

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ADMINISTRATION FOR CHILDREN AND FAMILIES

OFFICE OF CHILD CARE

**TRIBAL MATERNAL, INFANT, AND EARLY
CHILDHOOD**

HOME VISITING PROGRAM

GUIDANCE FOR SUBMITTING A NEEDS ASSESSMENT AND

PLAN FOR RESPONDING TO IDENTIFIED NEEDS

(PHASE 2 IMPLEMENTATION PLAN)

COHORT 3 GRANTEES

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OFFICE OF CHILD CARE

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WASHINGTON, DC 20447



TRIBAL MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

Guidance for Submitting a Needs Assessment and Plan for Responding to Identified Needs (Phase 2 Implementation Plan) Cohort 3 Grantees

Per the FY 2012 Funding Opportunity Announcement (HHS-2012-ACF-OCC-TH-0302) for the Tribal Maternal, Infant, and Early Childhood Home Visiting Program, at the start of Phase 1 of the cooperative agreement, HHS must provide grantees with detailed guidance for submitting both the needs assessment and plan for responding to identified needs, including a plan for measuring and reporting on program participants' progress toward meeting legislatively mandated benchmarks and a plan for rigorous evaluation of the home visiting program (i.e., Phase 2 Implementation Plan). Grantees are expected to submit the needs assessment and implementation plan within 10 months of the Year 1 award date. This document provides guidance for submitting the Needs Assessment (Section 1) and Phase 2 Implementation Plan (Sections 2-8), as well as several Appendices containing supplementary information and resources. HHS will work closely with and provide ongoing technical assistance to grantees as they develop their implementation plans and continuation applications. Instructions on submitting the continuation application will be provided separately.

Any questions and comments regarding this guidance may be addressed to:

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BACKGROUND

Section 511(h)(2)(A) of Title V of the Social Security Act, as added by Section 2951 of the Affordable Care Act of 2010 (P.L. 111-148) (ACA), authorizes the Secretary of HHS to award grants to Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to conduct an early childhood home visiting program. The legislation sets aside 3 percent of the total Maternal, Infant, and Early Childhood Home Visiting Program appropriation (authorized in Section 511(j)) for grants to Tribal entities and requires that the Tribal grants, to the greatest extent practicable, be consistent with the requirements of the Maternal, Infant, and Early Childhood Home Visiting Program grants to States and territories (authorized in Section 511(c)), and include conducting a needs assessment and establishing benchmarks.

ACA Maternal, Infant, and Early Childhood Home Visiting Program for States and Jurisdictions

The overall goals of the ACA Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program grants to States and Jurisdictions are to strengthen and improve maternal and child health programs; improve service coordination for at-risk communities; and identify and provide comprehensive home visiting services to families who reside in at-risk communities. The program responds to the diverse needs of children and families in communities at risk and provides an unprecedented and unique opportunity for collaboration and partnership at the Federal, State, and community levels to improve health and development outcomes for at-risk children and families through evidence-based home visiting programs. The funds are intended to assure effective coordination and delivery of critical health, development, early learning, child abuse and neglect prevention, and family support services to these children and families through home visiting programs. This program plays a crucial role in the national effort to build quality, comprehensive State- and community-wide early childhood systems for pregnant women, parents and caregivers, and young children and, ultimately, to improve health and development outcomes.

The Health Resource Services Administration (HRSA) and the Administration for Children and Families (ACF), the agencies collaborating to implement the MIECHV Program, believe that home visiting should be viewed as one of several service strategies to be embedded in a comprehensive, high-quality early childhood system that promotes optimal maternal, infant, and early childhood health and development and which relies on the best available research evidence to inform and guide practice. ACF and HRSA also believe that the MIECHV program provides an unprecedented opportunity to effect changes that will improve the health and well-being of vulnerable populations by envisioning child development within a life-course development framework and a socio-ecological framework. Life-course development points to broad social, economic, and environmental factors as underlying contributors to poor health and development outcomes for children, as well as to persistent inequalities in the health and well-being of children and families. The socio-ecological framework emphasizes that children develop within families, families exist within a community, and the community is surrounded by

the larger society. These systems interact with and influence each other to either decrease or increase risk factors or protective factors that affect a range of health and social outcomes.

The MIECHV Program for States and Jurisdictions (States) enables States to utilize what is known about effective home visiting services to provide evidence-based programs to deliver services that promote outcomes such as improvements in maternal and prenatal health, infant health, and child health and development; reduced child maltreatment; improved parenting practices related to child development outcomes; improved school readiness; improved family socio-economic status; improved coordination of referrals to community resources and supports; and reduced incidence of injuries, crime, and domestic violence. Under the home visiting program, grants are made to States to deliver effective evidence-based early childhood home visiting programs to pregnant women, expectant fathers, and primary caregivers of young children birth to kindergarten entry in communities identified through statewide needs assessments as being at risk.

The State program provides an exciting opportunity for States and the Federal government to work together to both deploy proven programs and continue to build upon the existing evidence base: it will allow for continued experimentation with new models and evaluation of both new and existing approaches so that, over time, policy makers and practitioners will have better information about which approaches work best; how different approaches work for different kinds of target populations or targeted outcomes; and the relative costs and benefits of different models. HRSA and ACF intend that the home visiting program will result in a coordinated system of early childhood home visiting, which has the capacity to provide infrastructure and supports to assure high-quality, evidence-based practice in every State.

Tribal Maternal, Infant, and Early Childhood Home Visiting Program

The Tribal MIECHV Program mirrors the State MIECHV program, with the goals of:

- Supporting the development of happy, healthy, and successful AIAN children and families through a coordinated home visiting strategy that addresses critical maternal and child health, development, early learning, family support, and child abuse and neglect prevention needs;
- Implementing high-quality, culturally-relevant, evidence-based home visiting programs in AIAN communities;
- Expanding the evidence base around home visiting interventions with Native populations; and
- Supporting and strengthening cooperation and coordination and promoting linkages among various programs that serve pregnant women, expectant fathers, young children, and families, resulting in coordinated, comprehensive early childhood systems in grantee communities.

Funds under the Tribal MIECHV Program support:

- Conducting a needs and readiness assessment of the tribal community (or communities) that considers community characteristics and the quality and capacity of existing home visiting programs and other supportive services, examines community readiness to implement a quality home visiting program, is coordinated with other relevant needs assessments, and involves community stakeholders as appropriate;
- Collaborative planning efforts to address identified needs by developing capacity and infrastructure to fully plan for, adopt, implement, and sustain high-quality home visiting programs that have strong fidelity to evidence-based models;
- Providing high-quality, evidence-based home visiting services to pregnant women, expectant fathers, and parents and primary caregivers of young children aged birth to kindergarten entry;
- Developing a data system and mechanism to measure, track, and report on progress toward meeting legislatively mandated benchmarks for participating children and families with reliability and validity; and
- Conducting rigorous local program evaluation activities that may include examining effectiveness of home visiting models in serving tribal populations, adaptations of home visiting models for tribal communities, or questions regarding implementation or infrastructure necessary to support implementation of home visiting programs in tribal communities.

In Phase 1 of the cooperative agreement, Tribal MIECHV grantees must: (1) conduct a comprehensive community needs and readiness assessment; and (2) develop a plan and begin to build capacity to respond to identified needs (including conducting benchmark data collection and rigorous evaluation activities). Grantees may engage in community needs and readiness assessment, planning, and capacity-building activities during Phase 1, but may not fully implement their plan and/or begin serving children and families through high-quality, evidence-based home visiting programs. Pending successful Phase 1 activities and submission of a non-competing continuation application that includes a needs assessment and approvable plan for responding to identified needs through an evidence-based home visiting program (including a plan for measuring and reporting on program participants' progress toward meeting legislatively mandated benchmarks and a plan for rigorous evaluation of the home visiting program), funds will be provided for Year 2, the first year of Phase 2 (Implementation Phase).

In Phase 2, the grantee will implement the various components of its approved plan to respond to identified needs (submitted at the end of Phase 1) and work closely with ACF and HRSA to ensure high-quality, evidence-based home visiting programs in its community.

Review and approval of the implementation plan provided in response to this document will be an iterative process between the grantee, Federal staff, and technical assistance providers. Further, delivery of services to children and families may not begin until grantee has been notified that the plan has been approved by ACF. Grantees that implement direct home visiting services to children and families prior to formal approval of the implementation plan by Federal

staff may be placed on corrective action and/or have financial restrictions placed on them for failure to comply with the terms and conditions of the award.

SECTION 1: COMMUNITY NEEDS ASSESSMENT

As part of Phase 1 of the grant, grantees must conduct a comprehensive needs assessment of the targeted community(ies) through a collaborative process that engages all stakeholders. A thorough needs assessment has two major components: an assessment of community needs and an analysis of the capacity of systems to meet these needs (community readiness for implementation of a home visiting program).

Through the needs and readiness assessment, grantees will set the stage for strengthened cooperation and coordination and promote linkages among various programs that serve pregnant women, expectant fathers, young children, and families in tribal communities. The assessment gives grantees the opportunity to consider community conditions, assess the quality and capacity of existing services to meet the needs of young children and families in the community, assess community readiness for implementation of a home visiting program, and identify and develop linkages with a comprehensive array of services at the community level, particularly across federal funding streams, such as the State MIECHV program, AIAN Head Start, tribal child care, Indian child welfare, and the Indian Health Service. Coordination across programs would ensure that high-quality, evidence-based home visiting programs are part of a comprehensive, aligned strategy for improving child and family well-being in tribal communities.

Grantees must provide the following information.

1. Identify and characterize the targeted community(ies) by providing data on the health and well-being of individuals and families in the community, as well as information on community strengths and risk and protective factors.
 - (i) Provide a general description of the grantee service area.
 - (ii) Define the targeted community(ies) that have been assessed for risk. Grantees may define a targeted community as either:
 - i. An entire Tribe within a discrete geographic region (i.e., on a reservation);
 - ii. Subgroups of a Tribe within a discrete geographic region (i.e., on a reservation); or
 - iii. Members of a Tribe(s) living scattered throughout a larger, non-Tribal geographic area interspersed with non-Tribal members (e.g., Indians living in an urban environment).
 - (iii) Describe the targeted community(ies), including demographics, geography, community strengths and risk and protective factors, and population characteristics.
 - (iv) For each targeted community, provide information on the following:
 - i. Premature BirthsFor example:

- Pre-term Birth Rate: # live births before 37 weeks/total # live births

ii. Low birth Weight

For example:

- Low Birth Weight Rate: # live births less than 2500 grams/total # live births

iii. Infant Mortality, including infant death due to abuse and neglect and Sudden Infant Death Syndrome

For example:

- Infant Mortality Rate (Birth to 1 year)
- Neonatal (0-28 days) Mortality Rate
- Post-neonatal (28 days to 1 year) Mortality Rate

iv. Leading Causes of Infant Death (e.g., Unintentional Injuries; Congenital Malformations, Deformations, and Chromosomal Abnormalities; Sudden Infant Death Syndrome; Abuse, Neglect, Homicide; Newborns Affected by Maternal Complications of Pregnancy; Disorders Relating to Short Gestation and Low Birth Weight; Other Illness)

v. Other risky prenatal, maternal, newborn, or child health and mental health conditions (such as maternal depression and suicide, child developmental delays, maternal and child overweight, diabetes, and child behavioral issues)

For example:

- High Birth Weight Rate: # live births over 4,000 grams/total # live births
- Average Gestational Age of Infant at Birth
- Average Age of Mother at Birth of First Child
- Percentage of Mothers under Age 20 at Birth of First Child
- Maternal Mortality Rate
- Maternal Diabetes Rate
- Child Diabetes Rate
- Maternal Overweight/Obesity Rate
- Child Overweight/Obesity Rate
- Maternal Tobacco Use
- Rate of Child Developmental Delay
- Rate of Child Behavioral Issues
- Rate of Maternal Depression or other mental or behavioral health issues
- Rate of Maternal Suicide

vi. Child Abuse and Neglect

For example:

