



OHIO DEPARTMENT OF HEALTH

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John R. Kasich / Governor

Theodore E. Wynnyk, M.D. / Director of Health

ADTS# 57672

DATE: November 28, 2012
TO: Prospective Applicants for the MIECHV Program
FROM: Karen Hughes, M.P.H. Chief *KAREN F. HUGHES (RPS)*
Division of Family and Community Health Services
SUBJECT: Notice of Availability of Funds – Competitive Grant Applications for SFY 2013

The Ohio Department of Health (ODH), Division of Family and Community Health Services (DFCHS), Bureau for Children with Developmental and Special Health Needs (BCDSHN) announces the availability of grant funds for evidence-based home visiting programs in Adams, Allen, Ashtabula, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Erie, Fayette, Gallia, Harrison, Jackson, Jefferson, Logan, Mahoning, Meigs, Muskingum, Scioto, Stark, and Summit counties to implement the Maternal, Infant, and Early Childhood Home Visiting Program. The Request for Proposals (RFP) will provide you guidance in completing the online application for the FY 2013-2014 competitive grant program period. Applications are due Monday, January 7, 2013 no later than 4:00 PM. **Late applications will not be accepted.**

A Bidders conference will be held on Thursday December 13, 2012 at 1:30 PM. The call in number is 1-800-510-7500 and the participant code is 4435620#. **Attendance at the Bidders conference is required for agencies who have never received an ODH grant. This call is optional for previously funded grantees. If you will be calling in for the Bidders conference, contact Jeffrey Wynnyk, Program Manager, by email at Jeffrey.Wynnyk@iodh.ohio.gov.**

Also please submit any questions about the RFP at the time you RSVP. Responses to questions received will be discussed at the Bidders conference.

To obtain a grant application packet:

- 1) Go to the ODH website at www.odh.ohio.gov
- 2) From the home page, click on "resources"
- 3) From the next page, click on "funding opportunities"
- 4) Next click on "ODH Grants"
- 5) Next click on "Grant request for Proposals". This will give you a pull down menu with current grant RFP's by name
- 6) Select and highlight the MIECHV Evidence-Based Home Visiting Programs FY13 Program RFP and click "Submit". This process invokes Adobe Acrobat and will display the entire RFP. You can then review the RFP to determine your organizations' ability to meet the requirements of the grant and your intent to apply.

All grant applications must be submitted via the Internet, using GMIS 2.0. To be eligible for funding, all interested applicants must: 1) submit the attached Notice of Intent to Apply for Funding form (Appendix E of the RFP) no later than Wednesday December 12, 2012 and; 2) attend or document in writing prior attendance at Grants Management Information System 2.0 (GMIS) training. Please complete and return the attached GMIS 2.0 Training form (Appendix A of the RFP) to schedule a specific training session date no later than Wednesday December 12, 2012.

If you have any questions, please contact the Program Manager Jeffrey Wynnyk by email at Jeffrey.Wynnyk@odh.ohio.gov or Program Consultant Sue Scott at Sue.Scott@odh.ohio.gov or by phone at (614) 644 – 8389.



ALL APPLICATIONS MUST BE SUBMITTED VIA THE INTERNET

OHIO DEPARTMENT OF HEALTH

DIVISION OF
FAMILY AND COMMUNITY HEALTH SERVICES

BUREAU OF
CHILDREN WITH DEVELOPMENTAL AND SPECIAL HEALTH NEEDS

*OHIO MATERNAL, INFANT AND EARLY CHILDHOOD
HOME VISITING (MIECHV) PROGRAM*

REQUEST FOR PROPOSALS (RFP)
FOR
FISCAL YEAR 2013
(2/1/2013 – 9/30/2013)

Local Public Applicant Agencies
Non-Profit Applicants

COMPETITIVE GRANT APPLICATION INFORMATION

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IV. ATTACHMENTS

- 1) Ohio MIECHV Budget Proposal Worksheet
- 2) Ohio MIECHV Program Eligibility Form
- 3) Letter of Affiliation from Selected Evidenced-Based Home Visiting Model
- 4) At least two letters of support on agency letterhead which endorse the applicant becoming a MIECHV evidence-based home visiting provider from each county the agency is proposing to serve. These letters must be from any two of the following public entities: the board of alcohol, drug addiction, and mental health services, including a board of alcohol and drug addiction or a community mental health board if the county is served by separate boards; the board of county commissioners; any board of health of the county's city and general health districts; the county department of job and family services; the county agency responsible for the administration of children services; the county board of developmental disabilities; any of the county's boards of education or governing boards of educational service centers; or the county's juvenile court.

I. APPLICATION SUMMARY and GUIDANCE

An application for an Ohio Department of Health (ODH) grant consists of a number of required parts – an electronic component submitted via the Internet Website: ODH Application Gateway – GMIS which includes various paper forms and attachments. All the required parts of a specific application must be completed and submitted by the application due date. **Any required part that is not submitted on time will result in the entire application not being considered for review.**

The application summary information is provided to assist your agency in identifying funding criteria:

A. Policy and Procedure: Uniform administration of all the ODH grants is governed by the ODH Grants Administration Policies and Procedures (GAPP) manual. This manual must be followed to ensure adherence to the rules, regulations and procedures for preparation of all sub-grantee applications. The GAPP manual is available on the ODH Website <http://www.odh.ohio.gov>. (Click on “Funding Opportunities” [located under At a Glance]; click on “ODH Grants” and then click on “GAPP”) Please refer to Policy and Procedure updates found on the GMIS bulletin board.

B. Application Name: Ohio Maternal, Infant, and Early Childhood Home Visiting Program

C. Purpose: On July 21, 2010, the Health Resources and Services Administration (HRSA) awarded formula grants to the fifty States and six jurisdictions to support Maternal, Infant, and Early Childhood Home Visiting. The diverse needs of children and their families in communities at risk are the target population to be served. The method of service is evidence-based home visiting which is designed to (1) strengthen and improve programs and activities carried out under Title V (Maternal and Child Health Block Grant), (2) to improve coordination of services for at-risk communities, and (3) to identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. The purpose of the sought proposals is to provide services to the identified at-risk communities using an evidence-based home visiting model and ultimately improve the lifelong health and well-being of those children, parents, and caregivers. Funds provided to an eligible entity receiving a grant shall supplement, and not supplant, funds from other sources for early childhood home visiting programs and initiatives.

D. Qualified Applicants: Eligible applicants are local public or non-profit agencies providing evidence-based home visiting services in any one or multiple counties that include: Adams, Allen, Ashtabula, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Erie, Fayette, Gallia, Harrison, Jackson, Jefferson, Logan, Mahoning, Meigs, Muskingum, Scioto, Stark, and Summit counties in Ohio. Applicant providers must be affiliated with either Healthy Families America (HFA) or Nurse Family Partnership (NFP) evidence-based home visiting model.

The following criteria must be met for grant applications to be eligible for review:

1. Applicant doesn't owe funds in excess of \$1,000 to the ODH
2. Applicant isn't certified to the Attorney General's (AG's) office
3. Applicant has submitted application and all required attachments by 4:00 p.m. on Monday January 7, 2013.

E. Service Area: Identified at-risk communities within Adams, Allen, Ashtabula, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Erie, Fayette, Gallia, Harrison, Jackson, Jefferson, Logan, Mahoning, Meigs, Muskingum, Scioto, Stark, and Summit counties in Ohio. ODH recognizes that within these counties there are communities, neighborhoods, and/or census tracts with individual and clustered risk indicators that rate even higher than the county or State averages. It is the objective and intent of the MIECHV program that the most at-risk community(ies) be targeted and served by evidence-based home visiting services.

F. Number of Grants and Funds Available: Funding is available for up to 21 projects. Approximately \$2,130,000.00 will be available to fund up to 21 projects.

The amount awarded to each successful applicant will depend on the money available, the number of individuals identified as at-risk, the number of families proposed to serve, and the estimated cost of the selected evidence-based home visiting model implemented.

ODH will be monitoring program implementation and based in part on MIECHV program enrollment may be conducting a mid-year reallocation of grant funds.

Funds provided to an eligible entity receiving a grant shall supplement, and not supplant, funds from other sources for early childhood home visiting programs and initiatives.

No grant award will be issued for less than \$30,000. The minimum amount is exclusive of any required matching amounts and represents only ODH funds granted. Applications submitted for less than the minimum amount will not be considered for review.

G. Due Date: All parts of the application must be completed and received by ODH electronically via GMIS or via ground delivery by 4:00 p.m. Monday, January 7, 2013. Applications and required attachments received late will not be considered for review.

Please contact the MIECHV Home Visiting program Consultant Sue Scott with any questions. Sue Scott can be reached at (614) 644-8755 or by email at Sue.Scott@odh.ohio.gov.

H. Authorization: Authorization of funds for this program is contained in the Catalog of Federal Domestic Assistance (CFDA) Number 93.505, Affordable Care Act

(ACA) Maternal, Infant and Early Childhood Home Visiting Program.

- I. Goals:** The Ohio Department of Health, as a grantee for the Maternal, Infant, and Early Childhood Home Visiting program, and in partnership with the U.S. federal government (HRSA and Administration for Children and Families), seeks to provide direct services to meet the diverse needs of children and their families in communities at risk. The method of service eligible for this funding is evidence-based home visiting. The goals of the service include improving newborn and maternal health; reducing child injury, abuse, neglect or maltreatment, and emergency room visits; improving school readiness and achievement; reducing domestic violence; increasing family economic self-sufficiency; and increasing coordination and referrals for other community resources and supports. For further specificity on the goals of this program, please see Appendix C: Ohio MIECHV Benchmarks and Performance Measures.

Program Priorities and Requirements: In Appendix C, Ohio MIECHV Benchmarks and Performance Measures, you will find the overall program priorities. These performance measures have been approved by the U.S. Department of Health and Human Services, Human Resource Services Administration and are the priorities which will lead Ohio to an effective, comprehensive early childhood system that supports the lifelong health and well-being of all children, parents, and caregivers whose social, economic, and/or environmental circumstances contribute to poor health and persistent inequalities.

ODH has selected two Home Visiting Models for agencies to choose from that align with the relevant outcomes of MIECHV. The models selected for consideration by the counties are: Healthy Families America (HFA) and Nurse Family Partnership (NFP).

Healthy Families America (HFA) www.healthyfamiliesamerica.org

Population served: 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.

Nurse-Family Partnership (NFP) www.nursefamilypartnership.org

Population served: 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 NFP program aims to improve maternal health and child health; improve pregnancy outcomes; improve child development; and improve economic self-sufficiency of the family.

Depending on the agencies determination of particular at-risk community(ies) that they will target for the evidence based home visiting program, one or both of these models may be chosen for implementation. Refer to Appendix F for more information on HFA and NFP.

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 increase or decrease risk and protective factors that affect the range of health and social outcomes. By connecting and establishing relationships with a community's most vulnerable individuals before or as they become parents has been shown to increase that individual's protective factors against the social and economic realities of their life.

Like Ohio's Help Me Grow Home Visiting program, this program helps to support eligible families through strengthening positive family environments for optimal growth and development of infants and young children. Successful applicants will use these funds to implement and maintain an evidence-based home visiting model which is coordinated with the other home visiting programs in its county and includes the following:

1. Informed consent for participation
2. Evidence-Based Home Visiting
3. Data collection, records keeping for validation, and program evaluation

The home visiting providers must assure that the MIECHV programs:

1. Adhere to the selected evidence-based home visiting model to ensure fidelity to the model.
2. Adhere to the selected evidence-based home visiting model's requirements for training, minimum qualifications, and certification as a service provider.
3. Adhere to the selected evidence-based home visiting model's requirement for eligibility and ensure that MIECHV program eligibility is diverse from Ohio's Help Me Grow Home Visiting Program's eligibility in order to not supplant state funding for home visiting programs.
4. Enter all data required into the state's early childhood data collection system, Early Track 3.0 accurately and completely, within 30 days of any program event with any participant.
5. Report to the Program Administrator, or their designee, within the Bureau for Children with Developmental and Special Health Needs at the Ohio Department

of Health as the statewide grant manager.

6. Receive all program referrals through the county's Central Coordination Contractor.
 7. Refer any child under the age of three with an identified developmental delay or disability to the state's Individuals with Disabilities Education Act, Part C program: Help Me Grow.
 8. Refer any child over the age of three to the Local Education Agency of his/her residence when a developmental disability has been identified or is suspected as potentially eligible for the Individuals with Disabilities Education Act, Part B (Special Education Preschool and Special Education).
- J. Program Period and Budget Period:** The program period begins February 1, 2013 and ends September 29, 2014. The budget period for this application is February 1, 2013 and ends September 30, 2013.
- K. Public Health Accreditation Board (PHAB) Standard(s):** This grant program will address PHAB Standard 3.1: Provide Health Education and Health Promotion Policies, Programs, Processes, and Interventions to Support Prevention and Wellness and PHAB Standard 10.1: Identify and Use the Best Available Evidence for Making Informed Public Health Practice Decisions.

<http://www.phaboard.org/wp-content/uploads/PHAB-Standards-Overview-Version-1.0.pdf>

- L. Public Health Impact Statement:** All applicant agencies that are not local health districts must communicate with local health districts regarding the impact of the proposed grant activities on the PHAB Standards.

1. Public Health Impact Statement Summary - Applicant agencies are required to submit a summary of the program to local health districts prior to submitting the grant application to ODH. The program summary, not to exceed one page, must include:
 - a) The Public Health Accreditation Board (PHAB) Standard(s) to be addressed by grant activities:
 - A description of the demographic characteristics (e.g., age, race, gender, ethnicity, socio-economic status, educational levels) of the target population and the geographical area in which they live (e.g., census tracts, census blocks, block groups);
 - A summary of the services to be provided or activities to be conducted; and,
 - A plan to coordinate and share information with appropriate local health districts.

The applicant must submit the above summary as part of their grant application to ODH. This will document that a written summary of the proposed activities was provided to the local health districts with a request for their support and/or comment about the activities as they relate to the PHAB Standards.

