

TRIBAL  
HOME  
VISITING

# **Tribal Maternal, Infant, and Early Childhood Home Visiting Program**

## **Implementation Plan Guidance & Form 1**

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**Tribal Maternal, Infant, and Early Childhood Home Visiting Program**

**Implementation Plan Guidance &  
Form 1: Demographic and Service Utilization Data**

As stated in the funding opportunity announcements for the Tribal Maternal, Infant, and Early Childhood Home Visiting (Tribal MIECHV) Program, the Administration for Children and Families (ACF) must provide grantees with detailed guidance for submitting a needs and readiness assessment and an implementation plan that describes how the grantee will carry out required grant activities in Years 2-5, including implementing home visiting services, conducting performance measurement and continuous quality improvement activities, and engaging in rigorous evaluation. Grantees are expected to submit the implementation plan by the end of Year 1 of the grant, with draft submission milestones throughout the first year.

This document provides guidance for submission of the implementation plan for both **Tribal MIECHV Development and Implementation** grantees and **Tribal MIECHV Implementation and Expansion** grantees. The document also includes Appendices containing supplementary information and resources, including key definitions.

It is important to note that many of the core requirements for both Tribal MIECHV grant programs are the same. Where there are differences in the guidance related to each grant program, the guidance includes specific instructions. Grantees are expected to respond to every section of the guidance and each element listed under each section, with the goal that by responding to each section and area, grantees will have developed a comprehensive plan that will outline critical activities that are required to successfully execute their Tribal MIECHV grants in Years 2-5. ACF will work closely with and provide ongoing technical assistance to grantees as they develop their implementation plans and approval of the plan will be an iterative process between the grantee and ACF as part of the cooperative agreement. As part of the non-competing continuation application for Years 3-5 of the grant, Tribal MIECHV grantees will update their implementation plans as necessary to ensure that the plan accurately reflects activities to be completed throughout the remainder of the grant.

This document also includes Tribal MIECHV Form 1: Demographic and Service Utilization Data, which grantees will submit annually.

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

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## **TRIBAL MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM**

### **IMPLEMENTATION PLAN GUIDANCE**

#### **Background and Implementation Plan Guidance Overview**

##### **Background**

Section 511 of Title V of the Social Security Act, as amended by the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (Public Law 114-10), authorizes the Secretary of the U.S. Department of Health and Human Services (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 Maternal, Infant, and Early Childhood Home Visiting program (MIECHV, the Federal Home Visiting Program), administered by HRSA in collaboration with ACF, responds to the diverse needs of children and families in communities at risk and provides an opportunity for significant collaboration and partnership at the Federal, state, tribal, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs. The goals of the MIECHV program are to: (1) strengthen and improve the programs and activities carried out under Title V of the Social Security Act; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for eligible families who reside in at-risk communities.

The legislation sets aside 3 percent of the total MIECHV appropriation for grants to tribal entities and requires that the tribal grants, to the greatest extent practicable, be consistent with the requirements of the MIECHV grants to states and territories, and includes conducting a needs assessment and establishing benchmarks.

##### **Tribal Maternal, Infant, and Early Childhood Home Visiting Program**

Along with the goals of the overall MIECHV program, the Tribal MIECHV Program has the specific goals of:

- Supporting the development of happy, healthy, and successful American Indian and Alaska Native (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.

The Tribal MIECHV program includes two grant programs, both of which are designed to meet the overall goals of Tribal MIECHV. First, through Tribal MIECHV Development and Implementation grants, funds support grantees to develop infrastructure needed for planning, implementing, and sustaining home visiting programs in tribal communities. Second, through Tribal MIECHV Implementation and Expansion grants, funds support grantees to sustain and/or expand their established infrastructure for home visiting services in tribal communities.