- Rate of reported substantiated maltreatment (substantiated/indicated/alternative response victim)¹
 - Rate of reported substantiated maltreatment by type
- vii. Poverty and use of public assistance

For example:

- Percent of residents below 100% Federal Poverty Line
- Percent of children 0-5 living below 100% Federal Poverty Line
- Rates of use of Temporary Assistance for Needy Families (TANF)
- Rates of use of Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Rates of use for other forms of public assistance

viii. Unemployment and underemployment

For example:

- Unemployment Rate
- Long-term Unemployment Rate
- Underemployment Rate

ix. Crime, including juvenile delinquency and incarceration

For example:

- Number of reported crimes/1,000 residents
- Number of crime arrests ages 0-19/100,000 juveniles age 0-19

x. Domestic or Intimate Partner Violence;

Appropriate metrics for the targeted community should be determined in conjunction with domestic or intimate partner violence service

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- *Child Victim*: A child for whom an incident of abuse or neglect has been substantiated or indicated by an investigation or assessment. A State may include some children with alternative dispositions as victims.
 - *Substantiated*: A type of investigation disposition that concludes that the allegation of maltreatment or risk of maltreatment was supported or founded by State law or State policy. This is the highest level of finding by a State Agency.
 - *Indicated or Reason to Suspect*: A report disposition that concludes that maltreatment cannot be substantiated under State law or policy, but there is reason to suspect that the child may have been maltreated or was at risk of maltreatment. This is applicable only to States that distinguish between substantiated and indicated dispositions.
 - *Alternative Response Victim*: A conclusion that the child was identified as a victim when a response other than investigation was provided.

providers at the State, Tribal, or community level. Useful sources of data may include State, Tribal, and local service statistics, State, Tribal, and local hotline statistics, fatality review teams, social service agencies, and other data already collected by State, Tribal, and local domestic or intimate partner violence service providers. It may also be helpful to look at the availability of services for victims and survivors of domestic or intimate partner violence.

xi. High school drop-out and graduation

For example:

- Percent high school drop-outs grades 9-12
- Other school drop-out rates as per State/local calculation

xii. Substance abuse

For example:

- Binge drinking in past month²
- Marijuana use in past month
- Nonmedical use of prescription drugs in past month
- Use of illicit drugs, excluding Marijuana, in past month

- (v) In addition to submitting information on their own targeted community(ies), grantees should **also** provide comparable data for populations or communities that allow for meaningful comparison and allow the grantee to articulate and contextualize the needs of the target community(ies) and the rationale for why this community(ies) has been selected. Comparable populations or communities could include the State in which the targeted community(ies) is located, surrounding counties or cities, the AIAN population in the U.S. as a whole, etc. Grantees should justify the selection of the comparable populations or communities.

2. Identify the quality and capacity of existing programs or initiatives for early childhood home visiting in the target community(ies),³ including:

² *Binge drinking*: A pattern of alcohol consumption that brings the blood alcohol concentration (BAC) level to 0.08% or more. This pattern of drinking usually corresponds to 5 or more drinks on a single occasion for men or 4 or more drinks on a single occasion for women, generally within about 2 hours.

³ Including State-funded, Federally-funded, Tribally-funded, locally-funded, and privately-funded programs in the community. Home visiting programs are defined for purposes of this requirement as those with home visiting as the primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents or primary caregivers of children birth to kindergarten entry, targeting the legislatively mandated participant outcome and benchmark areas.

- (i) Existing investments in home visiting services through various funding streams (Federal, State, Tribal, local, public, private), including the funder and the amount of the investment;
 - (ii) The number of individuals and families who are receiving services through home visiting programs or initiatives;
 - (iii) The characteristics of individuals and families who are receiving services through home visiting programs or initiatives;
 - (iv) The characteristics of models, programs, or initiatives that are being implemented;
 - (v) The extent to which such programs or initiatives are high-quality and meet the needs of eligible families (e.g., are accessible and culturally relevant);
 - (vi) The factors that limit additional investment and capacity for providing home visiting services;
 - (vii) Existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community (e.g., centralized intake procedures);
 - (viii) Existing availability of qualified staff, including supervisors and home visitors, in the community;
 - (ix) Existing buy-in from community members, including Tribal leaders and elders, for home visiting programs in the community; and
 - (x) Referral resources currently available and needed in the future to support families residing in the community.
3. Assess the community(ies)'s capacity for providing substance abuse treatment and counseling services to individuals and families in need of treatment or services, including:
- a. Existing investments in providing substance abuse treatment and counseling services through various funding streams;
 - b. The number and characteristics of individuals and families who are receiving substance abuse treatment and counseling services;
 - c. The types of service delivery strategies that are being employed;
 - d. The extent to which services are high-quality and meet the needs of individuals and families (e.g., are accessible and culturally relevant); and
 - e. The factors that limit additional investment and capacity for providing needed services.
4. Assess the community(ies)'s capacity to implement and integrate home visiting services into an early childhood system, including an assessment of existing or ongoing efforts or resources to develop a coordinated early childhood system at the community level. Coordination across programs serving young children and families, including AIAN Head Start/Early

Head Start, tribal child care, Indian child welfare, and the Indian Health Service, will help ensure that high-quality, evidence-based home visiting programs are part of a comprehensive, aligned strategy for improving child and family well-being in tribal communities.

- (i) List existing programs, services, supports, and other resources in the community that serve pregnant women, expectant fathers, and children from birth to age eight and their families (including Head Start/Early Head Start, child care, health, mental health, early learning, child welfare, child abuse prevention, nutrition, and other types of supportive services provided through Federal, State, Tribal, local, public, and private programs). Please be sure to include any other federal grants the tribe or organization has that impact this population, including the funding amount and funding source for each grant (i.e. agency name, funding opportunity title, funding amount per fiscal year or project period).
- (ii) Describe the extent to which the services listed above are high-quality and meet the needs of individuals and families (e.g., are accessible and culturally relevant), and the extent to which there are gaps in services;
- (iii) Describe the extent to which services described above are linked in a coordinated system or comprehensive and integrated set of community services, supports, and opportunities designed to improve outcomes for children and families. In particular, please describe the relationships across the MIECHV program and Head Start, Early Head Start, child care, child welfare, and Indian Health Service programs in the community, if applicable. If no relationships exist, please describe the capacity within the community for improving coordination across programs;
- (iv) Describe the extent to which the community has a sustainable governance structure (e.g., Tribal early childhood advisory council) or coordinated system of planning for services for pregnant women, young children, and their families;
- (v) Describe the extent to which the community has or is able to collect accurate and current data on an ongoing basis on the status and well-being of pregnant women, young children, and their families and the services available to them, and use these data for planning purposes;
- (vi) Describe the extent to which the community is able to measure the quality of services being delivered to pregnant women, young children, and families and provide information, incentives, and support for continuous improvement (e.g., professional development and training opportunities, data systems, dedicated financing); and

- (vii) Describe extent to which the community has a school system that is ready for children and has a strong connection to early childhood programs to facilitate a seamless transition to school and ensure continuity.
5. Describe the process used to conduct the needs and readiness assessment and the overall lessons of the needs and readiness assessment, including:
- (i) *Stakeholder Participation and Coordination with Other Needs Assessments.* A description of who participated in planning and carrying out the community needs and readiness assessment and how stakeholders were engaged and diverse perspectives ensured. Grantees should also describe the other needs assessments that this assessment was coordinated with or drew from, including assessments conducted by Federal, State, Tribal, local, and private entities within the community, including those related to maternal and child health (such as the State Title V maternal and child health needs assessment or Tribal Epidemiology Center needs assessment); public health; mental health and substance abuse; child maltreatment; domestic violence; crime; and poverty; and those conducted by Head Start/Early Head Start and other early education and care programs in the community.
 - (ii) *Needs Assessment Methodology.* A description of the methods used for gathering data (e.g., quantitative data, focus groups, surveys, etc.). How did the grantee collect data and information to measure each of the needs assessment data elements, and what strategies were used to gather hard-to-find data?
 - (iii) *Successes and Challenges.* Reflections on the successes and challenges that arose in the process of conducting the needs and readiness assessment (e.g., lessons learned). This section should include a summary of the factors that facilitated the assessment process (e.g., active involvement of the Tribal council) and challenges grantees faced (e.g., collecting current data across a wide range of agencies or organizations in a timely manner). This information will be used by ACF to continually refine the guidance offered to grantees in conducting this work.
 - (iv) *Lessons and Findings.* Describe key lessons and findings from the needs and readiness assessment that have been central to helping the grantee more clearly define its goals, objectives, activities, and outcomes and develop its program, including home visiting model selection, benchmark plan, and evaluation plan.

Relevant sessions from the Tribal Home Visiting Program Cohort 1 Kickoff Meeting:

- ***Planning and Conducting a Comprehensive and Collaborative Community Needs Assessment***

To view a video of this session, [click here](#).

 [Diane Paulsell Slides](#)

 [Beth Kelton \(Port Gamble S'Klallam\) Slides](#)

 [Jim LaRoche \(Lower Brule\) Slides](#)

- ***Plenary: What is an Early Learning Community?***

 [Joan Lombardi Slides](#)

 [Barb Fabre Slides \(White Earth Band of Ojibwe\)](#)

 [Ann Bullock Slides \(Minnesota Chippewa Tribe\)](#)

 [Chrissie Castro Slides \(Navajo\)](#)

SECTION 2: HOME VISITING PROGRAM GOALS AND OBJECTIVES

Grantees must specify the goal(s) and objectives of the proposed program, and include a logic model identifying inputs, activities, outputs, and short- and long-term outcomes. The logic model for the Home Visiting Program as a whole may build on the logic model of the home visiting model(s) selected to meet community needs, but should not duplicate it. See [Appendix A](#) for resources on logic models.

Relevant session from the Cohort 1 Tribal Home Visiting Program Cohort 1 Kickoff Meeting:

- ***Evidence Based Practices and the Logic Model in Tribal Communities***
 [Session Slides](#)

SECTION 3: SELECTION OF PROPOSED HOME VISITING MODEL(S) TO MEET IDENTIFIED COMMUNITY NEEDS

Grantees must include a description of the home visiting model(s) selected to respond to the needs and capabilities identified in the targeted community(ies) through the needs and readiness assessment, how the chosen model(s) responds to identified needs, and how the community has been and will be engaged in the selection and implementation of the model(s). If the grantee has selected a model that requires adaptations or enhancements to meet needs, grantees must describe their process for developing the adaptation or enhancement in consultation with the original model developer.

As noted in the Home Visiting Evidence of Effectiveness (HomVEE) systematic review report titled "Assessing the Evidence of Effectiveness of Home Visiting Models Implemented in Tribal Communities" (http://homvee.acf.hhs.gov/Tribal_Report_2012.pdf), **no home visiting models previously implemented in tribal communities were found to meet the criteria for evidence of effectiveness established for the State MIECHV Program** (as initially proposed in a Federal Register Notice dated July 23, 2010 and finalized in the Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program dated February 8, 2011).

Tribal MIECHV Program grantees may therefore propose a home visiting model that is a promising approach.

Grantees may select:

- A model for which there is currently little to no evidence of effectiveness. For example:
 - One of the models studied by the Tribal HomVEE review (http://homvee.acf.hhs.gov/Tribal_Report_2012.pdf), but found not to meet criteria for evidence of effectiveness
 - One of the models studied by the larger HomVEE review (<http://homvee.acf.hhs.gov>) but found not to meet criteria for evidence of effectiveness, adapted to meet the needs of the Tribal community
 - A model that was not studied by either the Tribal or the larger HomVEE review, adapted to meet the needs of the tribal community
 - A model developed by the grantee to meet community needs, in partnership with a national organization or institution of higher education, for the purposes of the Tribal MIECHV program
- An adapted or modified version of an evidence-based model for the State MIECHV Program that includes significant alterations to core components.
 - Any of the seven models found to meet evidence-based criteria through the larger HomVEE review, information on which can be found at <http://homvee.acf.hhs.gov>, adapted to meet the needs of the tribal community

The model that grantees implement:

- Should be grounded in relevant empirical work (evidence from research, theory, practice,

- culture, and/or context) and have an articulated theory of change.
- Must have been developed by (or in partnership with) or identified with a national organization or institution of higher education.
 - Must be evaluated through a well-designed and rigorous process, as described further in Section 6 of this guidance.