2. Public Health Impact Statement of Support - Include with the grant application a statement of support from the local health districts, if available. If a statement of

support from the local health districts is not obtained, indicate that when the program summary is submitted with the grant application. If an applicant agency has a regional and/or statewide focus, a statement of support must be submitted from at least one local health district, if available.

M. Incorporation of Strategies to Eliminate Health Inequities

The ODH is committed to the elimination of health inequities. Racial and ethnic minorities and Ohio's economically disadvantaged residents experience health inequities and, therefore, do not have the same opportunities as other groups to be healthy. Throughout the various components of this application (Program Narrative, Objectives, and Workplan), applicants are required to:

- 1) Explain the extent to which health disparities and/or health inequities are manifested within the problem addressed by this funding opportunity. This includes the identification of specific group(s) who experiences a disproportionate burden of disease or health condition (This information must be supported by data.);
- (2) Explain how specific social and environmental conditions (social determinants of health) put groups who are already disadvantaged at increased risk for health inequities; and
- (3) Explain how proposed program interventions will address this problem.

The following section will provide a basic framework and links to information to understand health equity concepts.

Understanding Health Disparities, Health Inequities, Social Determinants of Health & Health Equity:

*Certain groups in Ohio face significant barriers to achieving the best health possible. These groups include Ohio's poorest residents and racial and ethnic minority groups. Health disparities occur when these groups experience more disease, death or disability beyond what would normally be expected based on their relative size of the population. Health disparities are often characterized by such measures as disproportionate incidence, prevalence and/or mortality rates of diseases or health conditions. Health is largely determined by where people, live, work and play. Health disparities are unnatural and can occur because of socioeconomic status, race/ethnicity, sexual orientation, gender, disability status, geographic location or some combination of these factors. Those most impacted by health disparities also tend to have less access to resources like healthy food, good housing, good education, safe neighborhoods, freedom from racism and other forms of discrimination. These are referred to as **social determinants of health**. Social determinants are the root causes of health disparities. The systematic and unjust distribution of social determinants resulting in negative*

*health outcomes is referred to as **health inequities**. As long as health inequities persist, those aforementioned groups will not achieve their best possible health. The ability of marginalized groups to achieve optimal health (like those with access to social determinants) is referred to as **health equity**. Public health programs that incorporate social determinants into the planning and implementation of interventions will greatly contribute to the elimination of health inequities.*

This statement should not exceed 1.5 pages and must: (1) explain the extent in which health disparities are manifested within the health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) focus of this application; (2) identify specific group(s) who experience a disproportionate burden for the disease or health condition addressed by this application; and (3) identify specific social and environmental conditions which lead to health disparities (social determinants). This statement must be supported by data. The following section will provide a basic framework and links to information to understand health equity concepts. This information will also help in the preparation of this statement as well as respond to other portions of this application **(Required)**.

For more resources on health equity, please visit the ODH Website at:
<http://www.healthyohioprogram.org/healthequity/equity.aspx>.

N. Appropriation Contingency: Any award made through this program is contingent upon the availability of funds for this purpose. **The sub grantee agency must be prepared to cover the costs of operating the program in the event of a delay in grant payments.**

O. Programmatic, Technical Assistance and Authorization for Internet Submission: Initial authorization for Internet submission, for new agencies, will be granted after participation in the GMIS training session. All other agencies will receive their authorization after the posting of the RFP to the ODH Website and the receipt of the Notice of Intent to Apply for Funding (NOIAF).

Please contact *Sue Scott, BCDSHN/MIECHV Home Visiting Program Consultant at 614-644-8755 or Sue.Scott@odh.ohio.gov* for questions regarding this RFP.

Applicant must attend or must document in the NOIAF prior attendance at GMIS training in order to receive authorization for Internet submission.

P. Acknowledgment: An 'Application Submitted' status will appear in GMIS that acknowledges ODH system receipt of the application submission.

Q. Late Applications: Applications are dated the time of actual submission via the Internet utilizing GMIS. Required attachments and/or forms sent electronically must be transmitted by the application due date. Required attachments and/or forms mailed

that are non-Internet compatible must be postmarked or received on or before the application due date of **Monday, January 7, 2013 at 4:00 PM.**

Applicants should request a legibly dated postmark, or obtain a legibly dated receipt from the U.S. Postal Service, or a commercial carrier. Private metered postmarks shall **not** be acceptable as proof of timely mailing. Applicants can hand-deliver attachments to ODH, Grants Services Unit, Central Master Files; but they must be delivered by **4:00 p.m.** on the application due date. FAX attachments will not be accepted. **GMIS applications and required application attachments received late will not be considered for review.**

- R. Successful Applicants:** Successful applicants will receive official notification in the form of a "Notice of Award" (NOA). The NOA, issued under the signature of the Director of Health, allows for expenditure of grant funds.
- S. Unsuccessful Applicants:** Within 30 days after a decision to disapprove or not fund a grant application for a given period, written notification, issued under the signature of the Director of Health, or his designee shall be sent to the unsuccessful applicant.
- T. Review Criteria:** All proposals will be judged on the quality, clarity and completeness of the application. Applications will be judged according to the extent to which the proposal:
1. Contributes to the advancement and/or improvement of the health of Ohioans;
 2. Is responsive to policy concerns and program objectives of the initiative/program/activity for which grant dollars are being made available;
 3. Is well executed and is capable of attaining program objectives;
 4. Describe specific objectives, activities, milestones and outcomes with respect to time-lines and resources;
 5. Estimates reasonable cost to the ODH, considering the anticipated results;
 6. Indicates that program personnel are well qualified by training and/or experience for their roles in the program and the applicant organization has adequate facilities and personnel;
 7. Provides an evaluation plan, including a design for determining program success;
 8. Is responsive to the special concerns and program priorities specified in the RFP;
 9. Has demonstrated acceptable past performance in areas related to programmatic and financial stewardship of grant funds;
 10. Has demonstrated compliance to GAPP, Chapter 100;
 11. Explicitly identifies specific groups in the service area who experience a disproportionate burden of the diseases, health condition(s); or who are at an increased risk for problems addressed by this funding opportunity; and,
 12. Applicant describes activities which supports the requirements outlined in sections I. thru M. of this RFP.

The ODH will make the final determination and selection of successful/unsuccessful applicants and reserves the right to reject any or all applications for any given RFPs. **There will be no appeal of the Department's decision.**

- U. **Freedom of Information Act:** The Freedom of Information Act (5 U.S.C.552) and the associated Public Information Regulations require the release of certain information regarding grants requested by any member of the public. The intended use of the information will not be a criterion for release. Grant applications and grant-related reports are generally available for inspection and copying except that information considered being an unwarranted invasion of personal privacy will not be disclosed. For guidance regarding specific funding sources, refer to: 45 CFR Part 5 for funds from the U.S. Department of Health and Human Service.
- V. **Ownership Copyright:** Any work produced under this grant, including any documents, data, photographs and negatives, electronic reports, records, software, source code, or other media, shall become the property of ODH, which shall have an unrestricted right to reproduce, distribute, modify, maintain, and use the work produced. If this grant is funded in whole, or in part, by the federal government, unless otherwise provided by the terms of that grant or by federal law, the federal funder also shall have an unrestricted right to reproduce, distribute, modify, maintain, and use the work produced. No work produced under this grant shall include copyrighted matter without the prior written consent of the owner, except as may otherwise be allowed under federal law.

ODH must approve, in advance, the content of any work produced under this grant. All work must clearly state:

“This work is funded either in whole or in part by a grant awarded by the Ohio Department of Health; Bureau for Children with Medical Handicaps and Early Intervention Services; Maternal, Infant and Early Childhood Home Visiting Program and as a sub-award of a grant issued by the U.S. Department of Health and Human Services Health Resources and Services Administration CFDA number 93.505.”

- W. **Reporting Requirements:** Successful applicants are required to submit sub-grantee program and expenditure reports. Reports must adhere to the ODH, GAPP manual. Reports must be received before the department will release any additional funds.

Note: Failure to assure quality of reporting such as submitting incomplete and/or late program or expenditure reports will jeopardize the receipt of future agency payments.

Reports shall be submitted as follows:

1. **Program Reports:** Quarterly sub-grantees Program Reports must be completed and submitted via GMIS or the Sub-grantee Performance Evaluation System (SPES), as required by the sub-grant program by the following dates using the required format (Quarterly Report Form Appendix D.):

Program Period	Report Due Date
2/1/2013 – 3/31/2013	4/15/2013
4/1/2013 – 6/30/2013	7/15/2013
7/1/2013 – 9/30/2013	10/15/2013

Program Reports that do not include required attachments will not be approved. All program report attachments must clearly identify the authorized program name and grant number. *Submission of Sub-grantee Program Reports via the ODH’s (GMIS or SPES) indicates acceptance of the ODH GAPP.*

2. **Periodic Expenditure Reports:** Sub-grantee Expenditure Reports **must** be completed and submitted **via GMIS** by the following dates:

Budget Period	Report Due Date
2/1/2013 – 3/31/2013	4/15/2013
4/1/2013 – 6/30/2013	7/15/2013
7/1/2013 – 9/30/2013	10/15/2013

3. **Final Expenditure Reports:** A Sub-grantee Final Expenditure Report reflecting total expenditures for the fiscal year must be completed and submitted **via GMIS** by 4:00 P.M. on or before **November 15, 2013**. The information contained in this report must reflect the program’s accounting records and supportive documentation. Any cash balances must be returned with the Sub-grantee Final Expense Report. The Sub-grantee Final Expense Report serves as an invoice to return unused funds.

Submission of the periodic and final sub-grantee expenditure reports via the GMIS system indicates acceptance of ODH GAPP. Clicking the “Approve” button signifies authorization of the submission by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations.

4. **Inventory Report:** A listing of all equipment purchased in whole or in part with **current** grant funds (Equipment Section of the approved budget) must be submitted via GMIS as part of the Sub-grantee Final Expenditure Report. At least once every two years, inventory must be physically inspected by the sub-grantee. Equipment purchased with ODH grant funds must be tagged as property of ODH for inventory control. Such equipment may be required to be returned to ODH at the end of the grant program period.

X. Special Condition(s): Responses to all special conditions **must be submitted via GMIS within 30 days of receipt of the first quarter payment.** A Special Conditions link is available for viewing and responding to special conditions. This link is viewable only after the issuance of the sub-grantee's first payment. The 30day time period, in which the sub-grantee must respond to special conditions, will begin when the link is viewable. Failure to submit satisfactory responses to the special conditions or a plan describing how those special conditions will be satisfied will result in the withholding of any further payments until satisfied.

Y. Unallowable Costs: Funds **may not** be used for the following:

1. To advance political or religious points of view or for fund raising or lobbying; but must be used solely for the purpose as specified in this announcement;
2. To disseminate factually incorrect or deceitful information;
3. Consulting fees for salaried program personnel to perform activities related to grant objectives;
4. Bad debts of any kind;
5. Lump sum indirect or administrative costs;
6. Contributions to a contingency fund;
7. Entertainment;
8. Fines and penalties;
9. Membership fees -- unless related to the program and approved by ODH;
10. Interest or other financial payments;
11. Contributions made by program personnel;
12. Costs to rent equipment or space owned by the funded agency;
13. Inpatient services;
14. The purchase or improvement of land; the purchase, construction, or permanent improvement of any building;
15. Satisfying any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
16. Travel and meals over the current state rates (see OBM Website: <http://obm.ohio.gov/MiscPages/TravelRule>) Then click on OBM Travel Rule.
17. Costs related to out-of-state travel, unless otherwise approved by ODH, and described in the budget narrative;
18. Training longer than one week in duration, unless otherwise approved by ODH;
19. Contracts for compensation with advisory board members;
20. Grant-related equipment costs greater than \$300, unless justified and approved by ODH; and,
21. Payments to any person for influencing or attempting to influence members of Congress or the Ohio General Assembly in connection with awarding of grants.

Use of grant funds for prohibited purposes will result in the loss and/or recovery of those funds.

Z. Audit: Sub-grantees currently receiving funding from the ODH are responsible for submitting an independent audit report that meets OMB Circular A-133 requirements, a copy of the auditor's management letter, a corrective action plan (if applicable) and

a data collection form (for single audits) within 30 days of the receipt of the auditor's report, but not later than 9 months after the end of the sub-grantee's fiscal year.

Sub-grantees that expend \$500,000 or more in federal awards per fiscal year are required to have a single audit. The fair share of the cost of the single audit is an allowable cost to federal awards provided that the audit was conducted in accordance with the requirements of OMB Circular A-133.

Sub-grantees that expend less than the \$500,000 threshold require a financial audit conducted in accordance with Generally Accepted Government Auditing Standards. **The financial audit is not an allowable cost to the program.**

Once an audit is completed, a copy must be sent to the ODH, Grants Services Unit, Central Master Files address within 30 days. Reference: GAPP Chapter 100, Section 108 and OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations for additional audit requirements.

Sub-grantee audit reports (finalized and published, and including the audit Management Letters, if applicable) **which include internal control findings, questioned costs or any other serious findings, must include a cover letter which:**

- Lists and highlights the applicable findings;
- Discloses the potential connection or effect (direct or indirect) of the findings on sub-grants passed-through the ODH; and,
- Summarizes a Corrective Action Plan (CAP) to address the findings. A copy of the CAP should be attached to the cover letter.

AA. Submission of Application:

Formatting Requirements:

- Properly label each item of the application packet (ex. budget narrative, program narrative, etc.).
- Each section should use 1.5 spacing with one-inch margins.
- Program and Budget narratives must be submitted in portrait orientation 8 ½ by 11 paper.
- Number all pages (print on one side only).
- Program narrative should not exceed 20 pages (**excludes** appendices, attachments, budget and budget narrative).
- Use a 12 point font.
- Forms must be completed and submitted in the format provided by ODH.

