to the domain that best fits the intended use of the measure, some measures may fit under multiple domains. This list is not exhaustive. Web links are provided to obtain additional information about the assessments, some of which are links to publisher websites. These links are not an endorsement of the publishers, but a resource to obtain additional information. The domains include: Family (Family Functioning), Caregiver (Caregiver Physical Health, Domestic Violence, Caregiver Mental Health, Caregiver Alcohol and Substance Use, Social Support, Parenting, Parenting Stress, Parental Knowledge, and Relationship between Caregivers), Child (Child Physical Health, Child Behavior, Child Development, Child Development, Child Safety, Child Well-Being).

APPENDIX I: MATERNAL AND CHILD HEALTH PYRAMID

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



APPENDIX J: PROPOSAL FOR REVIEW OR RE-REVIEW OF A HOME VISITING MODEL BELIEVED TO MEET THE EVIDENCE CRITERIA

In the response to the Federal Register Notice issued on July 23, 2010, comments were received suggesting that there be a process by which states can request that a program that is not on the list of evidence-based programs on the HomVEE site be reviewed – or re-reviewed in the case of models that were reviewed but were not found to meet the evidence criteria. We agree with these comments and have created a process by which a state can request that a model that was not reviewed by HomVEE be reviewed to determine if it meets the evidence criteria. In addition, we have created a process by which a state or other stakeholders can request that a program model that was reviewed but which was determined not to meet the evidence criteria be re-reviewed by a second set of independent researchers. Both processes, which will be conducted on an ongoing basis throughout the MIECHV program, are described below.

(a) Requesting Review of a Program Model Not Reviewed by HomVEE

The systematic review conducted by HomVEE could not include all potential home visiting models in the time allotted. It is possible that there are home visiting models other than those identified as evidence-based by HomVEE (see Appendix B) that meet the HHS criteria for evidence of effectiveness.

If a state would like to propose using a home visiting model that was not reviewed by HomVEE, **the state must submit a proposal for selecting this alternative model¹⁴ to the HRSA Project Officer.**

The proposal must include the following information:

- Provide the name of the model (and any other known previous names of the model);
- Identify any affiliated organizations and researchers of the model;
- Provide copies of reports or journal articles for any known research on the model; and
- Discuss how the proposed model meets the legislative requirements of being in existence for at least three years, is grounded in relevant empirically-based knowledge, is linked to program-determined outcomes, and is associated with a national organization or institution of higher education that has comprehensive home visiting program standards that ensure high quality service delivery and continuous quality improvement.

The evidence-base for the proposed alternative model will be reviewed by the Secretary of Health and Human Services and a decision will be made regarding approval or disapproval of the proposed alternative model within 45 days of receipt of the request. If, upon review, the Secretary approves this alternative model for implementation under the MIECHV program,

¹⁴ For the purposes of the MIECHV, home visiting models have been defined as programs or initiatives in which home visiting is a primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children birth to kindergarten entry, targeting participant outcomes which may include improved maternal and child health; prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; improvements in the coordination and referrals for other community resources and supports; or improvements in parenting skills related to child development.

the state will be required to provide the following information applicable to implementation of the approved model within 30 days:

- Provide documentation of approval by the developer to implement the home visiting model proposed. The documentation should include verification that the model developer has reviewed and agreed to the plan as submitted including any proposed adaptation, support for participation in the national evaluation, and any other related HHS efforts to coordinate programmatic technical assistance. This documentation should include the state's status in any required certification or approval process to implement the home visiting program;
- Describe how the proposed alternative evidenced-based home visiting model(s) meets the needs of the community(ies) proposed. It is expected that the state will engage the proposed community to assess the fit of the model and the community's readiness to implement the program prior to the submission of the proposed plan and on an ongoing basis after implementation;
- Provide a description of the state's current and prior experience with implementing the model(s) selected, as well as their current capacity to support the model;
- Submit a plan for ensuring implementation, with fidelity to the model, and include a description of the following: the state's overall approach to home visiting quality assurance; the state's approach to program assessment and support of model fidelity; anticipated challenges and risks to maintaining quality and fidelity, and the proposed response to the issues identified; and
- Discuss anticipated challenges and risks of selected program model(s), and the proposed response to the issues identified and any anticipated technical assistance needs.

(b) Requests for Reconsideration of Evidence Determinations

If a state, researcher, model developer, or other interested individual believes the application of the HHS criteria for evidence of effectiveness for a particular model contained one or more errors and that, if these errors were addressed, the model would meet the evidence criteria, those concerns should be submitted to: HVEE@mathematica-mpr.com. Inquiries will only be accepted through this e-mail address. Individuals may request reconsideration of the evidence based determination based on misapplication of the HHS criteria, or missing information, or errors on the HomVEE website. To ensure independence from the original review, a re-review team composed of members external to the original contractor will conduct the new, independent review. The re-review team will provide assurance that they do not have any actual or perceived conflicts of interest. This re-review team will not consist of members who were involved in the original review. Similar to the original review, the re-review team will be certified and trained in the HomVEE standards. The re-review team will utilize the original empirical articles (see the program reports at: <http://homvee.acf.hhs.gov/>), any information submitted by the individual raising the concern, the original review team's reports, and make any needed queries to the original team. The Secretary will issue a final decision as to whether the standards were accurately applied or not within 45 days of the submission of the request for review. If following the re-review the model is approved as meeting the HHS criteria for evidence of effectiveness, a state wishing to implement this re-reviewed model must submit a proposal within 30 days of the evidence review decision made by the Secretary. The proposal must include the documentation listed above under Section 3 (c).