Grantees should select one or more home visiting model(s) as the intervention on the basis of the population and community(ies) it is designed to serve and the issue(s) it was developed to address. In selecting and implementing the program in the targeted community(ies), care should be taken to consider where there are service gaps, as well as to ensure that the proposed model(s) will be complementary, but not duplicative, of any existing home visiting or other services for families residing in the community. The grantee should also consider how to match the identified needs and priorities in the targeted community(ies) with the home visiting model(s) selected, within the confines of available resources. Finally, the grantee should consider the capacity and resources of the targeted community(ies) to implement the chosen model(s).

The HomVEE systematic reviews titled "Assessing the Evidence of Effectiveness of Home Visiting Models Implemented in Tribal Communities"

(http://homvee.acf.hhs.gov/Tribal_Report_2012.pdf) and "Home Visiting Evidence of Effectiveness Review: Executive Summary"

(http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2012.pdf) contain useful information grantees can use as they make decisions about which home visiting model(s) to implement in the targeted communities.

The grantee must include the following information:

1. Describe the model proposed, including:
 - a. Theoretical base (articulated theory of change and empirical basis) and principles of the model
 - b. Summary of existing research on implementation and/or efficacy of the model (provide reference to systematic reviews, reports, or journal articles for any known research on the model)
2. Identify the national organization or institution of higher learning affiliated with the model, or in partnership with which the model has been developed;
3. Specify how the proposed model meets the identified needs and priorities of the targeted community(ies), including how the community has been and will be engaged in the development, selection, and implementation of the model to assess the fit of the approach and community readiness to implement it prior to the submission of the Implementation Plan and on an ongoing basis throughout the implementation process;
4. If enhancements or adaptations are being proposed to a model to meet

community needs, culture, and context, provide a:

- a. Description of any proposed adaptations or enhancements;
 - b. Rationale for adaptations or enhancements, including the empirical evidence (from research, theory, practice, and/or culture and context) to support them; and
 - c. Description of the process for developing the adaptation or enhancement, including how information regarding changes will be gathered, decisions made, and changes piloted, and how the process will occur in consultation with and with approval from the original model developer and the community.
5. If working with a national model developer, provide documentation of approval by the model developer to implement the home visiting model as proposed. The documentation should include verification that the model developer has reviewed and agreed to the plan as submitted, including any proposed adaptation or enhancement, and support for participation in rigorous research and evaluation activities described in Section 6 and any HHS efforts to coordinate programmatic technical assistance and research activities. This documentation should include the grantee's status in any required certification or approval process to implement the home visiting model; and
 6. Provide a description of the grantee's current and prior experience with implementing the model, including its existing relationship with the model developer and plans for maintaining communication and relationship with the model developer, as well as its current capacity to support implementation of the model (this will be further elaborated in Section 4).

NOTE: If more than one model is being proposed for implementation, grantees must provide the above information for all proposed models, and carefully explain the rationale for implementing multiple models in the targeted community(ies).

Home Visiting Evidence of Effectiveness (HomVEE) Review Webinars:

- **Tribal HomVEE Webinar recording:** <http://www.youtube.com/watch?v=hLCMeagJ8S8>
- **HomVEE Webinar recording:** <http://www.youtube.com/watch?v=1IVikJzJiQA>

Relevant sessions from the Tribal Home Visiting Program Cohort 1 Kickoff Meeting:

- **Organizational Readiness for Implementing Evidence Based Practices**
To view a video of this session, [click here](#).
 -  [Debra Strong Slides](#)
 -  [Lisa Campbell-John Slides](#)
 -  [Doug Bigelow Slides](#)

- ***Planning and Conducting a Comprehensive and Collaborative Community Needs Assessment***

To view a video of this session, [click here](#).

 [Diane Paulsell Slides](#)

 [Beth Kelton \(Port Gamble S'Klallam\) Slides](#)

 [Jim LaRoche \(Lower Brule\) Slides](#)

- ***Collaboration and Partnership Strategies for Implementing Home Visiting Programs***

 [Julie Collins Slides](#)

 [Kari Hearod Slides \(Choctaw\)](#)

 [Lorrie Grevstad Slides](#)

 [Rosie Gomez Slides](#)

SECTION 4: PLAN FOR EFFECTIVE IMPLEMENTATION OF HOME VISITING PROGRAM

Grantees must propose a plan for the effective implementation of the home visiting program. Grantees should address plans for working with the community and model developers to address ongoing fit between the chosen model(s) and the cultural traditions and context of the target community(ies); recruitment, retention, training, professional development, and supervision of home visiting personnel; recruitment and retention of families; ongoing monitoring of implementation quality; and coordination among existing home visiting programs. In addition, grantees must describe how they will ensure that the home visiting program is part of a comprehensive, coordinated early childhood system in the target community(ies).

Grantees must provide the following information.

1. A description of the process for engaging the targeted community(ies) around the proposed home visiting program, including identifying the organizations, institutions, or other groups and individuals consulted. Please describe the composition and use of any advisory group(s) developed to support the planning and oversight of the home visiting program.
2. A description of the grantee's approach to the development of policy and standards for the home visiting program, including the development of a policies and procedures manual for the program.
3. A plan for working with model developer(s), including:
 - a. A description of plans to address ongoing fit between the chosen model(s) and the cultural traditions and needs of the community(ies);
 - b. A timeline for obtaining the model curriculum or other materials needed as well as any necessary training; and
 - c. A description of the technical assistance and support to be provided through the national model developer, and a description of the plan for ongoing communication and working relationship with the national model developer, if applicable.

NOTE: If more than one home visiting model is being proposed for implementation in the community(ies), a separate plan must be provided for each model.

4. A plan for how the proposed program will meet legislative requirements for a high-quality home visiting program, including:
 - a. Well-trained, competent staff
 - i. A description of how and what types of initial and ongoing training and professional development activities will be provided by the grantee and/or obtained from the national model

- developer, if applicable);
 - ii. A plan for recruiting, hiring, and retaining appropriate staff for all positions; if subcontracts will be used, a plan for recruitment of subcontractor organizations, and a plan for how the subcontractor(s) will recruit, hire, and retain staff of the subcontractor organization(s)
 - b. High quality supervision;
 - i. A plan to ensure high quality clinical supervision and reflective practice for all home visitors and supervisors, including the qualifications of those who will provide reflective supervision, how often supervision will be done, and how the grantee will ensure that supervision is effective.
 - c. Strong organizational capacity to implement activities involved;
 - d. Referral and service networks available to support the home visiting program and the families it serves in at-risk communities;
 - e. Monitoring of fidelity of program implementation to ensure services are delivered according to the requirements of the selected home visiting model;
 - i. A plan for monitoring, assessing, and supporting implementation with fidelity to the chosen home visiting model(s) and maintaining quality assurance.
 - ii. A discussion of anticipated challenges to maintaining quality and fidelity, and the proposed response to the issues identified.
 - f. How the grantee will comply with any model-specific prerequisites for implementation, if applicable.
5. The estimated number of families to be served, including:
- a. A plan for identifying and recruiting participants;
 - b. A plan for minimizing the attrition rates for participants enrolled in the program; and
 - c. An estimated timeline to reach maximum caseload in each location.
6. A plan for utilizing continuous quality improvement (CQI) strategies to support effective ongoing implementation of the program. For more information on CQI, see [Appendix B](#).
7. An operational plan for the coordination between the proposed home visiting program(s) and other existing home visiting programs in the community(ies), if applicable.
8. An operational plan for ensuring that the home visiting program is part of a

comprehensive, coordinated early childhood system spanning the prenatal to age 8 continuum in the community(ies) that includes maternal and child health, mental health, behavioral health, early childhood development (Head Start/Early Head Start and child care), substance abuse, domestic violence prevention, child maltreatment and injury prevention, child welfare, education, and other social and health services for pregnant women, expectant fathers, young children, and families.

9. A list of public and private partners at the Tribal, State, and local level, and a description of planned collaborative activities.
10. A plan for collaborating with the State MIECHV program grantee, if appropriate and applicable, to leverage shared resources and goals in implementing the home visiting program.
11. A sustainability plan for integrating the home visiting program into the grantee's ongoing activities and sustaining the project beyond the period of Federal funding provided under this grant.
12. A description of anticipated technical assistance needs such as for conducting a home visiting program, developing the home visiting program as part of a comprehensive early childhood system, implementing models with fidelity, conducting rigorous research and evaluation activities, identifying benchmarks, or other topics. The grantee should also identify areas or topics for which technical assistance is available or will be provided by existing resources, such as through technical assistance provided by model developers, if applicable. More details on technical assistance under this program are provided in [Appendix C](#).
13. Assurances:
 - a. Assurance that the home visiting program is designed to result in participant outcomes noted in the legislation;
 - b. Assurance that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments;
 - c. Assurance that participant families will receive services voluntarily;
 - d. Assurance that the grantee will comply with the non-supplantation requirement (i.e., that funds provided under this program shall supplement and not supplant existing investments by the grantee in early childhood home visiting programs);
 - e. Assurance that the grantee will engage in required rigorous research and evaluation activities, further described in Section 6, designed to build and strengthen the evidence base on home visiting interventions with AIAN populations;
 - f. Assurances that priority will be given to serve eligible participants who:

- Live in communities identified through the needs assessment;
 - Have low incomes;
 - Are pregnant women who have not attained age 21;
 - Have a history of child abuse or neglect or have had interactions with child welfare services;
 - Have a history of substance abuse or need substance abuse treatment;
 - Are users of tobacco products in the home;
 - Have, or have children with, low student achievement;
 - Have children with developmental delays or disabilities;
 - Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States;
- g. Assurance that the grantee will comply with the requirement for submission of an annual report and other data to the Secretary regarding the program and activities carried out under the program. The Annual Report to the Secretary shall be submitted to HHS by Tribal MIECHV grantees 90 days following the end of Years 2-5 of the grant. Reports shall be submitted per instructions to be provided to each grantee by the Federal Project Officer. More details on the annual report are provided in [Appendix D](#). Following Years 2-5 of the grant, grantees must also report to HHS on Demographic and Service Utilization Data for Enrollees and Children per instructions to be provided to each grantee by the Federal Project Officer. Following Years 4 and 5 of the grant, grantees must report on benchmark data per instructions to be provided to each grantee by the Federal Project Officer.

Relevant sessions from the Tribal Home Visiting Program Cohort 1 Kickoff Meeting:

- **Organizational Readiness for Implementing Evidence Based Practices**
To view a video of this session, [click here](#).
 -  [Debra Strong Slides](#)
 -  [Lisa Campbell-John Slides](#)
 -  [Doug Bigelow Slides](#)
- **Collaboration and Partnership Strategies for Implementing Home Visiting Programs**
 -  [Julie Collins Slides](#)
 -  [Kari Hearod Slides \(Choctaw\)](#)

 [Lorrie Grevstad Slides](#)

 [Rosie Gomez Slides](#)

- **Implementation of Evidence Based Models in Native Communities: Planning for, Ensuring, and Measuring Fidelity**

To view a video of this session, [click here](#).

 [Melissa Van Dyke Slides](#)

 [Jackie Counts Slides](#)

- **Recruitment, Retention, Training, Professional Development, and Supervision of Home Visiting Staff**

 [Brandon Coffee-Borden Slides](#)

 [Nancy Dickinson Slides](#)

- **Strategies for Recruitment and Retention of Families for Home Visiting Programs**

 [Marilyn Van Oostrum Slides](#)

- **Plenary: Maternal, Child and Family Health and Wellness- Considerations for Home Visiting Programs and Tribal Communities**

To view a video of this session, [click here](#).