The GMIS application submission must consist of the following:

**Complete
& Submit
Via Internet**

1. Application Information
2. Project Narrative
3. Project Contacts
4. Budget
 - Primary Reason
 - Funding
 - Cash Needs
 - Justification
 - Personnel
 - Other Direct Costs
 - Equipment
 - Contracts
 - Compliance Section D
 - Summary
5. Civil Rights Review Questionnaire (EEO Survey)
6. Assurances Certification
7. Federal Funding Accountability and Transparency Act (FFATA) reporting form
8. Electronic Funds Transfer (EFT) Form **(Required if new agency, thereafter only if banking information has changed.)**
9. IRS W-9 Form **(Required if new agency, thereafter only when tax identification number or agency address information has changed.) One of the following forms must accompany the IRS W-9 Form:**
 - a. Vendor Information Form **(New Agency Only)**
 - b. Vendor Information Change Form **(Existing agency with tax identification number, name and/or address change(s).)**
 - c. Change request in writing on Agency letterhead **(Existing agency with tax identification number, name and/or address change(s)).**
10. Public Health Impact Statement
11. Statement of Support from the Local Health Districts
12. Liability Coverage **(Non-Profit organizations only; proof of current liability coverage and thereafter at each renewal period)**
13. Evidence of Non-Profit Status **(Non-Profit organizations only)**
14. Attachments as required by Program
 - Attachment #1: Ohio MIECHV Budget Proposal Worksheet
 - Attachment # 2: Ohio MIECHV Program Eligibility Form
 - Attachment # 3: Letter of Affiliation from Selected Evidenced-Based Home Visiting Model

Attachment #4: Attach at least two letters of support on agency letterhead which endorse the applicant becoming a MIECHV evidence-based home visiting provider from each county the agency is proposing to serve. These letters must be from any two of the following public entities: the board of alcohol, drug addiction, and mental health services, including a board of alcohol and drug addiction or a community mental health board if the county is served by separate boards; the board of county commissioners; any board of health of the county's city and general health districts; the county department of job and family services; the county agency responsible for the administration of children services; the county board of developmental disabilities; any of the county's boards of education or governing boards of educational service centers; or the county's juvenile court.

One copy of the following documents must be e-mailed to audits@odh.ohio.gov or mailed to the address listed below:

**Complete
Copy &
E-mail or
Mail to
ODH**

1. Current Independent Audit (latest completed organizational fiscal period; **only if not previously submitted**)

**Ohio Department of Health
Grants Services Unit
Central Master Files, 4th Floor
246 N. High Street
Columbus, Ohio 43215**

One copy of the following documents must be mailed to the address listed below:

**Complete
Copy &
Mail To
ODH**

1. An original and 2 (TWO) copies of **Attachments** (non-Internet compatible) as required by program: **NONE**

**Ohio Department of Health
Grants Services Unit
Central Master Files, 4th Floor
246 N. High Street
Columbus, Ohio 43215**

II. APPLICATION REQUIREMENTS AND FORMAT

Access to GMIS, will be provided after GMIS training for those agencies requiring training. All others will receive access after the RFP is posted to the ODH Website.

All applications must be submitted via GMIS. Submission of all parts of the grant application via the ODH's GMIS system indicates acceptance of ODH GAPP. Submission of the application signifies authorization by an agency official and constitutes electronic acknowledgment and acceptance of GAPP rules and regulations in lieu of an executed Signature Page document.

- A. **Application Information:** Information on the applicant agency and its administrative staff must be accurately completed. This information will serve as the basis for necessary communication between the agency and the ODH.
- B. **Budget:** Prior to completion of the budget section, please review page 11 of the RFP for unallowable costs.

Match or Applicant Share is not required by this program. Do not include match or Applicant Share in the budget and/or the Applicant Share column of the Budget Summary. Only the narrative may be used to identify additional funding information from other resources.

- 1. **Primary Reason and Justification Pages:** Provide a detailed budget justification narrative that describes how the categorical costs are derived. Discuss the necessity, reasonableness, and allocability of the proposed costs. Describe the specific functions of the personnel, consultants and collaborators. Explain and justify equipment, travel, (including any plans for out-of-state travel), supplies and training costs. If you have joint costs refer to GAPP Chapter 100, Section 103 and the Compliance Section D (9) of the application for additional information.

The budget justification should specifically describe how each item will support the achievement of proposed objectives. Justification must specifically address how the grantee will meet proposed target number of families to be served. The budget period is from 2/1/2013 to 9/30/2013.

Be very careful about showing how each item in the "other" category is justified. Do NOT use the justification to expand the project narrative. Refer to "Budget Justification Example" on the GMIS Bulletin Board dated 10/15/2012.

- 2. **Personnel, Other Direct Costs, Equipment and Contracts):** Submit a budget with these sections and form(s) completed as necessary to support costs for the period 2/1/2013 to 9/30/2013. Please note: the intent of the MIECHV funding is to provide evidence-based home visiting services to families living in at risk communities and is to supplement not supplant current services. If the service

providers/home visitors for the MIECHV program are currently providing home visiting services through another program, please clearly state the percentage of time and salary that will support MIECHV home visiting services. Grant funds cannot be used to supplant existing home visiting program funds, and therefore, referrals of families eligible for the Help Me Grow (HMG) Home Visiting Program must first be made to approved HMG provider agencies that have the capacity to enroll families. If, and only if, the capacity of all HMG Home Visiting providers within a county has been reached can a potential participant, otherwise eligible for HMG Home Visiting, be referred to a MIECHV program.

Funds may be used to support personnel, their training, travel (see OBM Website) <http://obm.ohio.gov/MiscPages/TravelRule> and supplies directly related to planning, organizing and conducting the Initiative/program activity described in this announcement.

The applicant shall retain all contracts on file. The contracts should not be sent to ODH. A completed "Confirmation of Contractual Agreement" (CCA) form must be submitted via GMIS for each contract once it has been signed by both parties. The submitted CCA must be approved by ODH before contractual expenditures are authorized.

CCAs cannot be submitted until after the 1st quarter grant payment has been issued.

The applicant shall itemize all equipment (**minimum \$300 unit cost value**) to be purchased with grant funds in the Equipment Section.

3. **Compliance Section D:** Answer each question on this form as accurately as possible. *Completion of the form ensures your agency's compliance with the administrative standards of ODH and federal grants.*
4. **Funding, Cash Needs and Budget Summary Sections:** Enter information about the funding sources and forecasted cash needs for the program. Distribution should reflect the best estimate of need by quarter. Failure to complete and balance this section will cause delays in receipt of grant funds.
5. **Attachment #1 Ohio MIECHV Budget Proposal Worksheet:** Applicants will be required to use and submit Attachment #1 Ohio MIECHV Budget Proposal Worksheet. This attachment must indicate the following:
 - 1) Proposed number of families to be served during the budget period (2/1/13 – 9/30/13);
 - 2) The average cost per family for the proposed evidence-based home visiting model to be implemented (HFA: \$3300/family; NFP: \$4000/family); and
 - 3) Total Proposed Budget for 2/1/13 – 9/30/13.

C. Assurances Certification: Each sub-grantee must submit the Assurances (Federal and State Assurances for Sub-grantees) form. This form is submitted as a part of each application via GMIS. The Assurances Certification sets forth standards of financial conduct relevant to receipt of grant funds and is provided for informational purposes. The listing is not all-inclusive and any omission of other statutes does not mean such statutes are not assimilated under this certification. Review the form and then press the “Complete” button. By submission of an application, the sub-grantee agency agrees by electronic acknowledgment to the financial standards of conduct as stated therein.

D. Project Narrative:

1. Executive Summary: Identify the specific at-risk communities, target population, services and programs to be offered and what agency or agencies will provide those services, burden of health disparities and health inequities. Describe the public health problem(s) that the program will address.

2. Description of Applicant Agency/Documentation of Eligibility/Personnel:

- Briefly discuss the applicant agency's eligibility to apply. Provide information on the applicant organization's current mission and structure, and the scope of the organization's current activities related to home visiting.
- Identify which evidence-based home visiting model the agency is affiliated with (either Healthy Families America or Nurse Family Partnership). Refer to Appendix F: Evidence-Based Model Summaries for Healthy Families America and Nurse Family Partnership for more information.
 - Describe, if any, prior experience with implementing the model(s) selected as well as the current capacity to support the model.
 - Discuss any anticipated challenges and risks of selected program model(s), and the proposed response to the issues identified, and any technical assistance needs.
- Summarize the agency's structure as it relates to this program and, as the lead agency, how it will manage the MIECHV program. Include key personnel and their role in the application process, meeting reporting timelines and requirements; awareness of contractual responsibilities.
- List by name and role all personnel who will be directly involved in program activities. Include the relationship between program staff members, staff members of the applicant agency and other partners and agencies that will be working on the program. Describe plans for hiring and training, as necessary.
- If home visitors and/or other staff will serve other home visiting programs clearly state the percentage of time and salary that will support MIECHV home visiting services.
- Describe the capacity of your organization, its personnel or contractors to communicate effectively and convey information in a manner that is easily understood by diverse audiences. This includes persons of limited English proficiency, those who are not literate, have low literacy skills, and individuals with disabilities.

- Note any personnel or equipment deficiencies that will need to be addressed in order to carry out this grant.

3. **Description of the Problem/Need and Identification of Target Population:**

- Identify and describe the local health status concern that will be addressed by the program. The specific **health status concerns that the program intends to address may be stated in terms** of health status (e.g., morbidity and/or mortality) or health system (e.g., accessibility, availability, affordability, appropriateness of health services) indicators. The indicators should be measurable in order to serve as baseline data upon which the evaluation will be based.
- Identify the selected communities to be served, describe the community, and discuss the rationale for each selection taking into account the priority to provide services under the program to the high-risk populations. An explanation for this selection should include as much detailed information as possible regarding specific community risk factors and other characteristics and strengths.
- Provide community characteristics and strengths for each at-risk community (Race/ethnicity, Gender, Age, Marital status, Education levels, Language spoken, Employment, Income level, City, zip code or other geographic data).
- Describe how the unique needs of target populations of the communities served are routinely assessed and improved. Only restate national and state data if local data is not available.
- Clearly identify the target population and the specific eligibility for the program (Attachment #2).
- Describe how the evidence-based models selected meets the needs of the at-risk communities.

Appendix G: the Zero To Three Home Visiting Community Planning Tool, can be used to: Identify community needs and strengths based on data; explore current home visiting assets and service gaps; choose an evidence-based program model; and analyze components of both program- and system-level implementation that are critical to the replication of high-quality home visiting programs. Use of this tool is not required but can be submitted with an application at the discretion of the applicant to support (not replace) this section of the narrative.

Appendix H: Data has been provided for each county at the census tract level to help in making determinations for which at-risk communities will be targeted. Data included are: 2006 - 2009 Total Births, Unmarried Mother, Medicaid Deliveries, African-American Mothers, First-Time Mothers, Teen Mothers, < High School Education Mothers, Mothers Smoked During Pregnancy, No 1st Trimester Prenatal Care, Child Spacing <18 mos., Low Birth weight, Preterm Births. Services must be located in at least one of the 21 identified counties in Ohio but may be more specifically targeted to a community, neighborhood, zip code or census tract(s).

4. **Methodology:** In narrative form, identify the program goals, **Specific, Measureable, Attainable, Realistic & Time-Phased (SMART) process, impact, or outcome objectives** and activities. Indicate how they will be evaluated to determine the level of success of the program. If health disparities and/or health inequities have been identified, describe how program activities are designed will address these issues. Complete a program activities timeline to identify program objectives and activities and the start and completion dates for each.

- a) Specify the evidence-based model(s) that will be supported by the competitive funding. ODH approved models for this grant opportunity includes: Healthy Families America and Nurse Family Partnership. Additional information on these models that meet the HHS Criteria for Evidence of Effectiveness are can be found in Appendix G and at the U.S. Department of Health and Human Services Home Visiting Evidence of Effectiveness website: <http://homvee.acf.hhs.gov/Default.aspx>.
- b) As appropriate, identify meaningful support and collaboration with key stakeholders in planning, designing, implementing and evaluating all activities, including development of the application and, further, the extent to which these contributors reflect the cultural, racial, linguistic, and geographic diversity of the populations and communities served.
- c) Provide an implementation plan addressing the items listed below. Discussion of implementation should include the following information:
 - a. Plan to engage community;
 - b. Plan for monitoring, program assessment and support, and technical assistance;
 - c. Plan for professional development and training;
 - d. Plan for staffing and subcontracting;
 - e. Plan for recruiting and retaining participants;
 - f. Continuous Quality Improvement plan;
 - g. Plan to maintain fidelity to model;
 - h. Plan to collect data on legislatively-mandated benchmarks;
 - i. Plan to coordinate with appropriate entities/programs;
- d) Discuss challenges that are likely to be encountered in designing and implementing the MIECHV program and approaches that will be used to resolve such challenges.
- e) Describe the availability of resources to continue the proposed project after the grant period ends and the State's demonstrated commitment to home visiting.

E. Civil Rights Review Questionnaire - EEO Survey: The Civil Rights Review Questionnaire (EEO) Survey is a part of the Application Section of GMIS. Sub-grantees must complete the questionnaire as part of the application process. This questionnaire is submitted automatically with each application via the Internet.

F. Federal Funding Accountability and Transparency Act (FFATA) Requirements:

FFATA was signed on September 26, 2006. FFATA requires ODH to report all sub-grants receiving \$25,000 or more of federal funds. All applicants applying for ODH grant funds are required to complete the FFATA Reporting Form in GMIS.

All applicants for ODH grants are required to obtain a Data Universal Number System (DUNS) and a Central Contractor Registration Number (CCR) and submit the information in the grant application, Attachment B. For information about the DUNS, go to <http://fedgov.dnb.com/webform>. For information about CCR go to www.ccr.gov.

Information on Federal Spending Transparency can be located at www.USAspending.gov or the Office of Management and Budget's Website for Federal Spending Transparency at www.whitehouse.gov/omb/open.

(Required by all applicants, the FFATA form is located on the GMIS Application Page and must be completed in order to submit the application.)

G. Electronic Funds Transfer (EFT) Form: Print in PDF format and attach in GMIS. **Required only if new agency; thereafter, only when banking information has changed.)**

H. Internal Revenue Service (IRS) W-9 and Vendor Forms: Print in PDF format and attach in GMIS, **(Required if new agency; thereafter, only when tax identification number or agency address information has changed.) One of the following forms must accompany the IRS, W-9:**

1. **Vendor Information Form (New Agency Only), or**
2. **Vendor Information Change Form (Existing agency with tax identification number, name and/or address change(s).)**
3. **Change request in writing on Agency letterhead(Existing agency with tax identification number, name and/or address change(s).)**

Print in PDF format and mail to ODH, Grants Services Unit, Central Master Files address. The completed appropriate Vendor Form **must be** dated and signed, in blue ink, with original signatures. Submit the original and one copy of each.

I. Public Health Accreditation Board Standards: Attach in GMIS the PHAB standards that will be addressed by grant activities.

J. Public Health Impact: Only for applicants which are not local health departments, attach in GMIS the response/statement(s) of support from the local health district(s) to your agency's communication regarding the impact of the proposed grant activities on the PHAB Standards. If a statement of support from the local health district is not available, indicate that and submit a copy of the program summary your agency forwarded to the local health district(s).

- K. Liability Coverage:** Liability coverage is required for all non-profit agencies. Non-profit organizations **must** submit documentation validating current liability coverage. Attach in GMIS the Certificate of Insurance Liability (**Non-Profit organizations only; current liability coverage and thereafter at each renewal period.**)
- L. Non-Profit Organization Status:** Non-profit organizations **must** submit documentation validating current status. Attach in GMIS the Internal Revenue Services (IRS) letter approving non-tax exempt status
- M. Attachment(s):** Attachments are documents deemed necessary to the application that are not a part of the GMIS system. Attachments that are non-Internet compatible must be postmarked or received on or before the application due date. An original and the required number of copies of non-Internet compatible attachments must be mailed to the ODH, Grants Services Unit Central Master Files address by 4:00 p.m. on or before Wednesday September 12, 2012. All attachments must clearly identify the authorized program name and program number. All attachments must be submitted as a PDF, Microsoft Word or Microsoft Excel document.

For instructions on how to add attachments to the GMIS budget section, refer to the GMIS Bulletin Board, 3/4/2012 “How to Add Attachments in the Budget Section – REVISED.”

For instructions on how to add attachments to the GMIS special condition section, refer to the GMIS Bulletin Board, 3/4/2012 “How to Add Attachments in the Special Condition Section – REVISED.”

Attachment #1: Ohio MIECHV Budget Proposal Worksheet

Attachment #2: Ohio MIECHV Program Eligibility Form

Attachment #3: Letter of Affiliation from Selected Evidenced-Based Home Visiting Model

Attachment #4&5: At least two letters of support on agency letterhead which endorse the applicant becoming a MIECHV evidence-based home visiting provider from each county the agency is proposing to serve. These letters must be from any two of the following public entities: the board of alcohol, drug addiction, and mental health services, including a board of alcohol and drug addiction or a community mental health board if the county is served by separate boards; the board of county commissioners; any board of health of the county’s city and general health districts; the county department of job and family services; the county agency responsible for the administration of children services; the county board of developmental disabilities; any of the county’s boards of education or governing boards of educational service centers; or the county’s juvenile court.

Ohio Department of Health
GMIS 2.0 TRAINING

ALL INFORMATION REQUESTED MUST BE COMPLETED for EACH EMPLOYEE FROM YOUR AGENCY WHO WILL ATTEND A GMIS 2.0 TRAINING SESSION.
(Please Print Clearly or Type)

Grant Program _____ RFP due Date _____

County of Applicant Agency _____

Federal Tax Identification Number _____

NOTE: The applicant agency/organization name must be the same as that on the IRS letter. This is the legal name by which the tax identification number is assigned and as listed, if applicable, currently in GMIS.

Applicant Agency/Organization _____

Applicant Agency Address _____

Agency Employee to attend training _____

Telephone Number _____

E-mail Address _____

GMIS 2.0 Training Authorized by: _____
(Signature of Agency Head or Agency Fiscal Head) Required

Please Check One: _____ Yes – I ALREADY have access to the
ODH GATEWAY (SPES, ODRS, LHMIS, etc)

_____ No – I DO NOT have access to the ODH GATEWAY
Please indicate your training date choices: 1st choice _____, 2nd choice _____, 3rd choice _____

Mail, E-mail, or Fax To: Evelyn Suarez

Grants Services Unit
Ohio Department of Health
246 N. High Street
Columbus, Ohio 43215
E-mail: evelyn.suarez@odh.ohio.gov Fax: 614-752-9783

CONFIRMATION OF YOUR GMIS 2.0 TRAINING SESSION WILL BE E-MAILED TO YOU

Appendix B

**Fiscal Year 2013
Application for MIECHV Funds
Review Form**

County: _____

Applicant Organization: _____

Reviewer: _____

Section	Maximum Score	Comments
1. The Maternal, Infant and Early Childhood Home Visiting (MIECHV) in Ohio Application for funding was submitted by the due date and was complete with all Attachments.	10	
2. The applicant has identified the target population, services and programs to be offered and what agency or agencies will provide those services, burden of health disparities and health inequities. Described the community and discussed rationale for selection. Provided community characteristics. Provided detailed eligibility criteria.	10	
3. The applicant provided information on the applicant organization's current mission and structure, and the scope of the organization's current activities related to home visiting; summarized the agency's structure as it relates to this program and, as the lead agency, how it will manage the MIECHV program. Agency has identified EBHV model to be implemented and is affiliated with identified model.	10	
4. The applicant has identified key personnel and their role in the application process, meeting reporting timelines and requirements; awareness of contractual responsibilities. Has listed by name and role all personnel who will be directly involved in program activities. The applicant has described plans for hiring and training, as necessary. The applicant has clearly stated the percentage of time and salary that will support MIECHV home visiting services.	10	

<p>5. The applicant has provided an implementation plan addressing the following: Plan to engage community; plan for monitoring, program assessment and support, and technical assistance; Plan for professional development and training; Plan for staffing and subcontracting; Plan for recruiting and retaining participants; Continuous Quality Improvement plan; Plan to maintain fidelity to model; Plan to collect data on legislatively-mandated benchmarks; Plan to coordinate with appropriate entities/programs;</p>	<p>10</p>	
<p>6. The applicant has identified meaningful support and collaboration with key stakeholders in planning, designing, implementing and evaluating all activities, including development of the application and, further, the extent to which these contributors reflect the cultural, racial, linguistic, and geographic diversity of the populations and communities served.</p>	<p>10</p>	
<p>7. The application has discussed challenges that are likely to be encountered in designing and implementing the MIECHV program and approaches that will be used to resolve such challenges.</p>	<p>10</p>	
<p>8. The applicant has described the availability of resources to continue the proposed project after the grant period ends and the State's demonstrated commitment to home visiting.</p>	<p>10</p>	
<p>10. Budget: The applicant has completed all sections of the budget and provided a detailed budget justification for each budget period. No unallowable costs are included in the budget. It describes how the categorical costs are derived including: the necessity, reasonableness, and allocability of the proposed costs. The specific functions of personnel, consultants, and collaborators are described. An adequate explanation and justification of equipment, travel and training costs is included. The budget sections: Personnel, Other Direct Costs, Equipment, and Contracts & Confirmation of Contractual Agreement (CCA) Form have been submitted and completed with allowable costs as necessary to support costs for the proposed project. The applicant has provided a justification of the proposed number of families to be served (Attachment #1) and a plan to meet proposed target numbers.</p>	<p>10</p>	
<p>11. The applicant has described in detail any changes in program implementation from the plan that was submitted to ODH as part of the needs assessment process and from the first year of the project (9/1/2011-9/30/2012) using Attachment #2.</p>	<p>10</p>	

TOTAL POSSIBLE POINTS:	110															
8. <ul style="list-style-type: none"> a. Electronic Funds Transfer Form b. IRS W-9 Form & Vendor Forms (if applicable) c. Declaration Regarding Material Assistance/Non-Assistance to a Terrorist Organization Questionnaire (DMA) (signed & dated in blue ink) d. Two copies of the Public Health Impact Statement Summary e. Two copies of the Public Health Impact & Intent to Pursue Health Equity Statements f. Documentation of valid current liability coverage. Two copies of the Certificate of Insurance Liability. g. Two copies of the IRS letter approving non-tax exempt status. 	<table border="0"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO													
YES	NO															
YES	NO															
YES	NO															
YES	NO															
YES	NO															
YES	NO															
YES	NO															

Benchmarks

Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Reliability / Validity of (Yes or No)	Definition of Improvement	Persons responsible	Source	Population	Sampling	Schedule (Frequency)	Data Analysis or CQI (optional)
Benchmark 1: Improved maternal and newborn health											
1) Prenatal care	Average number of prenatal care visits completed.	N: Total prenatal care visits completed. D: Total participating mothers [see Population].	Administrative	No	An increase in the average number of prenatal care visits completed, comparing Year 1 data to Year 3 data.	ODH staff	Vital statistics data from birth records	Participating mothers enrolled during pregnancy.	No	Administrative data collected continuously. Data analysis completed at least annually.	Descriptive statistics, graphs, and summary reports will be used as appropriate and necessary. Analyses and CQI activities will consider annual data as well as cumulative data for the total length of participant enrollment and services.
2) Parental use of alcohol, tobacco, or illicit drugs	Proportion of mothers who smoked during pregnancy.	N: Mothers who smoked during pregnancy, and quit before the birth of their child. D: Total participating mothers who smoked during pregnancy [see Population].	Administrative	No	An increase in the proportion of participating mothers who smoked during pregnancy quitting before the birth of their child, comparing Year 1 data to Year 3 data.	ODH staff	Vital statistics data from birth records	Participating mothers enrolled during pregnancy.		Administrative data collected continuously. Data analysis completed at least annually.	
3) Preconception care	Proportion of mothers who maintain annual gynecological exams.	N: Mothers who completed an annual gynecological exam. D: Total participating mothers [see Population].	Self-report	No	An increase in the proportion of participating mothers who completed an annual gynecological exam, comparing Year 1 data to Year 3 data for Year 1 population.	Home visitors	Family interview	Participating mothers served postnatal or preconception.		Family interview completed within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	
4) Inter-birth intervals	Proportion of mothers provided information related to inter-birth spacing..	N: Mothers who were provided information related to inter-birth spacing. D: Total participating mothers [see Population].	Administrative	No	An increase or maintenance in the proportion of participating mothers who were provided information related to inter-birth spacing within one year post enrollment, comparing Year 1 data to Year 3 data.	Home visitors	Family interview	Participating mothers served postnatal or preconception.		Family interview completed within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	
5) Screening for maternal depressive symptoms	Proportion of mothers who are screened for maternal depressive symptoms.	N: Mothers screened for maternal depressive symptoms. D: Total participating mothers [see Population].	Tool	Yes	An increase or maintenance in the proportion of participating mothers screened for maternal depressive symptoms, comparing Year 1 data to Year 3 data.	Home visitors	EPDS	Participating mothers enrolled no more than six months beyond the birth of their youngest child.		EPDS administered within sixty days of enrollment. Data analysis completed at least annually.	
6) Breastfeeding	Proportion of mothers who breastfeed.	N: Mothers who breastfeed. D: Total participating mothers [see Population].	Administrative	No	An increase in the proportion of participating mothers who breastfeed within one year post enrollment, comparing Year 1 data to Year 3 data.	ODH staff	Vital statistics data from birth records	Participating mothers enrolled during pregnancy.		Administrative data collected continuously. Data analysis completed at least annually.	
7) Well-child visits	Average number of well-child visits completed.	N: Total well-child visits completed before child's first birthday. D: Total participating children [see Population].	Self-report	No	An increase in the average number of well-child visits completed, comparing Year 1 data to Year 3 data.	Home visitors	Family interview	Children of participating mothers enrolled during pregnancy.		Family interview completed within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Reliability / Validity of (Yes or No)	Definition of Improvement	Persons responsible	Source	Population	Sampling	Schedule (Frequency)	Data Analysis or CQI (optional)

8) Maternal and child health insurance status	Proportion of families who have either public or private health insurance.	N: Families with either public or private health insurance one year post enrollment. D: Total participating families [see Population].	Self-report	No	An increase in the proportion of families who have either public or private health insurance , comparing Year 1 data to Year 3 data for Year 1 population.	Home visitors	Family interview	Families served no less than six months.		Family interview completed within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	Descriptive statistics, graphs, and summary reports will be used as appropriate and necessary. Analyses and CQI activities will consider annual data as well as cumulative data for the total length of participant enrollment and services.
Benchmark 2: Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits											
9) Visits for children the emergency department from all causes	Average number of emergency department visits.	N: Total emergency department visits for children within one year post enrollment. D: Total participating children [see Population].	Self-report	No	A decrease in the average number of emergency department visits for children, comparing Year 1 data to Year 3 data for Year 1 population.	Home visitors	Family interview	Children of participating mothers served postnatal.		Family interview completed within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	Descriptive statistics, graphs, and summary reports will be used as appropriate and necessary. Analyses and CQI activities will consider annual data as well as cumulative data for the total length of participant enrollment and services.
10) Visits for mothers the emergency department from all causes	Average number of emergency department visits.	N: Total emergency department visits for mothers within one year post enrollment. D: Total participating mothers [see Population].	Self-report	No	A decrease in the average number of emergency department visits for mothers, comparing Year 1 data to Year 3 data for Year 1 population.	Home visitors	Family interview	All participating mothers.		Family interview completed within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	
11) Information provided or training on prevention of child injuries	Proportion of families who receive information or training on prevention of child injuries.	N: Families who received information or training on prevention of child injuries within one year post enrollment. D: Total participating families [see Population].	Self-report	No	An increase or maintenance in the proportion of families who receive information or training on prevention of child injuries, comparing Year 1 data to Year 3 data.	Home visitors	Family interview	Participating mothers served postnatal.		Family interview completed within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	
12) Incidence of child injuries requiring medical treatment	Proportion of children with injuries requiring medical treatment.	N: Children with injuries requiring medical treatment within one year post enrollment. D: Total participating children [see Population].	Self-report	No	A decrease in the proportion of children with injuries requiring medical treatment, comparing Year 1 data to Year 3 data for Year 1 population.	Home visitors	Family interview	Children of participating mothers served postnatal.	No	Family interview completed within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Reliability / Validity of (Yes or No)	Definition of Improvement	Persons responsible	Source	Population	Sampling	Schedule (Frequency)	Data Analysis or CQI (optional)