 [Susan Karol Slides \(Tuscarora Indian Nation\)](#)

 [Janet Saul Slides](#)

 [Larke Huang Slides](#)

 [Audrey Yowell Slides](#)

- **Plenary: Home Visiting Programs in Indian Country and Opportunities to Address and Prevent Domestic Violence and Child Maltreatment**

To view a video of this session, [click here](#).

 [Rebecca Levenson Slides](#)

- **Plenary: What is an Early Learning Community?**

 [Joan Lombardi Slides](#)

 [Barb Fabre Slides \(White Earth Band of Ojibwe\)](#)

 [Ann Bullock Slides \(Minnesota Chippewa Tribe\)](#)

 [Chrissie Castro Slides \(Navajo\)](#)

SECTION 5: PLAN FOR MEETING LEGISLATIVELY-MANDATED BENCHMARK REQUIREMENTS

Grantees must propose a plan for meeting the benchmark requirements specified in the legislation, including developing a data system and mechanism to measure, track, and report on outcomes of participating children and families with reliability and validity. The relevant outcomes for participating children and families include 1) improved maternal, newborn, and child health; 2) prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency room visits; 3) improvements in school readiness and child academic achievement; 4) reductions in crime or domestic violence; 5) improvements in family economic self-sufficiency; and 6) improvements in the coordination and referrals for other community resources and supports. [Appendix E](#) includes specific information on the requirements for each one of these six benchmark areas.

To show quantifiable, measurable improvement in benchmark areas, each grantee must provide a proposal for the initial and ongoing data collection for **each** of the six benchmark areas (and any other areas in which the grantee proposes to collect benchmark data, e.g. cultural engagement or cultural/language preservation). The following are parameters around the benchmark data collection:

- The grantee must collect data on **all** benchmark areas.
- The data must be collected for eligible families that have been enrolled⁴ in the program who receive services funded with Tribal MIECHV Program funds.
- Each benchmark area includes multiple constructs. **Grantees must collect data for all constructs under each benchmark area.**
- If the same construct appears in more than one benchmark area, grantees may utilize the same data for each applicable benchmark area. These instances are noted in the specific discussion of each benchmark area.
- To demonstrate improvements a benchmark area, the grantee must show improvement in at least **half** of the constructs under the benchmark area.
- Standard measures for the constructs within a benchmark area across home visiting models (if more than one home visiting model is implemented by a grantee) are strongly encouraged.
- We recommend that programs utilize these and other appropriate data for continuous quality improvement (CQI) to enhance program operation and decision-making and to individualize services. Please see [Appendix B](#) for more information on CQI.
- At a later date, a template will be provided for Tribal MIECHV grantees to report to HHS on benchmark results.
- **The measures proposed by grantees must be developmentally appropriate**

⁴ A family is to be considered enrolled as of the date of the first home visit.

measures for the corresponding constructs and appropriate for use with the populations served by the home visiting program.

- For the purposes of the benchmark requirement, it is recommended that data collected across all benchmark areas be coordinated and aligned with other relevant Tribal, State, or local data collection efforts (e.g., link data on children/families served by the home visiting program to data on the same children/families served by early childhood, child welfare, health care, or other programs).
- In addition to the reporting requirements for each benchmark area, grantees must collect individual-level demographic and service-utilization data on the participants in their program as necessary to analyze and understand the progress children and families are making. Tribal MIECHV grantees will also report to HHS on certain demographic and service utilization data for enrollees and children following Years 2-5 of the grant per instructions provided by the Federal Project Officer. Individual-level demographic and service-utilization data could include but are not limited to the following:
 - Family's participation rate in the home visiting program (e.g., number of sessions/number of possible sessions, duration of sessions);
 - Demographic data for the participant child(ren), pregnant woman, expectant father, parent(s), or primary caregiver(s) receiving home visiting services including: child's gender, age of all (including age in month for child) at each data collection point and racial and ethnic background of all participants in the family;
 - Participant child's exposure to languages other than English; and
 - Family socioeconomic indicators (e.g., family income, employment status).

Grantees must provide a plan for the collection of the benchmark data. It should include information about each construct and measure selection for each benchmark area, including the plan for data collection and analysis. The benchmark plan must include the following information for each benchmark area and its associated constructs. For more details on each of the individual benchmark constructs, please see [Appendix E](#). **(NOTE: the following information should be provided for each construct in the template format provided below.)**

1. Proposed measures:
 - a. For each construct within each benchmark area (e.g. "general cognitive skills" within the Improvement in School Readiness and Achievement benchmark area), specify the measure (or measures) proposed.
 - i. If use of administrative data is proposed, please also include a Memorandum of Understanding (MOU) from the agency with responsibility or oversight of those data, or describe the plan for working with this agency to collect data on this measure.
 - b. The source of the measure proposed and justification for why it is the most appropriate method of measurement for the construct.

- c. Reliability and validity of the measure proposed (demonstrating reliability and validity for the population with which the measure will be used).
 - d. The population to be assessed by each measure (e.g., parent or child) and the appropriateness of that measure, in terms of such factors as age of children, and in terms of specific population groups such as AIAN children, dual-language learner children, children with disabilities, etc.
2. Proposed definition of improvement for each measure within an individual construct (e.g., "improvement will be quantified as a decrease in the number of children identified as at risk by the Ages and Stages Questionnaire-Social Emotional Domain, ASQ-SE, for children's social-emotional development over one year of program enrollment").
3. Proposed data collection and analysis plan, including:
 - a. Planned data collection schedule, including how often the measure will be collected and analyzed (the minimum is specified under each benchmark area in [Appendix E](#), but we strongly encourage programs to consider more frequent data collection for CQI purposes);
 - b. A plan for ensuring the quality of data collection and analysis. The plan should include minimum qualifications or training requirements for administrators of measures, qualifications of personnel responsible for data management at the grantee and program level, qualifications of personnel responsible for data analysis at the grantee and program level, and the time estimated for the data collection-related activities by personnel categories;
 - c. A plan for the identification of scale scores, ratios, or other metrics most appropriate to the measure proposed;
 - d. A plan for analyzing the data at the grantee and program level (if applicable). This should include how data will be aggregated and disaggregated to understand the progress made within different communities (if applicable) and for different groups of children and families;
 - e. A plan for gathering and analyzing demographic and service-utilization data on the children and families served in order to better understand the progress children and families are making. This may include data on the degree of participation in services, the child's age in months, the child's race and ethnicity, the child's home language, the child's sex, the parent's education or employment, and other relevant information about the child and family;
 - f. A plan for using benchmark data for CQI at the grantee level, program level, community level, and/or Tribal level; and
 - g. A plan for data safety and monitoring including privacy of data,

administration procedures that do not place individuals at risk of harm (e.g., questions related to domestic violence and child maltreatment reporting), and compliance with applicable regulations related to Tribal oversight and approval of strategies for protection of human subjects, data safety and monitoring, and compliance with applicable regulations, other Institutional Review Board/human subject protections, Health Insurance Portability and Accountability Act (HIPAA), and Family Educational Rights and Privacy Act (FERPA). The plan must include training for all relevant staff on these topics.

4. Any anticipated barriers or challenges in the benchmark reporting process (including the data collection and analysis plan) and possible strategies for addressing these challenges.

For **each benchmark construct**, grantees will need to provide the above information in the following template format:

Benchmark Area X: Insert the benchmark area here. <i>Ex: Benchmark 1: Improved Maternal and Newborn Health</i>	
Construct	Insert the benchmark construct as listed in the Federal Guidance here. <i>Ex: vii. Well Child Visits</i>
Performance Measure	Insert how you are proposing to assess this benchmark construct here at rates, percentages, numbers, etc. and the specific population. State measure is a process or outcome indicator.
Operational definition (<i>target population, numerator, denominator</i>)	<i>Target population:</i> Insert the population to be assessed by the measure measure targeting? (e.g., pregnant women, all women enrolled, index subpopulations (e.g. children age birth to 1 year or pregnant women v trimester).
	<i>Numerator:</i> Insert the numerator here. Be as specific as possible and t aligns with the definition of improvement below. <i>Denominator:</i> Insert the denominator here. Be as specific as possible directly aligns with the definition of improvement below.
Definition of improvement and calculation	Insert the proposed performance objective here. How exactly do you (Increase, decrease, maintain, etc.) The definition of improvement sho numerator and denominator listed above as well as the objective in th should also include specific time frames for determining change, whet cohort, cross-sectional or individual comparison, and planned calculat percentages/rates.
Data source	Insert the source of the proposed measure here and justify why it is th measurement for this particular construct (e.g., interview, self-report, a visitor observation, etc.)
Measurement tool	Insert the name of the instrument being used to assess this construct subscales instead of the entire tool, please also specify that here. If th interview question or information from a home visit record, please spe ask or the form item that will be filled out.
Reliability/Validity	Insert information on reliability and validity for the measurement tool there is no measurement tool, you may put N/A.
Data Collection & Analysis Plan (<i>person resp., schedule, analysis,</i>)	<i>Person responsible:</i> Insert person responsible here. Who will collect thi worker, etc.) <i>Data collection schedule:</i> Insert data collection schedule here. How oft <i>Data analysis schedule:</i> Insert data analysis schedule here. How often a data points will be utilized for benchmark reporting?
Comments or Anticipated Challenges	Use this section for including any additional relevant information or q

Relevant sessions from the Tribal Home Visiting Program Cohort 1 Kickoff Meeting:

- ***Selecting Benchmark Indicators and Tools***
 -  [Lauren Supplee and Jill Filene Slides](#)
 -  [Nancy Whitesell Slides](#)
- ***Designing and Using an Effective Data Management System: Components and Considerations for Tribal Home Visiting Programs***
 -  [Session Slides](#)
- ***Using Continuous Quality Improvement to Improve Tribal Home Visiting Programs***
 -  [Session Slides](#)

SECTION 6: PLAN FOR RIGOROUS EVALUATION OF HOME VISITING PROGRAM

Grantees must propose a plan for participating in ongoing program evaluation activities that will result in building the knowledge base around successful strategies for implementing, adopting, providing, and sustaining high-quality, evidence-based home visiting services to AIAN populations. Based on the current knowledge base for the home visiting model(s) a grantee has selected, and their logic model for how a given model will result in desired changes, the grantee should propose a plan for adding to the knowledge base about that model (and/or its adaptation) and its impact with AIAN populations. Rigorous program evaluation activities could include examining effectiveness of promising approaches and/or components of home visiting; adaptations or enhancements of evidence-based home visiting models and/or components to AIAN populations; or questions regarding implementation or infrastructure necessary to support evidence-based home visiting models among AIAN populations.

These evaluations must include a comparison (e.g., the receipt of home visiting to not receiving home visiting; the provision of intensive coaching for implementation compared to implementation without coaching), either through a quasi-experimental design such as a matched comparison, a wait-list control, or multiple-baseline design (e.g., single-case design), or a randomized control design.

NOTE: Program evaluation is the use of good quality research methods to systematically study, appraise, and help improve social programs, including their conceptualization and design, their implementation and administration, their outcomes, their effectiveness, and their efficiency (Rossi, Freeman, & Lipsey, 2004). The most appropriate research methods to use for evaluation depend on the question being addressed (e.g., How well is home visiting working in our community? What type of cultural adaptation to an existing home visiting program is suitable for our community? What do we want and expect to change for children and families participating in home visiting? How will we know when things have changed, what has changed, for whom it has changed, and how it has changed?).

Grantees must include the following information regarding their plan for participating in ongoing research and program evaluation activities. The grantee's plan for rigorous research and evaluation of the proposed home visiting model(s) should identify evaluation partners and describe planned evaluation activities, including a description of the evaluation staffing, the plan for data collection and management, their strategy for community participation in evaluation, the systematic approach to adaptation and/or enhancement of home visiting (if applicable), the planned measurement of program implementation, the planned strategy for tribal oversight, the plan for protection of human subjects, a timeline of evaluation activities, and a plan for dissemination of evaluation findings.