13) Reported suspected maltreatment for children in the program	Proportion of children with reported suspected maltreatment.	N: Children with reported suspected maltreatment within one year post enrollment. D: Total participating children [see Population].	Administrative	No	A decrease in the proportion of children with reported suspected maltreatment, comparing Year 1 data to Year 3 data.	ODH & ODJFS staff	MOU in progress	Children of participating mothers served postnatal.		Administrative data collected continuously. Data analysis completed at least annually.	Descriptive statistics, graphs, and summary reports will be used as appropriate and necessary. Analyses and CQI activities will consider annual data as well as cumulative data for the total length of participant enrollment and services.
14) Reported substantiated maltreatment	Proportion of children with reported substantiated maltreatment.	N: Children with reported substantiated maltreatment within one year post enrollment. D: Total participating children [see Population].	Administrative	No	A decrease in the proportion of children with reported substantiated maltreatment, comparing Year 1 data to Year 3 data.	ODH & ODJFS staff	MOU in progress	Children of participating mothers served postnatal.	Administrative data collected continuously. Data analysis completed at least annually.		
15) First-time victims of maltreatment	Proportion of children who are first-time victims of maltreatment.	N: Children who are first-time victims of maltreatment within one year post enrollment. D: Total participating children [see Population].	Administrative	No	A decrease in the proportion of children who are first-time victims of maltreatment, comparing Year 1 data to Year 3 data.	ODH & ODJFS staff	MOU in progress	Children of participating mothers served postnatal.	Administrative data collected continuously. Data analysis completed at least annually.		
Benchmark 3: Improvements in School Readiness and Achievement											
16) Parent support for children's learning and development	Results of environmental screening.	N: Children with a decrease in concerns OR no concerns indicated with annual administration, compared to time initial. D: Total participating children [see Population].	Tool Sub-scales	Yes	A decrease in concerns indicated OR no concerns indicated via above/below cutoff.	Home visitors	HOME or NCAST T	Children of participating mothers served no less than twelve months beyond their birth.		Environmental screening administered within sixty days of enrollment and at least annually thereafter. Data analysis completed at least annually.	Descriptive statistics, graphs, and summary reports will be used as appropriate and necessary. Analyses and CQI activities will consider annual data as well as cumulative data for the total length of participant enrollment and services.
17) Parent knowledge of child development and of their child's developmental progress	Results of AAPI 2.	N: Families with a decrease in concerns OR no concerns indicated with annual administration, compared to initial. D: Total participating families [see Population].	Tool Sub-scales	Yes	A decrease in concerns indicated OR no concerns indicated via above/below cutoff.	Home visitors	AAPI 2	Participating families served no less than twelve months postnatal.		AAPI 2 administered within sixty days of enrollment and at least annually thereafter. Data analysis completed at least annually.	
18) Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)	Results of environmental screening.	N: Families with a decrease in concerns OR no concerns indicated with annual administration, compared to initial. D: Total participating families [see Population].	Tool Sub-scales	Yes	A decrease in concerns indicated OR no concerns indicated via above/below cutoff.	Home visitors	HOME or NCAST T	Participating families served no less than twelve months postnatal.		Environmental screening administered within sixty days of enrollment and at least annually thereafter. Data analysis completed at least annually.	
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Reliability / Validity of (Yes or No)	Definition of Improvement	Persons responsible	Source	Population	Sampling	Schedule (Frequency)	Data Analysis or CQI (optional)

19) Parent emotional well-being or parenting stress (note: <u>some</u> of these data may also be captured for maternal health under that benchmark area).	Results of PSI-SF.	N: Families with a decrease in concerns OR no concerns indicated with annual administration, compared to initial. D: Total participating families [see Population].	Tool	Yes	A decrease in concerns indicated OR no concerns indicated via above/below cutoff.	Home visitors	PSI-SF	Participating families served no less than twelve months postnatal.		PSI-SF administered within sixty days of enrollment and at least annually thereafter. Data analysis completed at least annually.	
20) Child's communication, language and emergent literacy	Communication results of developmental screening.	N: Children with a decrease in concerns OR no concerns indicated with time 2 administration, compared to initial. D: Total participating children [see Population].	Tool Sub-scales	Yes	A decrease in concerns indicated OR no concerns indicated via above/below cutoff.	Home visitors	ASQ	Children of participating mothers served no less than twelve months beyond their birth.		Developmental screening administered within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	
21) Child's general cognitive skills	Problem Solving results of developmental screening.	N: Children with a decrease in concerns OR no concerns with time 2 administration, compared to initial. D: Total participating children [see Population].	Tool Sub-scales	Yes	A decrease in concerns indicated OR no concerns indicated via above/below cutoff.	Home visitors	ASQ	Children of participating mothers served no less than twelve months beyond their birth.		Developmental screening administered within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	
22) Child's positive approaches to learning including attention	Results of environmental screening.	N: Families with a decrease in concerns OR no concerns indicated with annual administration, compared to initial. D: Total participating families [see Population].	Tool Sub-scales	Yes	A decrease in concerns indicated OR no concerns indicated via above/below cutoff.	Home visitors	HOME or NCAST T	Participating families served no less than twelve months postnatal.		Environmental screening administered within sixty days of enrollment and at least annually thereafter. Data analysis completed at least annually.	
23) Child's social behavior, emotion regulation, and emotional well-being	Results of social emotional screening.	N: Children with a decrease in concerns OR no concerns with time 2 administration, compared to initial. D: Total participating children [see Population].	Tool	Yes	A decrease in concerns indicated OR no concerns indicated via above/below cutoff.	Home visitors	ASQ: SE	Children of participating mothers served no less than twelve months beyond their birth.	No	Social Emotional screening administered within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	Descriptive statistics, graphs, and summary reports will be used as appropriate and necessary. Analyses and CQI activities will consider annual data as well as cumulative data for the total length of participant enrollment and services.
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Reliability / Validity of (Yes or No)	Definition of Improvement	Persons responsible	Source	Population	Sampling	Schedule (Frequency)	Data Analysis or CQI (optional)
24) Child's physical health and development.	Results of developmental screening.	N: Children with a decrease in concerns OR no concerns with time 2 administration, compared to initial. D: Total participating children [see Population].	Tool Sub-scales	Yes	A decrease in concerns indicated OR no concerns indicated via above/below cutoff.	Home visitors	ASQ	Children of participating mothers served no less than twelve months beyond their birth.		Developmental screening administered within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	Descriptive statistics, graphs, and summary reports will be used as appropriate and necessary. Analyses and CQI activities will consider annual data as well as cumulative data for the total length of participant enrollment and services.

Benchmark 4: Crime or Domestic Violence											
Crime											
25) Arrests											
26) Convictions	N/A										
Domestic Violence											
27) Screening for domestic violence	Proportion of participating families who are screened for domestic violence.	N: Families screened for domestic violence within one year post enrollment. D: Total participating families [see Population].	Tool	Yes	An increase or maintenance in the proportion of families who are screened for domestic violence, comparing Year 1 data to Year 3 data.	Home visitors	ODVN Screening	Families served no less than six months.		ODVN Screening administered within sixty days of enrollment and at least annually thereafter. Data analysis completed at least annually.	Descriptive statistics, graphs, and summary reports will be used as appropriate and necessary. Analyses and CQI activities will consider annual data as well as cumulative data for the total length of participant enrollment and services.
28) Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters, food pantries);	Proportion of families with DV identified who are referred.	N: Families referred RE: DV within one year post enrollment. D: Total participating families with DV identified [see Population].	Self-report	No	An increase in the proportion of families with DV identified who are referred RE: DV, comparing Year 1 data to Year 3 data.	Home visitors	Case record	Families with DV identified.	Case records are updated after every contact with or regarding participants.		
29) Of families identified for the presence of domestic violence, number of families for which a safety plan was completed.	Proportion of families with DV identified who have a safety plan completed.	N: Families with DV safety plans completed within one year post enrollment. D: Total participating families with DV identified [see Population].	Self-report	No	An increase in the proportion of families with DV identified who have safety plans completed, comparing Year 1 data to Year 3 data.	Home visitors	Case record	Families with DV identified.	Case records are updated after every contact with or regarding participants.		
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Reliability / Validity of (Yes or No)	Definition of Improvement	Persons responsible	Source	Population	Sampling	Schedule (Frequency)	Data Analysis or CQI (optional)
Benchmark 5: Family Economic Self-Sufficiency											
30) Household income and benefits (See SIR for definitions.)	Total household income and benefits.	N: Families with an increase in household income and benefits within one year post enrollment. D: Total participating families [see Population].	Self-report	No	An increase in the proportion of families with increased total household income and benefits, comparing Year 1 data to Year 3 data.	Home visitors	Family interview	Families served no less than twelve months.		Family interview completed within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	Descriptive statistics, graphs, and
31) Employment or Education of adult members of the household	Educational attainment of adults in participating families.	N: Families with an adult who increased his/her educational attainment (including program participation) within one year post enrollment. D: Total participating families [see Population].	Self-report	No	An increase in the proportion of families with an adult who increased his/her educational attainment (including program participation), comparing Year 1 data to Year 3 data.	Home visitors	Family interview	Families served no less than twelve months with an adult who is interested in increasing his/her education attainment (including program participation).	Family interview completed within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.		

32) Health insurance status	Proportion of families who have either public or private health insurance.	N: Families with either public or private health insurance one year post enrollment. D: Total participating families [see Population].	Self-report	No	An increase in the proportion of families who have either public or private health insurance , comparing Year 1 data to Year 3 data for Year 1 population.	Home visitors	Family interview	Families served no less than six months.	No	Family interview completed within sixty days of enrollment and at least every 180 days thereafter. Data analysis completed at least annually.	Descriptive statistics, graphs, and summary reports will be used as appropriate and necessary. Analyses and CQI activities will consider annual data as well as cumulative data for the total length of participant enrollment and services.
Benchmark 6: Coordination and Referrals for Other Community Resources and Supports											
33) Number of families identified for necessary services	Proportion of families assessed for necessary services using all required tools.	N: Families assessed for necessary services using all tools prescribed by the department. D: Total participating families [see Population].	Self-report	No	An increase or maintenance in the proportion of families assessed for necessary services using all tools prescribed by the department.	Home visitors	Case record	Families served no less than six months.		Case records are updated after every contact with or regarding participants.	Descriptive statistics, graphs, and summary reports will be used as appropriate and necessary.
Construct	Performance Measure	Operational Definition	Measurement (Tool or Administrative)	Reliability / Validity of (Yes or No)	Definition of Improvement	Persons responsible	Source	Population	Sampling	Schedule (Frequency)	Data Analysis or CQI (optional)
34) Number of families that required services and received a referral to available community resources	Proportion of families that required services and received a referral.	N: Families referred. D: Total participating families identified to require services [see Population].	Self-report	No	An increase or maintenance in the proportion of families identified to require services who are referred [see Population].	Home visitors	Case record	Families assessed for necessary services using all required tools who required services.		Case records are updated after every contact with or regarding participants.	Analyses and CQI activities will consider annual data as well as cumulative data for the total length of participant enrollment and services. Descriptive statistics, graphs, and summary reports will be used as appropriate and necessary. Analyses and CQI activities will consider annual data as well as cumulative data for the total length of participant enrollment and services.
35) MOUs: Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community	Number of formal agreements with other social service agencies	Number of formal agreements with other social service agencies	Administrative	No	An increase or maintenance in the number of formal agreements.	ODH staff	ODH records				
36) Information sharing: Number of agencies with which the home visiting provider has a clear point of contact.	Number of social service agencies that engage in regular communication with the home visiting provider	Number of social service agencies that engage in regular communication with the home visiting provider	Administrative	No	An increase or maintenance in the number of social service agencies.	ODH staff	ODH records	N/A		N/A	
37) Number of completed referrals	Proportion of families referred for identified required services that received services.	N: Families received required services. D: Total participating families referred for identified required services [see Population].	Self-report	No	An increase or maintenance in the proportion of families referred for identified required services who received services [see Population].	Home visitors	Case record	Families that required services and received a referral.	No	Case records are updated after every contact with or regarding participants.	

Appendix: D MIECHV Quarterly Report Form

Purpose: The Ohio Department of Health Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program requires submission of the *MIECHV Contractor Quarterly Report* as part of the provider grant. This report informs the MIECHV Program Consultants and ODH management on how to assist with appropriate technical assistance to local contractors. It also provides a mechanism for reporting implementation details and successful strategies/best practices with ODH.

Instructions: Complete this form and submit electronically to your respective MIECHV Program Consultant.

Program Period	Report Due Date
2/1/2013 – 3/31/2013	4/15/2013
4/1/2013 – 6/30/2013	7/15/2013
7/1/2013 – 9/30/2013	10/15/2013

Agency Name: _____ Contract Manager: _____

Reporting Period: *from* _____ *to* _____

Submitted by: _____ Submission Date: _____

Number of PROPOSED Families to be served: _____

Number of Families CURRENTLY being served: _____

Staffing

(Report the following staffing information for this reporting period)

How many home visitors are currently employed? (FTE)	
How many HV supervisors are currently employed? (FTE)	
How many other staff supports the MIECHV program? (FTE and roles)	
List all currently vacant positions and describe plan and timelines to fill these positions.	
Describe how your program supports and monitors supervision (reflective, administrative and field).	

Organizational Coordination Outreach and Referral

(List all agencies that you have a relationship with, including those with funding agreements and those with whom you have less formal arrangements (i.e., partners on a collaborative workgroup, memorandum of understanding (MOU), etc.)

Name of agency, contact information, and name of specific contact person	Date if MOU or other formal agreement (if applicable)	Do you refer to this agency?	Does this agency refer to you?	Brief description of organization, nature of relationship, types of services provided, and any shared funding or resources (in kind, facilities, etc)

Are there any organizations that you would like to partner with but have not yet? Please describe the group, whether you have a plan for collaborating in the future, as well as any challenges to collaboration with this organization.

Are there community leaders that you have engaged? Please describe their role, how you have established this relationship and how you maintain this relationship.

Describe and attach any outreach materials you have developed and implemented for the program. Include a description of the materials intended audience, purpose and distribution plans.

Describe all targeted program and participant outreach activities conducted for this reporting period. Include targeted communities, staff involved, venues, challenges, strategies to overcome challenges, and outcomes. Identify any future outreach plans for the next reporting period.

Describe how your agency leadership supports the MIECHV Program

Evidence-Based Home Visiting Model Affiliation
(Report the following EBHV information for this reporting period)

What EBHV model are you implementing?	
Is your EBHB model affiliation current?	
Have all EBHV model fees been paid?	
Have you consulted with the EBHV national office to request model fidelity TA or with any other questions? What TA was requested? Did you receive the TA needed?	
Is all staff trained in the EBHV model being implemented? If no, what is your plan to have all staff trained?	
What research-based parenting education curriculum are you implementing?	
Is all staff trained in the research-based parenting education curriculum being implemented? If no, what is your plan to have all staff trained?	
Provide any other relevant updates or comments for this reporting period regarding EBHV model affiliation and/or research-based parenting education curriculum.	

Program Narrative & Planning:

(Describe the status of program implementation of the MIECHV program related components such as staff recruitment and professional development, supervision, referral/outreach progress, participant enrollment/retention, home visiting service delivery, Early Track data system, billing and payments)

Successes	Challenges and Barriers	Strategies to Overcome Challenges/Barriers
Provide any other relevant updates or comments for this reporting period:		
Describe any <i>Continuous Quality Improvement</i> processes or strategies being implemented:		
List major activities planned or goals for the next reporting period:		

Technical Assistance/Training Needs:

(Describe areas where improved knowledge and skills for staff are needed and indicate technical assistance and/or trainings that would meet these needs and relate to program implementation)

Identified Needs	Technical Assistance Request	Training Request

Family Success Story:

(Describe how your staff and/or home visiting program positively affected the lives of MIECHV participants after enrollment commenced. Please provide specific examples and preserve confidentiality of participants by not identifying participants using any identifiable information)

Appendix E: NOTICE OF INTENT TO APPLY FOR FUNDING
Ohio Department of Health
Division of Family & Community Health Services
Bureau for Children with Developmental and Special Health Needs

ODH Program Title: Maternal, Infant, & Early Childhood Home Visiting (MIECHV) in Ohio
ALL INFORMATION REQUESTED MUST BE COMPLETED.
(Please Print Clearly or Type)

County of Applicant Agency _____

Federal Tax Identification Number _____

NOTE: The applicant agency/organization name must be the same as that on the IRS letter. This is the legal name by which the tax identification number is assigned.

Type of Applicant Agency (Check One) County Agency Hospital Local Schools
 City Agency Higher Education Not-for Profit

Applicant Agency/Organization _____

Applicant Agency Address _____

Agency Contact Person/Title _____

Telephone Number _____

E-mail Address _____

Please check all applicable: Yes, our agency will need GMIS 2.0 training
 No, our agency has completed GMIS 2.0 training
 First time applying for an ODH grant
 Our agency will attend the Bidder's Conference

Mail, E-mail or Fax To: Jeffrey Wynnyk, Program Manager
Bureau for Children with Developmental and Special Health Needs
Maternal, Infant, & Early Childhood Home Visiting in Ohio
Ohio Department of Health
246 N. High Street, 5th floor
Columbus, Ohio 43215
E-mail: Jeffrey.Wynnyk@odh.ohio.gov
Fax: 614-728-9163

Appendix F: A. Evidence-Based Model Summaries for Healthy Families America and Nurse Family Partnership

Implementing Healthy Families America (HFA)

Program Model Overview

Implementation Support

Healthy Families America (HFA) is a program of Prevent Child Abuse America (PCA America). The national office, located in Chicago, Illinois, provides support, technical assistance, training, affiliation, and accreditation to HFA programs. In addition, PCA America supports state systems development and advocacy efforts.

Twelve states have HFA systems in place to support HFA implementation (Arizona, Florida, Georgia, Illinois, Indiana, Iowa, Maryland, Massachusetts, New Jersey, New York, Oregon, and Virginia). A state system is a network of support for HFA programs in a state. State systems are designed to facilitate the sharing of resources and information, provide an environment for supportive learning, and enhance a state's ability to access funding.

Theoretical Model

HFA is based upon a set of critical elements that serve as the framework for program development and implementation. HFA program model components are theoretically rooted in a strength-based approach. The strength-based approach recognizes that all families have strengths and that programs should build on these strengths rather than focus on correcting weaknesses. Family support workers (FSWs; HFA home visitors) help families build their own abilities to manage life's challenges.

Target Population

HFA is designed for parents facing challenges such as single parenthood, low income, childhood history of substance abuse, mental health issues, and/or domestic violence. Individual programs select the specific characteristics of the target population they plan to serve.

HFA requires that families be enrolled prenatally or within the first three months after a child's birth. Once enrolled, HFA programs provide services to families until the child enters kindergarten.

Targeted Outcomes

HFA aims to (1) reduce child maltreatment; (2) increase utilization 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.

Program Model Components

HFA includes (1) screenings and assessments, and (2) home visiting services. In addition, many HFA programs offer services such as parent support groups and father involvement programs. HFA allows local sites to formulate program services and activities that correspond to the specific needs of their communities.

Program Model Intensity and Length

HFA sites offer at least one home visit per week for the first six months after the child's birth. After the first six months, local programs determine the frequency of the visits. Typically, home visits last a minimum of one hour.

HFA programs begin to provide services prenatally or at birth and continue through the first three to five years of life. Each local program determines the length of the program.

Location

HFA programs are located in 32 states and the District of Columbia (Alabama, Arizona, California, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oregon, South Carolina, Tennessee, Texas, Utah, Virginia, West Virginia, and Wisconsin).

Prerequisites for Implementation

Staffing Requirements

HFA has three primary staff positions: (1) family support workers (FSWs) who conduct home visits with families; (2) family assessment workers (FAWs) who conduct family and child assessments and sometimes screen families for enrollment in the program; and (3) program managers/supervisors who oversee program operations, funding, quality assurance, evaluation, and supervision of staff.

Staff Education and Experience

HFA does not provide specific educational requirements for direct-service staff. It recommends selecting staff based on their personal characteristics; their willingness to work in, or experience working with, culturally diverse communities; their experience working with families with multiple needs; and their ability to maintain boundaries between personal and professional life. HFA requires all staff to complete mandatory HFA training.

Supervision Requirements

HFA recommends one supervisor for every five staff persons. Although the HFA credentialing guidelines allow a ratio of 1:6, a ratio of 1:5 is considered optimal.

HFA recommends program managers/supervisors spend a minimum of 1.5 to 2 hours per employee each week on formal supervision and additional time shadowing the FSWs and FAWs to monitor and assess their performance and provide constructive feedback and development.

Staff Ratio Requirements

HFA recommends that one FSW should serve no more than 15 families. In some instances, the caseload may need to be reduced to accommodate families with multiple needs or to accommodate communities in which there are long distances between home visits.

Data Systems/Technology Requirements

HFA requires that implementing agencies use the Program Information Management System (PIMS), a computerized data collection, management, and reporting tool that enables HFA programs to manage and report on the community programs and participant services they provide; site, community, and staff characteristics; funding sources; agency collaborations; and preliminary outcomes information.

Training to Support Implementation

Requirements for Certification

Established home visitation programs, as well as new programs, can affiliate with HFA. Completion of this process reflects a commitment to implementing the 12 critical elements. All single-site programs interested in affiliating with the HFA initiative and using the "Healthy Families" name must complete the HFA Application for Affiliation. The HFA credentialing process has three steps: (1) a site self-assessment, (2) an external peer review performed by a team of at least two HFA-certified reviewers, and (3) a credentialing decision made by the HFA credentialing panel.

Programs are credentialed by PCA America based on adherence to the critical elements that serve as the foundation for HFA program development and implementation. HFA programs are required to complete accreditation every four years.

Pre-Service Staff Training

HFA primary training is a mandatory five-day workshop delivered by certified national or state HFA trainers. The training (1) prepares program staff to provide services specific to their job responsibilities, (2) introduces staff to HFA, and (3) describes the HFA critical elements and the best practices of family-centered and strength-based service provision. HFA recommends that direct service staff receive this training before working with clients, and, at a minimum, it should occur within the first six months of employment. In addition, sites can offer to staff prenatal training (Great Beginnings Start Before Birth). Prenatal training provides home visitors with strategies for supporting families during the prenatal period and helping parents enhance prenatal bonding, stimulate brain development, and reduce stress. Prenatal training lasts between three and four days, depending on the experience level of staff.

In-Service Staff Training

HFA encourages sites to provide in-service training that includes information about the challenges faced by the community's families and the local resources available to support those families. HFA recommends that staff devote one-third of their time to in-service training within the first six months of employment, equaling about 80 hours.

Training Materials

Training materials are available through HFA.

Qualified Trainers

HFA training is provided by certified national or state HFA trainers. PCA America is responsible for observing HFA certified trainers. It partners with Great Kids, Inc. to mentor new trainers and prepare them to offer HFA training to direct service staff.

Technical Assistance

Technical assistance is available from state systems, regional centers, a peer network, and PCA America program staff on an as-needed basis.

Materials and Forms to Support Implementation

Operations Manuals

The *Healthy Families America Site Development Guide* (2000) is a guidebook that provides information for sites on developing and implementing an HFA program.

Assessment Tools

Most HFA programs use the Kempe Family Stress Checklist (FSC) as their assessment tool, although programs may choose an assessment tool that meets their particular needs. This assessment tool is used to assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes.

Curriculum

HFA does not recommend or require a specific curriculum.

Fidelity Measurement

To validate adherence to the HFA critical elements, sites apply for credentialing, conduct a program self-assessment, and undergo a peer-review site visit that is conducted by at least two external, trained peer reviewers.

Fidelity Standards

All HFA programs are required to adhere to 12 critical elements across their program areas (service initiation, service content, and staff characteristics) that serve as the framework for program development and implementation. The critical elements include:

Service Initiation

1. Initiate services prenatally or at birth.
2. Use a standardized assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes.
3. Offer services voluntarily and use positive outreach efforts to build family trust.

Service Content

4. Offer services intensively (for example, at least once a week) with well-defined criteria for increasing or decreasing frequency of service and service over the long term (for example, three to five years).
5. Services should be culturally competent such that the staff understands, acknowledges, and respects cultural differences among participants; staff and materials used should reflect the cultural, linguistic, geographic, racial, and ethnic diversity of the populations served.
6. Services should focus on supporting the parent as well as supporting parent-child interaction and child development.
7. At a minimum, all families should be linked to a medical provider to ensure optimal health and development. Depending on the family's needs, it may also be linked to additional services.
8. Services should be provided by staff with limited caseloads to ensure that home visitors have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities.

Staff Characteristics

9. Service providers should be selected because of their personal characteristics, their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.
10. Service providers should have a framework, based on education or experience, for handling the variety of situations they may encounter when working with at-risk families. All service providers should receive basic training in areas such as cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community.

11. Service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation.
12. Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations so that they can see that they are making a difference and in order to avoid stress-related burnout.

Estimated Costs of Implementation

Average Cost per Family

According to a survey conducted by PCA America in 2004 of HFA programs in 15 states, the average cost of HFA per family per year is \$3,348, with a range of \$1,950 to \$5,768. No information is available about the costs included in the cost per family estimation.

Purchase of Program Model or Operating License

Affiliated sites are responsible for an annual fee of \$1350 for a single site or \$1150 for a multi-site affiliation.

Materials and Forms

The *Healthy Families America Site Development Guide* (2000) is available free of charge on the HFA website. The Application for Affiliation and Site Profile are available through HFA.

Training and Technical Assistance

Training costs include (1) \$3,800 per certified HFA trainer, and (2) a materials fee of \$75 per participant. Two trainers are provided for each primary training: one to train the FSWs and one for the FAWs. The maximum number of participants allowed in an FSW training group is 15; for an FAW training group the maximum number is 12.

Infrastructure

Costs associated with PIMS include mandatory two-day training and technical assistance for the first year of implementation. There is no charge for system upgrades. No information is available on estimated costs.

HFA Program Model Contact Information

Where to Find Out More

Healthy Families America National Office

228 S. Wabash, 10th Floor

Chicago, IL 60604

Phone: (312) 663-3520

Fax: (312) 939-8962

Website: <http://www.healthyfamiliesamerica.org/home/index.shtml>

HFA Central Regional Center

Traci Lansing

tlansing@preventchildabuse.org

Implementing Nurse Family Partnership (NFP)

Program Model Overview

Implementation Support

The Nurse Family Partnership, a Colorado nonprofit organization referred to as the National Service Office (NSO), helps communities implement and sustain Nurse Family Partnership[®] (NFP).

NFP NSO has established partnerships for the provision of consultative services in some states, including Colorado, Pennsylvania, Louisiana, Texas, and New York.

Theoretical Model

NFP is shaped by human attachment, human ecology, and self-efficacy theories. The nurse home visitors use principles of motivational interviewing to promote low-income, first-time mothers' health during pregnancy, care of their child, and own personal growth and development. Nurse home visitors guide parents to reinforce the model's goals.

Target Population

NFP is designed for first-time, low-income mothers and their children.

NFP requires a client to be enrolled in the program early in her pregnancy and to receive a first home visit no later than the end of the woman's 28th week of pregnancy. Services are available until the child is 2 years old.

Targeted Outcomes

NFP is designed to (1) improve prenatal health and outcomes, (2) improve child health and development, and (3) improve families' economic self-sufficiency and/or maternal life course development.

Program Model Components

NFP includes one-on-one home visits between a trained public health nurse and the client.