1. Plan for Collaboratively Building a Knowledge Base for Home Visiting and its Impact with AIAN Populations
 - a. Strategy for community participation in and Tribal oversight of evaluation plans and activities

- b. Evaluation partners (relevant experience, partnership history)
- c. Summary of the current knowledge base (generally and specific to AIAN) regarding the impact and/or implementation of home visiting programs to address the needs of the targeted community(ies) (e.g, implementation feasibility, outcomes, cultural adaptation). This should link to Section 3 and include knowledge to support the foundations of the model (including empirical research, theory, and cultural ways of knowing), adapted or created new, and justify any adaptations necessary.
- d. Overview of the goals for evaluation (clearly link to described logic model from Section 2)
- e. Overview of the four year evaluation plan (if iterative, describe)

2. Evaluation Design

- a. Evaluation question(s) to be addressed
*As previously noted, Tribal MIECHV grantees have the option of focusing their evaluations on measuring outcomes associated with the home visiting model as a whole **or** a component of the intervention (like a specific curriculum activity or an enhancement), **or** grantees may ask a question about an aspect of implementation (like recruitment, retention, home visitor competencies, etc.).*

Clearly state your evaluation question(s) as a PICO question:

Evaluation Question:	
P	<i>The target population you plan to serve</i>
I	<i>The intervention or program to be evaluated</i>
C	<i>The comparison you will make to understand how well the program works in your community</i>
O	<i>The intended outcomes you want to see achieved</i>

- b. Based upon the evaluation question above, clearly state the hypothesis that you mean to test. What is your expectation for the results that your evaluation will produce? (e.g., it's expected that mothers who receive home visiting services will have decreased substance use compared to mothers who receive services as usual).
- c. Research design and method(s)
 - i. Rationale and considerations for proposed research design and methods to address evaluation questions
 - ii. Research design

Please briefly diagram your evaluation design in the box provided below. In this diagram: O's will represent observations/points of measurement, and X's will represent the introduction of the intervention/component. An example of a comparison group design is provided below.

Example Evaluation Question:
 Does the HV intervention decrease substance abuse, more than existing services?
 In this example, the X represents the HV intervention, and the O's represent the observations/administration of measures of the targeted outcome; and the T's represent each data collection time point (time 1 to time 4).

Quasi-Experimental Design					
	T ₁		T ₂	T ₃	T ₄
HV Program	O	X	O	O	O
Services as Usual	O		O	O	O

1. Random assignment strategy and plan (if applicable)
 2. Plan for creating non-experimental comparison groups (if applicable)
 3. Plan for ensuring integrity of control or comparison groups (non-contamination) (if applicable)
- iii. Sample size(s)
- iv. Estimated power to detect impacts (if applicable)
- d. Planned measures and instruments (please provide in a table format)

Measure/Instrument & Source Information	Evaluation Plan element to be measured (e.g., outcome; intervention, output)

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- e. Data sources (see table below for 2 d., e., & f.)
- f. Data collection process (see table below for 2 d., e., & f.)
 - i. Description of current and/or planned system(s) for collecting program management and evaluation data (basic design, software, potential access for evaluation, challenges or barriers to accessing data)
- g. Data collection schedule (see table below for 2 d., e., & f.)

Intervention/home visiting component or Short-term Outcome(s)	Measure/ Indicator	Data Source	Measurement Interval	Data Collection Method	Person Responsible
Specify the distinct home visiting component (independent variable) or short-term outcome (dependent variable) to be measured.	What is the operational definition of the variable? How will it be systematically measured (percent of recommended home visits received, number of books in the home, etc.)?	What tool or method will be used to collect the data on a given measure (e.g., attendance logs, client self-report, etc.)?	How frequently will the data be collected (e.g., every 6 months, at intake and 1 year post-enrollment, etc.)?	What format or method will you use (e.g., electronic data system, ACASI, hard copy, etc.)?	Who will record the data (e.g., home visitor, evaluator, etc.)?
1.					
2.					
3.					
4.					
5.					
6.					

- h. Analysis plan
 - i. Describe plan for analyzing attrition etc.
 - ii. Describe your analysis plan for answering each of your research questions/hypotheses.
 - iii. If using quantitative analysis, include information on your selected statistical method for each planned comparison (i.e., descriptive and

inferential statistics), and how each of the variables in 2.g above will be analyzed.

- iv. If using primarily qualitative data analysis, include discussion of plans for data reduction (i.e., coding, defining themes and patterns), testing validity (i.e., triangulation, validation procedures), and qualitative data analysis software to be utilized.
 - v. If you will be utilizing a consultant for your data analysis, please describe your plan for the data analysis consultation process.
3. Tribal Oversight and Institutional Review Board Requirements and Plan
 - a. Documentation of Office of Human Subjects Protection approved Federal-wide Assurance (see <http://www.hhs.gov/ohrp/assurances/forms/domesticfwainstructions.html>).The Federal-wide Assurance (FWA) is an assurance of compliance with the Federal regulations for the protection of human subjects in research. It is approved by the Office for Human Research Protections (OHRP) for all human subjects research conducted or supported by the Department of Health and Human Services (HHS).
 - b. Plan for human subjects protection and Tribal oversight (if applicable)
 - c. Confidentiality procedures
 - d. Plans for submission of proposed evaluation design to IRB(s)
 - e. Plan for staff training related to human subjects protection
 4. Data Collection and Management Plan
 - a. Organization(s) Responsible for Collecting and/or Reporting Evaluation Data
 - i. Organization name, qualifications, location, and role in the project
 - ii. Contact name and information
 - b. Plans for data safety and monitoring (storage, access, disposal, relevant staff training)
 5. Evaluation Staffing, Timeline, and Budget
 - a. Evaluation organization chart/staffing
 - b. Timeline (e.g., evaluation planning, Tribal oversight and IRB approval, instrument development, staff recruitment and training, data collection schedule, administration of instruments, analysis, reporting)

Please indicate the month and year that each of the following evaluation tasks will begin and end:

Evaluation Task	Month/ Year							
Evaluation planning								
Tribal oversight and IRB approval								
Instrument development								

Staff recruitment and training								
Data collection								
Administration of instruments								
Data analysis								
Reporting								

c. Budget for evaluation activities described in above table

6. Planned Evaluation Dissemination Activities

Please indicate which of the following evaluation dissemination activities are planned and then elaborate on each as needed:

✓	Dissemination Activity
	Internal newsletter/publication
	External newsletter/publication
	Conference presentations/posters
	Tribal Organization Publication
	Website publication
	Peer reviewed evaluation journal

7. Challenges and Risks to the Evaluation Plan (if any), and Proposed Response

Relevant sessions from the Tribal Home Visiting Program Cohort 1 Kickoff Meeting:

- **Best Practices for Research and Evaluation that Benefits Tribal Communities**
 To view a video of this session, [click here](#).
 -  [Nancy Whitesell Slides](#)
 -  [John Walkup Slides](#)
 -  [Joan LaFrance Slides \(Turtle Mountain Chippewa\)](#)
 -  [Erik Stegman Slides \(Carry the Kettle First Nation \(Assiniboine\)\)](#)
 -  [Aleta Meyer Slides](#)

- **Community-University Partnerships for Research, Evaluation, and Technical Assistance in AIAN Communities**
 -  [Session Slides](#)

SECTION 7: PLAN FOR ADMINISTRATION OF THE HOME VISITING PROGRAM

Grantees must describe the administrative infrastructure that will support the home visiting program, such as the fiscal and administrative management plan, job descriptions and organizational charts, management capacity, collaborative partners, and other essential infrastructure. In providing this description, please provide the following:

1. The lead agency for the program;
2. A list of collaborative partners (including sub-grantees, consultants, contractors, and subcontractors) in the private and public (tribal, state, local) sectors and their roles and responsibilities in the implementation and evaluation of the program. Please be sure to describe the composition and use of any advisory group(s) developed to support the planning and oversight of the home visiting program;
3. An overall fiscal and administrative management plan for the program that describes who will be responsible for ensuring the successful implementation and evaluation of the program, including a plan for overseeing partners, sub-grantees, consultants, contractors, and subcontractors;
4. An overall project implementation timeline, including clearly defined roles, responsibilities, and milestones for accomplishing project tasks and ensuring quality;
5. Job descriptions for key positions, and resumes of staff or proposed staff in these positions. If there have been any changes to staffing since the start of the grant, please provide an update and explanation for changes; and
6. An organizational chart.

SECTION 8: BUDGET AND BUDGET JUSTIFICATION

As part of the non-competing continuation application package, the grantee must submit a SF-424 – Application for Federal Assistance and SF-424A – Budget Information for Non-Construction Programs for the Year 2 budget for the Implementation Plan, under the Tribal MIECHV Program.

Each grantee must provide 1) a line item budget and 2) a budget narrative using the object class categories on the SF-424A for a project and budget period corresponding to Year 2 of the grant (i.e., for Cohort 3 grantees, September 30, 2013-September 29, 2014). The total requested amount of Federal funds for Year 2 shall be entered in Items 18a and 18g on the SF-424. NOTE: No non-federal funds are required for this program.

Provide a budget narrative that explains the amounts requested for each line in the budget, including detailed calculations of estimation methods, quantities, unit costs, and other similar quantitative detail sufficient for the calculation to be duplicated. The narrative budget justification should describe how the categorical costs are derived including a discussion of the necessity, reasonableness, and allocation of the proposed costs. Remember not to include “cents” in your budget; under 49¢ round down to the nearest dollar and 50¢ or more round up to the nearest dollar. Please do NOT submit budgets for Years 3-5 of the grant.

The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for 12 months only and corresponds to Year 2 of the grant under the Tribal MIECHV Program. Grantees should NOT use the justification to expand the project narrative.

If the grantee elects to utilize contracts to implement any part of the home visiting program, the budget narrative should describe the amount the grantee will provide for each contract and provide a justification.

Include the following in the Budget Justification narrative:

1. **Personnel:** Personnel costs should be explained by listing each employee (not consultants) who will be supported with federal funds, name (if possible), position title, percent full time equivalency, and annual salary. NOTE: A job description and resume for each new key staff member should be included as an attachment to the application.
2. **Fringe Benefits:** List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plan, and tuition reimbursement for each employee. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project.
3. **Travel:** List travel costs according to long distance travel. The budget should also reflect the travel expenses associated with participating in meetings and other proposed conferences, trainings, or workshops. The budget must allocate sufficient funds to

provide for at least two and up to four representatives from the grantee to attend: 1) a two- to three-day Federally-initiated grantees meeting (likely in Washington, DC) and 2) a one- to two-day Federally-initiated regional meeting (likely in a location near the grantee). Attendance at the grantees' meetings is a grant requirement.

Grantees may also include "optional" travel, which is defined as travel for home visiting staff to attend up to three national, State, regional, or local conferences and meetings related to the Tribal MIECHV program. Also included in this category are expenses for home visiting staff to attend training sponsored by the developer of its selected home visiting model, if applicable.

4. **Equipment:** Equipment" means an article of nonexpendable, tangible personal property having a useful life of more than one year and an acquisition cost that equals or exceeds the lesser of: (a) the capitalization level established by the organization for the financial statement purposes, or (b) \$5,000. (Note: Acquisition cost means the net invoice unit price of an item of equipment, including the cost of any modifications, attachments, accessories, or auxiliary apparatus necessary to make it usable for the purpose for which it is acquired. Ancillary charges, such as taxes, duty, protective in-transit insurance, freight, and installation, shall be included in or excluded from acquisition cost in accordance with the organization's regular written accounting practices).

For each type of equipment requested provide: a description of the equipment; the cost per unit; the number of units; the total cost; and a plan for use on the project; as well as use and/or disposal of the equipment after the project ends.

A grantee organization that uses its own definition for equipment should provide a copy of its policy, or section of its policy, that includes the equipment definition.

5. **Supplies:** Specify general categories of supplies and their costs. Show computations and provide other information that supports the amount requested. In this category, separate office supplies from medical purchases. Supplies include: computers, printers, scanners, cameras, video recorders, cell phones, blackberries, paper, pens, toner cartridges, folders, flip charts, etc.; medical supplies include syringes, blood tubes, plastic gloves, etc.