Program Model Intensity and Length

NFP nurses conduct weekly home visits for the first month after enrollment and then every other week until the baby is born. Visits are weekly for the first six weeks after the baby is born, and then every other week until the baby is 20 months. The last four visits are monthly until the child is 2 years old. Home visits typically last 75 minutes.

NFP NSO recommends that programs begin conducting visits early in the second trimester (14–16 weeks gestation) and requires programs to begin visits by the end of the 28th week of pregnancy. Clients are enrolled until the child turns 2 years old.

Location

NFP programs are located in 32 states, serving clients in 385 counties.

Adaptations and Enhancements

Any adaptations or enhancements to the program model are managed under the leadership of Dr. David Olds at the University of Colorado.

Prerequisites for Implementation

Type of Implementing Agency

NFP NSO does not specify a type of implementing agency eligible for participation but does require that implementing agencies are organizations known in the community for being successful providers of prevention services to low-income families.

Staffing Requirements

NFP NSO requires that nurse home visitors and nursing supervisors are registered professional nurses with a minimum of a Baccalaureate degree in nursing. NFP NSO prefers that supervisors have a master's-level degree in nursing. The program also requires nurse home visitors and nursing supervisors to complete core education sessions offered by NFP NSO. (Adaptation can be explored if a position cannot be filled with a BSN after reasonable hiring efforts have been made).

Supervision Requirements

NFP NSO requires that a full-time nursing supervisor provides supervision to no more than eight individual nurse home visitors. A Supervisor can be a .5 FTE although a full-time supervisor is preferred.

Nursing supervisors provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role. Supervisory activities include one-on-one clinical supervision, case conferences, team meetings, and field supervision.

Staff Ratio Requirements

NFP NSO requires that a full-time nurse home visitor carry a caseload of no more than 25 active clients.

Data Systems/Technology Requirements

NFP NSO requires implementing agencies use a web-based data system, called Efforts to Outcome(ETO), to enter data, including staff and client characteristics, maternal and child health, and home visit documentation.

Training to Support Implementation

Requirements for Certification

Agencies are considered official NFP implementing agencies only after a formal contract is signed by both the local administrator and NFP NSO.

Before a contract is offered to a prospective implementing agency, program development staff from the NFP NSO engage in a formal due diligence process with the prospective implementing agency. During

this process the agency: (1) demonstrates a community need for NFP services and demonstrates the presence of other programs in the community that aim to serve the same client population; (2) provides NSO with the number of low-income, first-time births in the catchment area per year; (3) identifies a plan for the sound financing of the program; (4) articulates their experience with innovative programs; (5) demonstrates community support for NFP or the potential of that support; (6) identifies their ability to coordinate with existing health and human services programs; (7) demonstrates the ability to establish a highly effective referral procedure, ensuring an adequate number of voluntary enrollments in the program; and (8) demonstrates the ability to recruit and retain qualified registered nurses.

Pre-Service Staff Training

NFP NSO requires that nurse home visitors complete three core education sessions, in both distance and face-to-face training formats. The sessions take place over a 9-month time frame. There is only one face to face training for nurse home visitors.

Nursing supervisors must complete the same core education sessions as the nurse home visitors. Additionally, they must complete four supervisor core education sessions, including two face-to-face sessions.

In-Service Staff Training

See requirements for “Pre-Service Staff Training.”

Training Materials

Training materials are available through NFP NSO and are provided to attendees of the core education sessions.

Qualified Trainers

Training is provided by professional nurse educators based at NFP NSO.

Technical Assistance

NFP NSO provides ongoing targeted coaching and consultation through nurse consultants to implementing agencies. NFP NSO has established partnerships for the provision of consultative services in some states, including Colorado, Pennsylvania, Louisiana, Texas, and New York.

Materials and Forms to Support Implementation

Operations Manuals

Reference materials (including handbooks, online documents, and CD/DVDs) available through NFP NSO are provided to nurse home visitors and supervisors.

Service Delivery Forms

Required forms are incorporated into the ETQ.

Assessment Tools

Assessments are incorporated into the ETQ.

Curriculum

NFP NSO requires nurse home visitors follow visit-by-visit guidelines; they are instructed to adapt these guidelines to meet the individual needs of families.

Available Languages

NFP is available in English and Spanish. Additionally, in service areas with high concentrations of immigrants local agencies offer services, curricula, and materials in other languages.

Fidelity Measurement

NFP NSO monitors data entered into the ETQ to ensure that the program is meeting fidelity benchmarks. The NFP NSO reports data to agencies to assess and guide program implementation; agencies use these reports to monitor variation in implementation.

Fidelity Standards

NFP NSO requires implementing agencies to adhere to 18 fidelity standards, including:

1. Clients participate voluntarily in NFP.
2. Clients are first-time mothers.
3. Clients meet low-income criteria at intake.
4. Clients are enrolled in NFP early in the pregnancy and receive the first home visit by no later than the end of the 28th week of pregnancy.
5. Clients are visited one to one (one nurse home visitor to one first-time mother and her family).
6. Clients are visited in their homes.
7. Clients are visited throughout their pregnancy and the first two years of their children's lives in accordance with NFP guidelines.
8. Nurse home visitors and nursing supervisors are registered professional nurses with a minimum of a B.A. in nursing.
9. Nurse home visitors and nursing supervisors complete core educational sessions required by NFP NSO and deliver NFP with fidelity to the model.
10. Nurse home visitors use professional knowledge, judgment, and skill and apply the NFP visit guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains.
11. Nurse home visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology, and attachment theories in their work with clients.
12. A full-time nurse home visitor carries a caseload of no more than 25 clients.

13. A full-time nursing supervisor provides supervision to no more than eight individual nurse home visitors.
14. Nursing supervisors provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities, including one-to-one clinical supervision, case conferences, team meetings, and field supervision.
15. Nurse home visitors and nursing supervisors collect data specified by NFP NSO and use NFP reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality, and demonstrate program fidelity.
16. NFP implementing agencies are located in and operated by organizations known in the community for being successful providers of prevention services to low-income families.
17. NFP implementing agencies convene a long-term Community Advisory Board that meets at least quarterly to promote a community support system to the program and to promote program quality and sustainability.
18. Adequate support and structure are in place to support nurse home visitors and nursing supervisors to implement the program and to ensure that data are accurately entered in the ETQ in a timely manner.

Estimated Costs of Implementation

Average Cost per Family

According to NFP NSO, the average cost of NFP per family per year is \$4,500, with a range of \$2,914 to \$6,463 (2008 dollars). This estimate includes costs for program materials, training, salaries for nursing staff, and access to the centralized electronic data collection and reporting system. The primary factor affecting the range in costs is nurses' salaries, which vary by geographic region and setting.

Labor Costs

Labor costs are included in the cost per family estimation.

Purchase of Program Model or Operating License

Agencies under contract to implement NFP are granted a non-exclusive, limited right and license to use NFP proprietary property.

Materials and Forms

(See full sample implementing budget in FHVI State Toolkit on NFP website, www.nursefamilypartnership.org)

Materials and forms are included in ETO; see sample budget on NFP website for estimated costs.

Training and Technical Assistance

The 2011 fee for technical assistance is \$8,816. The 2011 fees for training include \$3,950 for nurse home visitors and \$4663 for supervisors. Educational materials cost \$502.

Infrastructure

Costs for ETO is \$1,424 (2011 fees).

Recruitment and Retention

The estimated costs for client recruitment vary by community.

Program Model Contact Information

Where to Find Out More

Nurse-Family Partnership National Service Office
1900 Grant Street, Suite 400
Denver, CO 80203
Phone: (866) 864-5226
Fax: (303) 327-4260
E-mail: info@nursefamilypartnership.org
Website: <http://www.nursefamilypartnership.org>

Kimberly Friedman
Program Developer (Indiana, Kentucky, Michigan, and Ohio)
303.865.8402
kimberly.friedman@nursefamilypartnership.org

ZERO TO THREE HOME VISITING COMMUNITY PLANNING TOOL



Introduction

Early childhood home visiting has been shown to be an effective service delivery model for at-risk young children and their families. When establishing new home visiting programs or expanding existing services using an evidence-based home visiting model, communities should consider several factors in order to ensure high-quality service delivery that is true to the intent of those who developed the model and that meets expressed community need.

Home visiting services are most successful when key components are integrated. These include the following:

- A community that understands the program and supports its development
- Program staff that are well-trained and supported through high-quality supervision
- Strong administrative support
- Ongoing evaluation of program implementation so that quality issues can be addressed in a timely manner
- An environment where the need for the program is clearly understood and there is no duplication of efforts
- A spirit of collaboration with other early childhood programs
- Strong local leadership to nurture the development of the services

Planning for new home visiting capacity is a long-term and ongoing process. This tool can be used by communities to:

- Identify community needs and strengths based on data.
- Explore current home visiting assets and service gaps.
- Choose an evidence-based program model.
- Analyze components of both program- and system-level implementation that are critical to the replication of high-quality home visiting programs.

¹ Erin Harris, "Six Steps to Successfully Scale Impact in the Nonprofit Sector," *The Evaluation Exchange*, Harvard Family Research Project, Volume XV no 1, Spring 2010, www.hfrp.org.

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It is not expected that a community will be able to address all topics in this tool at one time. Rather, the tool can serve as a guide that will take you through key elements of program planning, enable you to customize your approach to your community's unique and evolving needs, and align work at the local level with state efforts.

The 2010 Patient Protection and Affordable Care Act allocated significant funds to states to expand evidence-based home visiting programs in at-risk communities through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. The planning process for this new opportunity is detailed further below. However, though this community planning tool was developed with the new federal resources in mind, it has utility beyond this particular funding opportunity and is relevant to any situation in which home visiting services are being explored, whether resources are available at the time or not. For example, this tool could be used as a component of a community process to build an early childhood system, as an approach to integrating an additional home visiting program model into a community, or as a way to think about how to adapt services to a specific population whose needs are currently not being met.

If your community uses this tool, ZERO TO THREE would like your feedback on its use, the process, and the results for your community. Please share your experience with Barbara Gebhard at bgebhard@zerotothree.org.

Starting New or Expanding Existing Home Visiting Services

Whether you are starting a new home visiting program or expanding existing services, you should carefully consider the process you are going to use to do so. It is important to include a wide variety of stakeholders in the process, such as representatives of early childhood programs and other community services, health and mental health professionals, researchers, funders, advocates, parents, elected officials, and other community leaders. Create an inclusive process that involves these initial steps:

- Establish consensus, to the extent possible, among the stakeholders to pursue additional home visiting services.
- Use the information collected by this tool to explore community demographics, assets, and gaps.
- Work with stakeholders in matching this analysis to the most appropriate evidence-based home visiting program model.
- Engage with your state's planning efforts so that an integrated and consistent plan evolves to grow home visiting services.

The process mandated by the current federal funding opportunity requires extensive assessment and planning processes to determine the best strategy for replicating high-quality programs to

meet the needs of the target communities. The Updated State Plans required to receive funds from the legislation must fully articulate an implementation plan for use of the expansion funds.

Components of the Updated State Plan² include:

- The process for engaging at-risk communities around the proposed home visiting plan
- A plan for working with the national model developer(s)
- A description of initial and ongoing training and professional development activities
- A plan for recruiting, hiring, and retaining appropriate staff for all positions
- A plan to ensure high-quality clinical supervision and reflective practice for all home visitors and supervisors
- The estimated number of families served
- A plan for identifying and recruiting participants and minimizing attrition rates
- An operational plan for coordination between the proposed home visiting program(s) and other existing programs and resources in those communities
- An explanation of the state's approach to monitoring, assessing, and supporting implementation, with fidelity to the chosen model(s) and maintaining quality assurance
- Assurance that individualized assessments will be conducted of participating families and that services will be provided in accordance with those individual assessments

Information contained in both the Statewide Needs Assessment and Updated State Plan can be accessed through your state lead agency. In many states, the lead agency will be the state health department. A complete list is available at www.acf.hhs.gov/earlychildhood/index.html.

The State of Your Community

How do you define your “community” for the purposes of this tool (i.e., zip codes, town/city boundaries, townships, county borders, other)?

² <http://www.hrsa.gov/grants/manage/homevisiting/sir02082011.pdf>

Community Demographic Information^a

Construct	Community Data	State Data ^b
Number of children <ul style="list-style-type: none"> • ages 0-3 • ages 4-5 		
Premature births <ul style="list-style-type: none"> • percent: # of live births before 37 weeks/total # live births 		
Low birth weight. <ul style="list-style-type: none"> • percent: # resident live births less than 2,500 grams/# live births 		
Infant mortality <ul style="list-style-type: none"> • # infant deaths ages 0 -1/ 1,000 live births 		
Poverty <ul style="list-style-type: none"> • # residents below 100% Federal Poverty Level (FPL)/total # of residents • # residents below 185% FPL/total # of residents 		
Crime <ul style="list-style-type: none"> • # of reported crimes/1,000 residents • # of crime arrests ages 0 -19/ 100,000 juveniles ages 0 -19 		
School dropout rates <ul style="list-style-type: none"> • percent high school dropouts grades 9 -12 • other school dropout rates as per state/local calculation 		
Substance abuse <ul style="list-style-type: none"> • prevalence rate: binge alcohol use in past month • prevalence rate: marijuana use in past month • prevalence rate: nonmedical use of prescription drugs in past month • prevalence rate: use of illicit drugs, excluding marijuana, in past month 		
Unemployment rate <ul style="list-style-type: none"> • percent: # unemployed and seeking work/ total workforce 		

^a Many of the data constructs in this chart were required for the Statewide Needs Assessment (www.hrsa.gov/grants/apply/assistance/homevisiting/homevisitingsupplemental.pdf). Each state submitted its assessment in September 2010.

^b State data for some of the constructs are available in Child Trends, "Home Visiting Application Process: A Guide for Planning State Needs Assessments." *Early Childhood Highlights* 1, no. 4 (2010): 1 -25, www.childtrends.org.

<p>Child maltreatment</p> <ul style="list-style-type: none"> • rate of reported substantiated maltreatment by child age • rate of reported substantiated maltreatment by type 		
<p>Domestic violence</p> <ul style="list-style-type: none"> • (contact your state lead for appropriate data constructs) 		
<p>Health insurance</p> <ul style="list-style-type: none"> • percent of children under 6 covered by health insurance 		
<p>Teen pregnancy</p> <ul style="list-style-type: none"> • percent of live births to females less than 20 years of age 		
Other		
Other		

Given the above data and your community's comparison to your state's averages, what are your community's primary needs?

<ol style="list-style-type: none"> 1. 2. 3. 4. 5.
--

What are your community's identified strengths?

<ol style="list-style-type: none"> 1. 2. 3. 4. 5.
--

Existing Home Visiting Services^a

Name of Program	Home Visiting Model	Service(s) Provided	Targeted Goals/ Outcomes of Program	Eligibility Criteria	# of Children or Families Served	Geographic Area Served

^a This information can be found in your state's Statewide Needs Assessment. Depending on how the information was collected, local service providers may have to be contacted for more information.

Strengths and Gaps in Home Visiting Services

Based on the chart of existing home visiting services on the previous page, what are the major strengths of current programs?

- 1.
- 2.
- 3.
- 4.
- 5.

What are the populations currently not served by existing home visiting programs?

What are areas of need that are not being met by existing programs?

What geographic locations most lack services?

Key Considerations When Choosing a Home Visiting Model

Several considerations should be taken into account at the community level when selecting a home visiting program model to implement. Such considerations include:

- The existing research that validates a particular model
- The synergy between the model's intended goals/outcomes and the community's needs
- The ability to maintain fidelity to a particular model (i.e., community resources to implement the model's goals, objectives, and program standards)
- The pool of qualified applicants available to meet the model's staff qualifications
- The availability and accessibility of early childhood, maternal and child health, mental health, and social services
- The approximate cost per family per year

Matching Community Needs to Evidence-Based Models

As part of the MIECHV federal funding initiative, Mathematica Policy Research conducted an analysis of the existing home visiting research literature and determined criteria that would define the evidence-based home visiting models eligible for federal funding. Based on this analysis, seven models were determined by Mathematica to meet the criteria. Detailed information on the seven selected models (as well as models not selected for inclusion and the criteria used) can be found at www.acf.hhs.gov/programs/opre/homvee.

The models endorsed by Mathematica represent a cadre of programs that met specific criteria created for this particular funding initiative. Other home visiting models have been validated by research data and warrant exploration for replication. Some of these models are national, while others are more state-based or locally-driven. The entity that developed the model should be contacted for resources and information before replication is attempted. Some tips for connecting to a model developer include:

- Engage with the staff knowledgeable about the details and nuances of program implementation and the development of new programs to discuss these issues in light of the particular needs of your community.
- Build your program around a model's program standards and adhere to an accreditation/quality assurance process (if one exists) to ensure that you are maintaining fidelity to the model.
- Access timely information from the model developer to the extent possible via conferences, community meetings, websites, publications, and any technical support offered.

Based on service design and target population, which evidence-based model(s) most appropriately address(es) the needs of your community?

Please answer either of the following two sections (A or B) depending on the existence of home visiting services in your community.

A. If home visiting services exist in your community:

Do existing evidence-based home visiting programs in your community have the capacity to serve more children and families?

Which evidence-based model(s) overlap(s) most with existing home visiting services in the community?

Do(es) the model(s) match the identified needs?

What, if any, implementation components would need to be altered?

What resources would be needed for expansion?

B. If no home visiting services exist in your community:

What agencies or organizations might be able to house and provide the necessary administrative support for a new home visiting program?

What assets might the host organization bring to support and sustain the home visiting program?

What community services could provide support to a new home visiting program?

What resources would be needed to implement home visiting services in your community?

What challenges do you anticipate in implementing a new home visiting program, and what are some possible solutions?

Public Engagement

What is the level of community buy-in for home visiting programs?

What sectors in your community lend the strongest support?

How could buy-in be strengthened?

Based on local needs, gaps, and resources, what are the key messages that community members need to hear about home visiting?

How can those messages be incorporated into an outreach plan?

Recruitment, Engagement, and Retention of Families

What are the various avenues for engaging and recruiting families in your community to participate in home visiting programs?

Is there a process to ensure that families' needs and interests are understood so they receive the appropriate service at the correct intensity level?

What strategies exist to promote families' continued participation in the home visiting program?

What opportunities exist for parents to influence program development and implementation decisions?

Staff Qualifications and Professional Development

Are potential candidates present in the community with the experience, skills, and qualities needed to fill staff positions (i.e., experience with home visiting and working with children and families, culturally diverse populations, maternal and child health issues, child development from birth to age 3, and high-risk populations)?

Do these candidates have the professional or paraprofessional credentials required by the model(s) chosen?

Does your state have a credentialing, licensing, or endorsement structure that could serve as a vehicle for staff development?

What training capacity is available to meet program model requirements (i.e., in-state trainers, distance learning opportunities)?

What pre-service and in-service training is available locally?

Topic	Required by Model(s)? (Y/N)	Available? (Y/N)
History of Home Visiting and Program Model		
Model Specifics (i.e., program principles, procedures, role of home visitors, reporting requirements)		
Strengths-Based Practice in Home Visiting		
Adult Mental Health/Perinatal Depression		
Infant/Child Mental Health and Attachment		
Understanding Family Systems		
Child Development and Brain Development		
Prenatal Development and Pregnancy		
Substance Abuse		
Domestic Violence		
Developmental Screening		
High-Risk Screening and Identification		
Creating Safe and Nurturing Home Environments		
Conducting Effective Home Visits and Motivational Interviewing		

Recognizing and Reporting Child Abuse and Neglect		
Maximizing Referrals and Community Resources		
Cultural Competency		
Working with Special Populations (i.e., teenage mothers, children with developmental delays, military families)		
Reflective Supervision		
Other		
Other		

Based on the above chart, what are the gaps in training in your community?

1. 2. 3. 4. 5.

What funding exists to bring needed professional development resources into your community?

--

How do program supervisors get the support they need to be able to fulfill their responsibilities, including reflective supervision, to their staff?

--

Partnerships and Collaboration

If multiple home visiting programs exist in the community, how do they communicate, collaborate, and share resources?

Can families transition with ease between home visiting and other early childhood programs if their needs change or children age out of a program?

Are there formal agreements or a system for referrals between early childhood programs in your community?

Please answer either of the following two sections (A or B) depending on the existence of home visiting services in your community.

A. If home visiting services exist in your community:

Use this chart to document to what extent the home visiting program(s) partner with the following community support services.

Community Service	Limited Collaboration	Moderate Collaboration	High-Level Collaboratin
Pre-K			
Child Care Centers			
Child Care Homes			
Early Head Start/Head Start			
Schools/School Districts			
Early Intervention			
Child Care Resource and Referral Agencies			
Infant Toddler Specialist Networks			

Infant Mental Health Networks			
Family Resource Centers			
Parenting Classes			
Family Literacy Programs			
SNAP (food stamps)			
WIC			
Local Health Department			
Community Health Centers			
Pediatric Practices/Clinics			
Birth/MCH Hospitals			
Transitional Housing			
Food Pantries			
Mental Health/Counseling Services			
Substance Abuse Treatment			
Domestic Violence Shelters/Services			
Faith-Based Services			
Funding Entities (United Way, local foundations)			
Advocacy Groups			
Community Facilities (libraries, community centers, higher education, parks)			
Other			

Based on the above chart, what partnerships could be strengthened or new partnerships developed?

- 1.
- 2.
- 3.
- 4.
- 5.

B. If no home visiting services exist in your community:

Which community services listed in the previous chart should be priorities for partnership?

1.
2.
3.
4.
5.

Coordinated Governance

What community-level coalitions with multiple early childhood stakeholders exist to address challenges, advocate for improvements, or assist in starting a home visiting program?

--

What entity, if any, “takes the lead” for home visiting efforts in your community?

--

Who are the key people and organizations in the community to have at the table?

--

Financing and Sustainability

Do local home visiting programs receive, or have the potential to receive, funds from the following sources?

Funding Source	Received by Programs? (Y/N)	Potential to Be Received? (Y/N)
Children's Trust Fund		
Criminal Justice		
Child Welfare		

Child Care		
Social Services		
Public Health		
Education		
State General Revenue		
Medicaid/SCHIP/Private Insurance		
TANF		
Early Intervention		
Tobacco Funds		
Domestic Violence Funds		
United Way		
Local Individual Donations		
City Funds		
County Funds		
Local Private or Public Foundations		
Other		
Other		

What “in-kind” resources are available to support new or expanded home visiting services in your community?

Is all funding spent on day-to-day program operations, or is some funding available to support administrative structures and program enhancements?

Are there ways that funds could better be used at the local level among programs to help minimize competition and streamline administrative requirements?

Evaluation and Quality Assurance

Whether your community has existing home visiting services or is starting a new program, the collection and analysis of data from the inception of the program is a critical effort. In particular, the MIECHV initiative mandated key benchmarks that have to be reached for continuation funding. They are outlined in Appendix D to the Supplemental Information Request (<http://www.hrsa.gov/grants/manage/homevisiting/sir02082011.pdf>). Each state's Updated State Plan details information on data collection, which can serve as a guide when you are developing an evaluation plan for new or expanded home visiting programs in your community.

Please answer either of the following two sections (A or B) depending on the existence of home visiting services in your community.

A. If home visiting services exist in your community:

How are data on key home visiting indicators and statistics collected by existing home visiting programs in the community?

What are the limitations in the data that are currently collected?

What steps could be taken to enhance program data collection?

How are home visiting programs using data for ongoing quality assurance efforts?

B. If no home visiting services exist in your community:

Do other early childhood programs in your community have data collection mechanisms that could be accessed or adapted to support a new home visiting program?

How can you develop and improve upon your community's capacity to collect data?

What tools from the developers of your community's proposed model might be used to build an evaluation infrastructure?

*Authors: Lisa Schreiber, ZERO TO THREE Policy Center Consultant; Barbara Gebhard, ZERO TO THREE Policy Center Assistant Director of Public Policy; Jamie Colvard, ZERO TO THREE Policy Center State Policy Analyst
April 2011*

ABOUT US

The ZERO TO THREE Policy Center is a nonpartisan, research-based, nonprofit organization committed to promoting the healthy development of our nation's infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at <http://www.zerotothree.org/policy>



Census Tract Level Data

Census Tract Level Data will be presented and discussed at the Bidder's Conference scheduled for December 13, 2012.

Ohio Maternal, Infant and Early Childhood Home Visiting Program
ATTACHMENT #1: Ohio MIECHV Budget Proposal Worksheet

Purpose: The Ohio Department of Health Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program requires submission of the *Ohio MIECHV Budget Proposal Worksheet* as part of the RFP grant application.

Instructions: Use the format below to calculate and submit the number of families to be served by the MIECHV program for the budget period 2/1/2013 to 9/30/2013. This attachment must indicate the following:

1. Proposed number of families to be served during the budget period (2/1/2013 – 9/30/13);
2. The average cost per family for the proposed evidence-based home visiting model to be implemented (HFA: \$3300/family; NFP: \$4000/family); and
3. Total Proposed Budget for 2/1/2013 – 9/30/2013.

The ODH will be monitoring program implementation and based in part on MIECHV program enrollment may be conducting a mid-year reallocation of grant funds.

Funds provided to an eligible entity receiving a grant shall supplement, and not supplant, funds from other sources for early childhood home visiting programs and initiatives.

Agency Name: _____ **Contract Manager:** _____

Submitted by: _____ **Submission Date:** _____

Ohio Maternal, Infant and Early Childhood Home Visiting Program
ATTACHMENT #1: Ohio MIECHV Budget Proposal Worksheet

<input type="text"/>		<input type="text"/>		<input type="text"/>
Total # of Families To be served 2/1/13 – 9/30/13		EBHV Model Cost/Family*		Total Proposed Budget

*Evidence Based Home Visiting Model estimated average costs/family:

HFA = \$3300.00/family

NFP = \$4000.00/family

Ohio Maternal, Infant and Early Childhood Home Visiting Program
ATTACHMENT #2: Ohio MIECHV Eligibility Form

Purpose: The Ohio Department of Health Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program requires submission of the *Ohio MIECHV Eligibility Form* as part of the RFP grant application.

Instructions: Use the form below to identify the eligibility criteria for proposed MIECHV program. Be as specific as possible.

Note, when identifying eligibility for the program, grant funds cannot be used to supplant existing home visiting program funds, and therefore, referrals of families eligible for the Help Me Grow (HMG) Home Visiting Program must first be made to approved HMG provider agencies that have the capacity to enroll families. If, and only if, the capacity of all HMG Home Visiting providers within a county has been reached can a potential participant, otherwise eligible for HMG Home Visiting, be referred to a MIECHV program.

Agency Name: _____ **Contract Manager:** _____

Submitted by: _____ **Submission Date:** _____

Ohio Maternal, Infant and Early Childhood Home Visiting Program
ATTACHMENT #2: Ohio MIECHV Eligibility Form

Agency: _____

EBHV Model: HFA NFP

Program will follow EBHV model to fidelity: Yes No

Will use a screening tool to determine eligibility: Yes No
If Yes, what tool? _____ What score will determine eligibility? _____

County: _____

Census tracks: _____

Define "Parent": _____

Define "Primary Caregiver": _____

Parent enrolled is: First time only First and second time only Second/Multiple Only
Any pregnancy/birth

Families enrolled prenatal: Yes No

Families enrolled until child is: 3 months 6 months Other (specify): _____

Families will remain enrolled until child is: 2 years 3 years 5 years
Other (specify): _____

Siblings of enrolled child will be served: Yes No

Race/Ethnicity of families served: All Hispanic only Other (specify): _____

Families will be eligible for HMG home visiting programs in county: Yes No

Families must meet financial eligibility? Yes No
If Yes, specify: _____

All families will meet these criteria? Yes No

If No, please specifically document the percentage of families enrolled who will meet these criteria AND specifically document other family criteria that will make family eligible and enrolled in MIECHV program:

Percent of families who must meet targeted criteria: _____

Other eligibility criteria: _____