NOTE: This category does not include "program supplies and materials" such as: test protocols, training materials, children's books, toys, training videotapes, book bags, computers, etc. All "program supplies and materials" belong in the "Other" category. This category also excludes telephone service, postage, printing, copying, and service contracts; all "services" belong in the "Other" category. This also applies to third parties.

6. **Contractual:** Grantees are responsible for ensuring that their organization and/or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts to this grant. Grantees must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential sub-recipients that entities receiving sub-awards must provide the recipient with their DUNS number. Costs of all contracts for services and goods except for those that belong under other categories such as equipment, supplies, construction,

etc. Include third party evaluation contracts, if applicable, and contracts with secondary recipient organizations, including delegate agencies and specific project(s) and/or businesses to be financed by the grantee.

Demonstrate that all procurement transactions will be conducted in a manner to provide, to the maximum extent practical, open and free competition. Recipients and sub-recipients, other than States that are required to use 45 CFR Part 92 procedures, must justify any anticipated procurement action that is expected to be awarded without competition and exceeds the simplified acquisition threshold fixed at 41 U.S.C. 403(11), currently set at \$100,000. Recipients may be required to make pre-award review and procurement documents, such as requests for proposals or invitations for bids, independent cost estimates, etc. available to ACF.

Note: Whenever the grantee intends to delegate part of the project to another agency, the grantee must provide a detailed budget and budget narrative for each delegate agency, by agency title, along with the same supporting information referred to in these instructions.

7. **Other:** All costs that do not belong in any other category belong in this category. Provide an explanation of each cost. In some cases, grantee rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate. Local travel is also included in this category. Provide the mileage rate, number of miles, reason for travel, and staff member/ consumers completing the travel. Other such costs, where applicable and appropriate, may include, but are not limited to: consultants; temporary hires; conference room rental; food; professional services costs; printing; copying; computer use and support; software; training costs, such as tuition and stipends; staff development costs; and administrative costs.
8. **Indirect Costs:** Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, which might include the cost of operating and maintaining facilities, depreciation, and administrative salaries. If an organization applying for an assistance award does not have an indirect cost rate, the grantee may wish to obtain one through HHS's Division of Cost Allocation (DCA). Visit DCA's website at: <http://rates.psc.gov/> to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

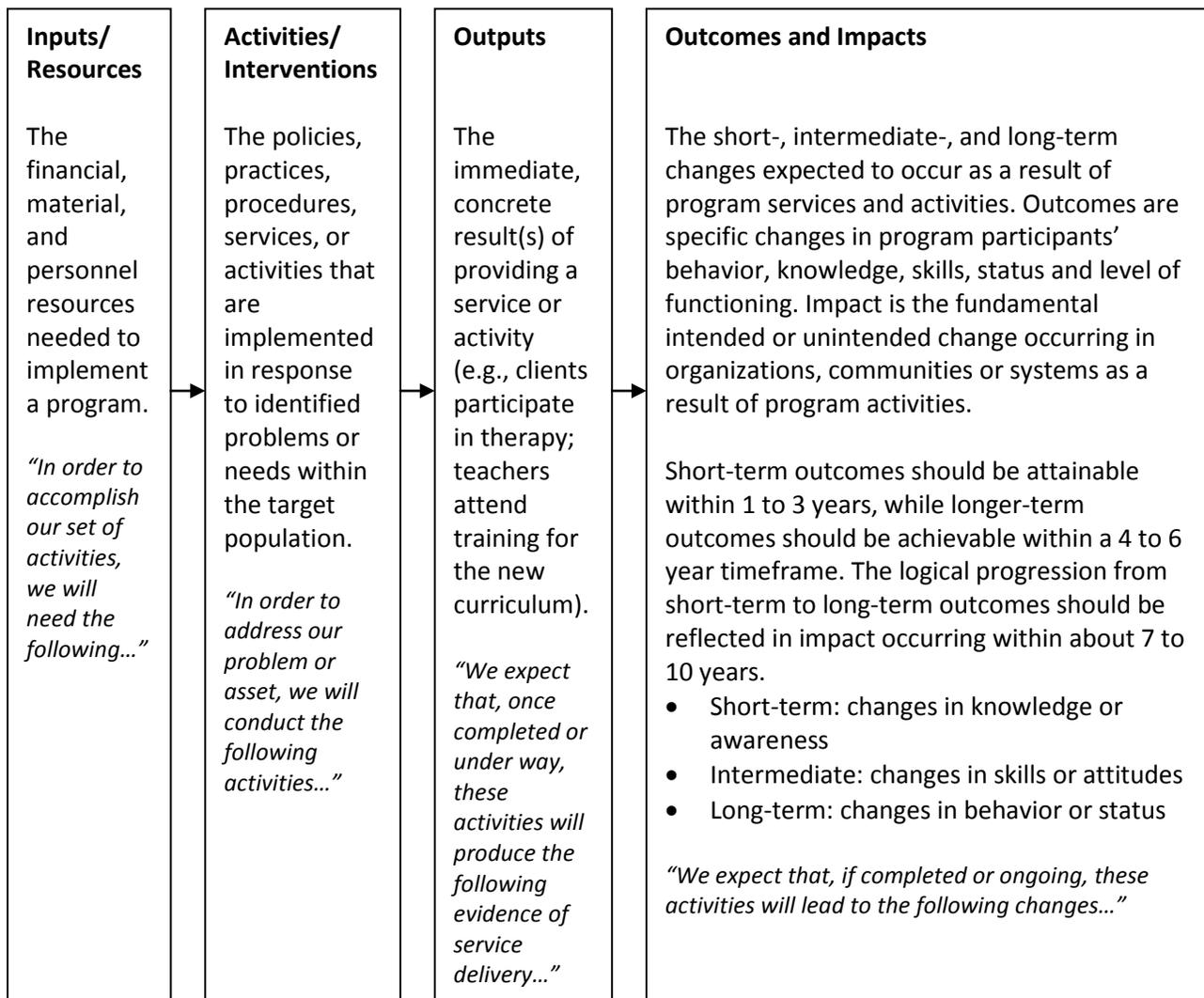
A grantee that will charge indirect costs to the grant must enclose a copy of the current rate agreement. Please submit your official indirect cost rate agreement from Program Support Center (PSC) or another Federal agency that PSC accepts. If the grantee organization is in the process of initially developing or renegotiating a rate, upon notification that an award will be made, it should immediately develop a tentative indirect cost rate proposal based on its most recently completed fiscal year, in accordance with the cognizant agency's guidelines for establishing indirect cost rates, and submit it to the cognizant agency. Grantees awaiting approval of their indirect cost proposals may also request indirect costs. Please note that grantees without a current

indirect cost rate agreement that wish to charge indirect costs to the grant may have their indirect costs restricted from draw down in the Payment Management System until PSC has received a current, unexpired indirect cost rate agreement. Retroactive or expired indirect cost rate agreements will not be accepted.

APPENDIX A: RESOURCES ON THE LOGIC MODEL

From the Kellogg Foundation: A logic model is a systematic and visual way to present and share your understanding of the relationships among the resources you have to operate your program, the activities you plan, and the changes or results you hope to achieve. The logic model provides a picture of your program – the theory and assumptions underlying the program – and links outputs and outcomes (both short- and long-term) with inputs, program activities/processes, and the theoretical assumptions/principles of the program.

General Format of a Logic Model (Adapted from James Bell Associates and Kellogg Foundation):



Underlying Assumptions and Theoretical Framework

Select Resources:

Center for Aboriginal Health Research

Draft strategic plan and logic model:

<http://www.cahr.uvic.ca/docs/CAHR%20Logic%20Model.pdf>

Department of Justice, Office of Justice Programs, Bureau of Justice Assistance

Resources on developing and working with logic models:

<http://www.ojp.usdoj.gov/BJA/evaluation/guide/pe4.htm>

FRIENDS National Resource Center for Community-Based Child Abuse Prevention

Basic info on step-by-step process of building a logic model:

<http://toolkit.childwelfare.gov/toolkit/assets/pdfs/logicmodel.pdf>

Logic Model Builder:

<http://toolkit.childwelfare.gov/toolkit/createEditToolkit/programInfo.do?modelTypeId=1>

Innovation Network:

Logic Model Workbook that provides an introduction to logic models and guidance on the development process:

http://www.innonet.org/client_docs/File/logic_model_workbook.pdf

James Bell Associates

Information on reasons to develop a logic model, as well as examples of logic models and data collection plans:

<http://www.jbassoc.com/reports/documents/developing%20a%20logic%20model.pdf>

Kellogg Foundation

Kellogg Foundation's Logic Model Development Guide. Provides an introduction to logic models and their usage, examples of logic models, guidance on developing program-specific models, and using a logic model for the purpose of evaluation:

<http://www.wkkf.org/knowledge-center/resources/2010/Logic-Model-Development-Guide.aspx>

National Implementation Research Network Library

Includes a variety of information on logic models, including: general information, types of logic models, step-by-step instructions for building a logic model, and examples:

<http://www.researchutilization.org/logicmodel/index.html>

One Sky Center:

Paper including information on the logic model in Tribal communities.

<http://www.oneskycenter.org/mhsa/documents/CBIDescription5rev2b11Jan2010.docx>

RTI International:

Poster presentation on the development and usage of logic models.

http://www.rti.org/pubs/apha07_burke_poster.pdf

APPENDIX B: CONTINUOUS QUALITY IMPROVEMENT

As described in Sections 4 and 5 of this guidance, grantees must propose a plan describing how continuous quality improvement strategies will be utilized to support effective ongoing implementation of the program. Continuous Quality Improvement (CQI) is a systematic approach to specifying the processes and outcomes of a program or set of practices through regular data collection and the application of changes that may lead to improvements in performance.

Widespread use of the CQI approach in the prevention field has been encouraged for several reasons. A CQI approach has the potential to:

- Provide a means for community-based programs to benchmark their processes and outcomes and thus document results in the absence of comparison groups;
- Inform the adaptation of evidence-based home visiting models to the unique community settings in which they are implemented, taking advantage of local insights;
- Develop and incorporate new knowledge and practices in a data-driven manner;
- Inform programs about training and technical assistance needs;
- Help monitor fidelity of program implementation;
- Strengthen referral networks to support families;
- Provide rapid information on a small scale about how change occurs;
- Identify key components of effective interventions; and
- Empower home visitors and program administrators to seek information about their own practices through the provision of regular reports that summarize performance on a variety of indicators associated with their processes and outcomes.⁵

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

⁵ Ammerman et al: "Development and Implementation of a Quality Assurance Infrastructure in a Multisite Home Visitation Program in Ohio and Kentucky." *Journal of Prevention and Intervention in the Community*. Vol 34. No.1/2. 2007. <http://theohiopartnership.org/images/EveryChildSucceedsArticle.pdf>

APPENDIX C: TECHNICAL ASSISTANCE

HHS intends to provide training and technical assistance to grantees throughout the planning and implementation of the Tribal MIECHV Program, in accordance with the requirements for HHS's substantial involvement under the cooperative agreement. The overall goal of this technical assistance is to build grantee capacity to develop an Implementation Plan that meets requirements; plan for and implement approved programs effectively and with fidelity to evidence-based models or promising approaches; and ensure that the Tribal MIECHV program is integrated into comprehensive systems of support for pregnant women, expectant fathers, young children, and their parents and primary caregivers. HHS will use a multi-dimensional and multi-faceted approach for the provision of technical assistance. ACF and HRSA are working jointly to provide technical assistance that will include collaboration and coordination with other Federal government agencies, Tribal entities, States, and model developers.

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

As stated in Section 4, the grantee should include in the Implementation Plan a description of anticipated technical assistance needs, such as for conducting a home visiting program, developing a comprehensive early childhood system, implementing models with fidelity, conducting rigorous research and evaluation activities, identifying benchmarks, or other topics. The grantee should also identify areas or topics for which technical assistance is available or will be provided by existing resources, such as through technical assistance provided by model developers, if applicable.

APPENDIX D: ANNUAL REPORT

Following Years 2-5 of the grant, Affordable Care Act Tribal Maternal, Infant, and Early Childhood Home Visiting grantees must provide a written update regarding the program and activities carried out under the program that includes the following.

Section 1: Update on Home Visiting Program Goals and Objectives

- Progress made under each goal and objective (as stated by the grantee in its Phase 2 Implementation Plan) during the reporting period
- Barriers to progress that have been encountered and strategies/steps taken to overcome them
- Any updates/revisions to goals and objectives identified in the Implementation Plan
- Updates or changes to logic model, if necessary

Section 2: Update on the Implementation of Home Visiting Program in Targeted Community(ies)

Please provide updates regarding experience in planning and implementing the home visiting programs selected for targeted community(ies), as identified in the Implementation Plan, addressing each of the items listed below. Where applicable, grantees should discuss any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges.

- Update on the grantee's progress in engaging the targeted community(ies) around the home visiting program
- Update on work to-date with the developer of the implemented home visiting model(s), including:
 - Description of any technical assistance and support provided to-date through the model(s)
 - Update on securing curriculum and other materials needed for the home visiting program
 - Update on training and professional development activities obtained from the home visiting model developer
- Update on staff recruitment, hiring, professional development activities, and retention for all positions including subcontracts
- Update on participant recruitment and retention efforts
- Update on challenges to maintaining quality and fidelity of each home visiting program, and the responses to the issues identified
- Update on grantee efforts to meet the following legislative requirements, including a discussion of any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges:
 - Training efforts to ensure well-trained, competent staff
 - Steps taken to ensure high quality reflective supervision
 - Steps taken to ensure referral and services networks to support the home visiting program and the families it serves in at-risk communities

- Updates on new policy(ies) created by the grantee, Tribe, organization, or community to support home visiting programs
- Update on the development of a coordinated early childhood system that includes home visiting programs, including coordination and collaboration between home visiting program(s) and other existing programs and resources for pregnant women, expectant fathers, young children, and families in the community(ies)
- Testimonials, vignettes, and photos regarding the implementation of the home visiting program, if desired

Section 3: Progress toward Meeting Legislatively Mandated Benchmark Requirements

Please provide a narrative discussing the benchmark data collection efforts, including a summary of barriers/challenges encountered during data collection efforts and steps taken to overcome them.

Section 4: Update on Rigorous Evaluation Activities

Please provide an update on the grantee's rigorous evaluation activities, including:

- General update on the progress of rigorous evaluation
- Any revisions to your evaluation plan
- Barriers and challenges encountered and steps taken to overcome them
- List of materials/products or publications developed for dissemination. If applicable, please also provide copies of reports or materials developed. Relevant materials/products could include:
 - Peer-reviewed publications in scholarly journals – published and submitted
 - Books and book chapters
 - Reports and monographs (including policy briefs and best practices reports)
 - Conference presentations and posters presented
 - Web-based products (Blogs, podcasts, Web-based video clips, etc.)
 - Electronic products (CD-ROMs, DVDs, audio or videotapes)
 - Press communications (TV/Radio interviews, newspaper interviews, public service announcements, and editorial articles)
 - Newsletters (electronic or print)
 - Pamphlets, brochures, or fact sheets
 - Academic course development and distance learning modules
 - Doctoral dissertations/Master's theses

Section 5: Home Visiting Program Continuous Quality Improvement (CQI) Efforts

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

Section 6: Administration of Home Visiting Program

- Updated organizational chart and fiscal/management plan for program implementation and evaluation, if applicable
- Updates regarding changes to key personnel, if any (note: changes in key personnel require prior approval by HHS)

Section 7: Technical Assistance Needs

An update on technical assistance needs anticipated for implementing and evaluating the home visiting program or for developing a coordinated early childhood system. For example:

- Programmatic (e.g., outreach and recruitment, workforce and professional development, effective collaboration, implementation)
- Evaluation-related
- Benchmarks
- Data Systems
- Continuous Quality Improvement
- Sustainability

APPENDIX E: SPECIFIC GUIDANCE REGARDING INDIVIDUAL BENCHMARK AREAS

At this time, grantees are required to collect data on all constructs listed under each benchmark area. It should be noted that one benchmark requires collection of data for “reduction in crime or domestic violence.” Given this language, grantees are not required to report on both domains, but may elect one or the other. For all other benchmark areas, grantees must collect data for all benchmark areas and for all constructs listed under each benchmark area. Grantees may choose to collect data for additional constructs within a benchmark area or in additional areas in which the grantee is interested (for example, benchmarks related to cultural or linguistic retention). In order to capture quantifiable, measurable improvement, grantees must collect, at a minimum, data for each benchmark area and construct when the family is enrolled in the program and at one year post-program enrollment. If measurement of a benchmark is not practicable within a given community (e.g., emergency department visits), grantee must describe process for identifying an alternative proxy of that outcome.

Technical assistance related to the benchmark requirement will be available to the grantees during the process of preparing for and submitting the Implementation Plan as well as during the implementation of the program.

1. Improved Maternal, Newborn, and Child Health
 - a. Constructs that must be reported for this benchmark area (all constructs must be measured that are relevant for the population served; e.g., if newborns are not being served, constructs related to birth outcomes will not need to be reported):
 - i. Prenatal care
 - ii. Parental use of alcohol, tobacco, or illicit drugs
 - iii. Inter-conception care
 - iv. Inter-birth intervals
 - v. Screening for maternal depressive symptoms
 - vi. Breastfeeding
 - vii. Well-baby visits
 - viii. Regular visits to a primary healthcare provider or medical home (this could include traditional medicine) for both mothers and children
 - ix. Maternal and child health insurance status (note: some of these data may also be utilized for family economic self-sufficiency benchmark area)
 - b. Definition of quantifiable, measurable improvement:
 - o For prenatal care, inter-birth intervals, screening of maternal depression, breastfeeding, adequacy of well-baby visits, adequacy of regular visits to a primary healthcare provider or medical home, and health insurance coverage, improvement is defined as changes over time for mothers, infants, and children;
 - o For pre- and post-natal parental use of alcohol, tobacco, or illicit drugs improvement is defined as rate decreases over time.

- c. Sources of data:
 - o Data can be collected from interviews and surveys with families or through administrative data, if available, at the individual and family level.

For more information, see *Healthy People 2020*.

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

- d. Format to report data
 - o Depending on the measure used and the grantee's plan for data utilization, the format of the data should include rates for each relevant construct. For example, the percentage of children birth to kindergarten entry in families participating in the program who receive the recommended schedule of well-baby or well-child visits; the percentage of mothers enrolled in the program prenatally who breastfeed their infants at six months of age.
- 2. Child Injuries, Child Abuse, Neglect, or Maltreatment, and Reduction of Emergency Department Visits
 - a. Constructs that must be reported for this benchmark area (all constructs must be measured):
 - (i) Visits for children to the emergency department (ED) from all causes
 - (ii) Visits of mothers to the emergency department from all causes
 - (iii) Information provided or training of participants on prevention of child injuries including topics such as safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety (i.e. drowning), and playground safety
 - (iv) Incidence of child injuries requiring medical treatment
 - (v) Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated)
 - (vi) Reported substantiated maltreatment (substantiated/indicated/alternative response victim) for children in the program
 - (vii) First-time victims of maltreatment for children in the program
 - b. Definition of quantifiable, measurable improvement:
 - o Decreases over time for identified constructs other than information provided or training on preventing child injuries, for which increases are considered improvement.
 - c. Specifying source of data:
 - o For reductions in emergency department visits and child injury prevention: Data can be collected through participant report, medical records, emergency department patient records or hospital discharge systems. Injury-related medical treatment includes ambulatory care, ED visits and hospitalizations due to injury or ingestions.
 - o For child abuse, neglect and maltreatment: It is preferred that data be collected through administrative data provided by the State, tribal, or local child welfare agencies. Grantees may propose collecting the data through self-report or direct measurement if it utilizes a valid and reliable tool.

For more information see:

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

d. Format to report data:

- For reductions in emergency department visits: The data format should include emergency department visits divided by the number of children or mothers enrolled in the program.
- For child injuries training or information: The construct can be reported as the percentage of participants who receive information or training on injury prevention by the total number of families participating in the program.
- For reduction of incidence of child injuries: The construct should be reported as the rate of child injuries requiring medical treatment (i.e., ambulatory care, emergency department visits or hospitalizations) for children participating in the program.
 - For child abuse, neglect and maltreatment: Each construct can be reported as a rate for children prior to kindergarten entry participating in the program.
 - The rate for **suspected maltreatment** is the number of cases of suspected maltreatment of children in the program, divided by the number of children in the program.
 - The rate for **substantiated maltreatment** would be calculated by counting the number of cases of substantiated maltreatment of children in the program and dividing by the number of children in the program.
 - To calculate the rate of **first-time victims**: Count the number of children in the program who are first-time victims divided by the number of children in the program. A first time victim is defined as a child who:
 - had a maltreatment disposition of "victim" and
 - never had a prior disposition of victim

3. Improvements in School Readiness and Achievement

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

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

For more information see:

- o http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/index.html
- o http://eclkc.ohs.acf.hhs.gov/hslc/ecdh/eecd/Assessment/Child%20Outcomes/edudev_art_00090_080905.html
- o Kagan, S. L., Moore, E., & Bredekamp, S. (1995). Reconsidering children's early development and learning: Toward common views and vocabulary. Washington, DC: National Education Goals Panel, Goal 1 Technical Planning Group. (See Child Trends summary here: http://www.childtrends.org/schoolreadiness/testsr.htm#_Toc502715209)
- b. Definition of quantifiable, measurable improvement:
 - Increases over time in the developmental progress of children between entry to the program and one year after enrollment.
- c. Specifying source of data: Data can be collected from a variety of sources including observation (e.g., teacher or other independent observer), direct assessment, administrative data or health records (e.g. program-specific clinical information systems), parent-report, teacher-report or samples of children's work. The grantee must collect and report data from the source appropriate to the method and measurement of the construct proposed.
- d. Format to report data:
 - Depending on the measure used and the grantee plan for using the data, the data should be reported in either one or both of the following ways:
 - Scale scores. When they are available, scores should be the calculated score for individual scales in the measure. Individual item-level data should not be reported. The scale scores should be calculated as instructed in the manual or other documentation provided by the measure developer; and,
 - Rates of children in a particular risk category (e.g. rates of children at risk for language delay).

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

1. http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_title.html
 2. http://www.casel.org/downloads/Compendium_SELTools.pdf
 3. <http://journal.naeyc.org/btj/200401/Maxwell.pdf>
 4. <http://www.earlylearning.ubc.ca/research/initiatives/early-development-instrument/>
4. Crime or Domestic Violence
- The legislation includes a requirement for States to report on reduction in “crime or domestic violence.” Given this language, States are not required to report on both domains, but must report on at least one.

CRIME

- a. If the grantee chooses to report crime, constructs that must be reported for this benchmark area (all constructs must be measured) for caregivers served by the home visiting program:
 - (i) Arrests
 - (ii) Convictions
- b. Definition of quantifiable, measurable improvement:
 - (i) For family level crime rates, improvement shall be defined as rate decreases over time in the identified constructs.
- c. Sources of data:
 - Data can be collected from interviews and surveys with families (i.e. with validated and reliable instruments) or through administrative data if available at the individual level.
- d. Format to report data:
 - Data can be reported as annual aggregate rates for parents participating in the program. Data should be reported broken down by reason for the arrest or conviction.

DOMESTIC VIOLENCE

- a. If the grantee chooses to report on domestic violence, constructs that must be reported for this benchmark area (all constructs must be measured) include:
 - (i) Screening for domestic violence
 - (ii) Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters, food pantries);
 - (iii) Of families identified for the presence of domestic violence, number of families for which a safety plan was completed.
- b. Definition of quantifiable, measurable improvement:
 - For screenings, improvement shall be defined as increases in the rate compared to the population served completed over time.

- For referrals and completion of safety plans related to domestic violence, improvement shall be defined as an increase over time.

c. Sources of data:

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

For more information see:

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

d. Format to report data:

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

I. Family Economic Self-Sufficiency

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

(i) Household income and benefits

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

(ii) Employment or Education of adult members of the household

(iii) Health insurance status

B. Definition of quantifiable, measurable improvement:

- For household income, improvement shall be defined as an increase in total household income and benefits over time.
- Note that the second construct above refers to employment *or* education. We

recognize that there can be an inverse relationship between the two in the short-run, i.e., while people are pursuing education, they may reduce their participation in the labor force, and vice versa. Therefore, while sites should measure both constructs, improvement in one or the other shall be considered sufficient to show positive results for this construct.

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

C. Specifying source of data:

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

D. Format to report data:

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

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

- "Observations from the Interagency Technical Working Group on Developing a Supplemental Poverty Measure," March 2010,
http://www.census.gov/hhes/www/povmeas/SPM_TWGObservations.pdf.

- “National Directory of New Hires,”
<http://www.acf.hhs.gov/programs/cse/newhire/ndnh/ndnh.htm>
- Evaluation Data Coordination Project
http://www.acf.hhs.gov/programs/opre/other_resrch/eval_data/index.html

II. Coordination and Referrals for Other Community Resources and Supports

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

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

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

B. Definition of quantifiable, measurable improvement:

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

C. Specifying source of data:

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

D. Format to report data:

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

APPENDIX F: GLOSSARY OF TERMS

Administration for Children and Families	The Administration for Children and Families (ACF), within the Department of Health and Human Services (HHS) is responsible for Federal programs that promote the economic and social well-being of families, children, individuals, and communities
Affordable Care Act (Patient Protection and Affordable Care Act of 2010)	In March 2010, Congress passed and the President signed into law the Affordable Care Act (Public Law 111-148), which puts in place comprehensive health insurance reforms to make quality, affordable health care available to all Americans, reduce costs, improve health care quality, enhance disease prevention, and strengthen the health care workforce. Through a provision authorizing the creation of the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program, the Act responds to the diverse needs of children and families in communities at risk and provides an unprecedented opportunity for collaboration and partnership at the Federal, State, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.
Aggregate Data	Data combined from multiple measures and/or across multiple subjects.
Benchmark Data	Data collected for the purposes of measuring progress towards an intended goal.
Continuous Quality Improvement	A systematic approach to improving processes and outcomes through regular data collection, examination of performance relative to predetermined targets, review of practices that promote or impede improvement, and application of changes in practices that may lead to improvements in performance.
Enrollment	A family is to be considered enrolled in a home visiting program as of the date of the first home visit.
Evidence-informed	Grounded in relevant empirical work, including evidence from research, theory, practice, culture, and/or context.
Federal Education Rights and Privacy Act of 1974 (FERPA)	A Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education. See http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html .
Health Resources and Services Administration (HRSA)	An agency of the U.S. Department of Health and Human Services, the primary Federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	A Federal law that protects the privacy of health information. The HHS Office for Civil Rights enforces the HIPAA Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the

	security of electronic protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety. For more information, see http://www.hhs.gov/ocr/privacy/ .
Home Visiting Evidence of Effectiveness (HomVEE) Review	The Department of Health and Human Services launched Home Visiting Evidence of Effectiveness (HomVEE) to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting program models that target families with pregnant women and children from birth to age 5. To carry out the HomVEE review, Mathematica Policy Research conducted a thorough search of the research literature on home visiting, issued a call for studies to identify additional research, reviewed the literature, assessed the quality of research studies, and evaluated the strength of evidence for specific home visiting program models. The results of the HomVEE review can be found at http://homvee.acf.hhs.gov .
Home Visiting Model	Programs where home visiting is the primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents or primary caregivers of children birth to kindergarten entry, targeting the legislatively mandated participant outcome and benchmark areas.
Infants	Children less than one year of age not included in any other class of individuals. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bggguideforms.pdf)
Institutional Review Board	A specially constituted review body established or designated by an entity to protect the welfare of human subjects recruited to participate in biomedical or behavioral research. http://www.hhs.gov/ohrp/archive/irb/irb_glossary.htm
Key Positions	Any position that is vital to the planning, implementation, administration and evaluation of the home visiting program.
Legislatively Mandated Benchmarks	1) Improved maternal and newborn health. 2) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency room visits. 3) Improvements in school readiness and child academic achievement. 4) Reductions in crime or domestic violence. 5) Improvements in family economic self-sufficiency. 6) Improvements in the coordination and referrals for other community resources and supports.
Legislatively Mandated Participant Outcomes	(i) Improvements in prenatal, maternal, and newborn health, including improved pregnancy outcomes. (ii) Improvements in child health and development, including the prevention of child injuries and maltreatment and improvements in cognitive, language, social-emotional, and physical developmental indicators. (iii)

	Improvements in parenting skills. (iv) Improvements in school readiness and child academic achievement. (v) Reductions in crime or domestic violence. (vi) Improvements in family economic self-sufficiency. (vii) Improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with State child welfare agency training.
Life Course Development	A theory that points to broad social, economic, and environmental factors as contributors to poor and favorable health and development outcomes for children, as well as to persistent inequalities in the health and well-being of children and families.
Low Income	An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [Title V, Sec. 501 (b)(2)]
Medical Home	An approach to providing comprehensive primary care that facilitates partnerships between individual patients and their personal healthcare providers, and when appropriate, the patient's family. The provision of medical homes may allow better access to health care, increase satisfaction with care, and improve health and well-being.
Memorandum of Understanding (MOU)	A document that expresses mutual accord on an issue between two or more parties and sets forth the basic principles and guidelines under which the parties will work together to accomplish their goals. MOUs are generally recognized as binding, even if no legal claim could be based on the rights and obligations laid down in them. To be legally operative, an MOU must (1) identify the contracting parties, (2) spell out the subject matter of the agreement and its objectives, (3) summarize the essential terms of the agreement, and (4) must be signed by the contracting parties.
Office of Child Care	The Office of Child Care supports low-income working families through child care financial assistance and promotes children's learning by improving the quality of early care and education and afterschool programs. The Office of Child Care was established in September 2010 and replaces the former Child Care Bureau.
Perinatal	Period from gestation of 28 weeks or more to 7 days or less after birth. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf)
Pregnant Woman	A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf)

Primary Healthcare Provider	A physician or doctor who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.
Promising Approach	<p>Either:</p> <ul style="list-style-type: none"> • A home visiting model for which there is currently little to no evidence of effectiveness. For example: <ul style="list-style-type: none"> ○ One of the models studied by the Tribal HomVEE review but found not to meet criteria for evidence of effectiveness ○ One of the models studied by the larger HomVEE review (http://homvee.acf.hhs.gov) but found not to meet criteria for evidence of effectiveness, adapted to meet the needs of the Tribal community ○ A model that was not studied by either the Tribal or the larger HomVEE review, adapted to meet the needs of the Tribal community ○ A model developed by the grantee to meet community needs, in partnership with a national organization or institution of higher education, for the purposes of the Tribal MIECHV program <p>OR</p> <ul style="list-style-type: none"> • An adapted or modified version of an evidence-based model for the State Home Visiting Program that includes significant alterations to core components. <ul style="list-style-type: none"> ○ Any of the seven models found to meet evidence-based criteria through the larger HomVEE review, information on which can be found at http://homvee.acf.hhs.gov, adapted to meet the needs of the Tribal community <p>The promising approach:</p> <ul style="list-style-type: none"> • Should be grounded in relevant empirical work and have an articulated theory of change. • Must have been developed by (or in partnership with) or identified with a national organization or institution of higher education. • Must be evaluated through a well-designed and rigorous process.
Protective Factors	Conditions in families and communities that, when present, increase the health and well-being of children and families. These attributes serve as buffers, helping parents to find resources, supports, or coping strategies that allow them to parent effectively, even under stress.

	<p>Research has shown that the following protective factors are linked to a lower incidence of child abuse and neglect:</p> <ul style="list-style-type: none"> • Nurturing and attachment • Knowledge of parenting and of child and youth development • Parental resilience • Social connections • Concrete supports for parents
Reflective Practice	<p>“The process of continuous learning through thoughtful examination of one’s work.” From Mentoring, Coaching, and Reflective Practice: An Annotated Resource List http://nitcci.nccic.acf.hhs.gov/resources/final_resources_for_mentoring.pdf.</p>
Reliability of Measurement	<p>Consistency of a measure to capture the intended construct (e.g., a person answering the questionnaire will most likely answer in a similar way both today and tomorrow). It is most frequently quantified through inter-rater reliability, test-retest reliability or internal consistency.</p>
Risk Factors	<p>Scientifically established direct causes of, and contributors to, negative outcomes for a specific population, such as maltreatment, juvenile delinquency, morbidity and or mortality. Changes in behavior or physiological conditions are the indicators of achievement of risk factor targets. Risk factor reduction tends to be considered an intermediate, rather than a final outcome.</p>
Sampling	<p>Selecting a group of participants that are representative of the population to which the data is intended to generalize. Sampling is used in instances where it is not feasible or appropriate to measure every single member of a specific population.</p>
Socio-Ecological Perspective	<p>Emphasizes that children develop within families, families exist within a community, and the community is surrounded by the larger society. This perspective reflects the understanding that development is a process involving <i>transactions</i> between the growing child and the social environment or ecology in which development takes place and considers the complex interplay between individual, family, community, and societal factors.</p>
State Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program	<p>Grants authorized by Section 511(c) of Title V, as amended, to States and Jurisdictions to strengthen and improve maternal and child health programs; improve service coordination for at-risk communities; and identify and provide comprehensive home visiting services to families who reside in at-risk communities. The Tribal MIECHV program is to be consistent, to the greatest extent practicable, with the requirements of the State Maternal, Infant, and Early Childhood Home Visiting Program grants.</p>

System	A set of connected elements, forming a complex unit with an overall purpose, goal, or function that is achieved only through the actions and interactions of all the elements.
Targeted Community	A community targeted for home visiting services with concentrations of: premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school dropouts; substance abuse; unemployment; or child maltreatment. Grantees may define a targeted community as either: <ul style="list-style-type: none"> i. An entire Tribe within a discrete geographic region (i.e., on a reservation); ii. Subgroups of a Tribe within a discrete geographic region (i.e., on a reservation); or iii. Members of a Tribe(s) living scattered throughout a larger, non-Tribal geographic area interspersed with non-Tribal members (e.g., Indians living in an urban environment).
Technical Assistance	The process of providing grant recipients with expert assistance to build their capacity to fully meet the requirements and successfully implement the program. Technical assistance may be provided by Federal staff or contract providers and may include training, research, peer learning, and consultation on the Federal requirements which include a broad range of topics regarding health and human services and program administration and evaluation.
Title V	The authorizing legislation for the Maternal and Child Health Block Grant to States program, which is found in Title V of the Social Security Act. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bggguideforms.pdf)
Traditional Medicine	Per the World Health Organization, “the health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose, and prevent illnesses or maintain well-being.”
Tribal Home Visiting Evidence of Effectiveness (HomVEE) Review	A report, the full title of which is “Assessing the Evidence of Effectiveness of Home Visiting Program Models Implemented in Tribal Communities”, that can be found at http://homvee.acf.hhs.gov/Tribal_Report_2012.pdf . <u>The report is a systematic review focused specifically on studies of home visiting models relevant to Tribal communities. The review included studies of home visiting program models implemented in Tribal communities in the U.S., implemented in indigenous communities outside the U.S., or evaluated with American Indian</u>

	<u>and Alaska Native families and children. This report describes the review process and findings, descriptive information about the program models evaluated, and lessons learned across studies, with a focus on cultural relevance and implementation.</u>
Validity of Measurement	The degree to which a measure is capturing the construct it is intending to capture (e.g. the measure is capturing depressive symptoms and not anxiety). It is frequently expressed as construct validity, content validity or criterion validity.