During the 5-year project periods of the cooperative agreements, funds support:

- Conducting a coordinated needs and readiness assessment of at-risk tribal communities through a collaborative process that engages all relevant stakeholders;
- 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 in AIAN communities;
- Implementing high-quality, culturally relevant, evidence-based home visiting programs that meet the needs of at-risk tribal communities;
- Engaging with tribal, local, and state early childhood program partners and other stakeholders to maximize the success of home visiting programs and support the comprehensive needs of pregnant women, parents and caregivers, and children from birth to kindergarten entry living in at-risk tribal communities;
- Conducting performance measurement and continuous quality improvement activities; and
- Conduct rigorous evaluation activities using quality research methods that answer questions of interest to grantee communities and the broader field.

The activities that grantees carry out throughout this grant will support tribally and locally driven decision-making, development, implementation, and evaluation of grant-funded projects that are high-quality, evidence-based, and culturally responsive to the community. Throughout the cooperative agreement, ACF and contractors will provide technical assistance and support to carry out required activities while respecting tribal sovereignty and self-determination.

### ***Tribal MIECHV Development and Implementation Grants***

The Tribal MIECHV Development and Implementation Grants funds support 5-year grants (cooperative agreements) between ACF and federally-recognized Indian tribes (or a consortium of Indian tribes), tribal organizations, or urban Indian organizations to: conduct community needs assessments; develop the infrastructure needed for widespread planning, adopting, implementing, and sustaining of evidence-based maternal, infant, and early childhood home visiting programs; provide high-quality evidence-based home visiting services to pregnant women and families with young children aged birth to kindergarten entry; implement performance measurement systems and engage in continuous quality improvement activities;

engage in activities to strengthen early childhood systems of support for families with young children; and conduct rigorous program evaluation activities.

Year 1 grant activities are designed to support grantees in understanding the needs and capacities of their communities and designing and building capacity to implement and evaluate programs that meet these needs and fulfill grant requirements. In Year 1 of the cooperative agreement, grantees must therefore: (A) conduct a comprehensive community needs and readiness assessment; (B) build organizational and community infrastructure and capacity to implement high-quality evidence-based home visiting services, conduct performance measurement and continuous quality improvement activities, and conduct rigorous program evaluation; and (C) develop an implementation plan that describes how the grantee will carry out these activities during Years 2-5.

Grantees must engage in needs and readiness assessment, planning, and capacity-building activities during Year 1, but will not fully implement their plan. Grantees are expected to submit the Implementation Plan by the end of Year 1 of the grant, with draft submission milestones throughout Year 1.

### ***Tribal MIECHV Implementation and Expansion Grants***

The Tribal MIECHV Implementation and Expansion grantees support 5-year grants (cooperative agreements) between ACF and federally-recognized Indian tribes (or a consortium of Indian tribes), tribal organizations, or urban Indian organizations that are currently operating an evidence-based home visiting program and propose to conduct or update a needs and readiness assessment, sustain and/or expand their established infrastructure for home visiting services in tribal communities, implement performance measurement systems and engage in continuous quality improvement activities; engage in activities to strengthen early childhood systems of supports for families with young children; and conduct or participate in rigorous evaluation activities.

Year 1 grant activities are designed to support grantees in refining their understanding of community needs and adjusting, modifying, sustaining, and/or expanding their programs to meet these needs and fulfill grant requirements, without disrupting critical ongoing home visiting services to eligible families. In Year 1 of the cooperative agreement, grantees must therefore: (A) conduct or update a comprehensive community needs and readiness assessment; (B) improve and enhance organizational and community infrastructure and capacity to sustain and/or expand high-quality evidence-based home visiting services, conduct performance measurement and continuous quality improvement activities, and engage in rigorous program evaluation; (C) develop an implementation plan that describes how the grantee will carry out these activities during Years 2-5; and (D) maintain existing home visiting services to expectant families and families with young children.

Grantees must engage in needs and readiness assessment, planning, and capacity-building activities during Year 1, and are expected to continue serving children and families under their

existing home visiting program, but will not fully implement their plan. Grantees are expected to submit the Needs Assessment and Implementation Plan by the end of Year 1 of the grant, with draft submission milestones throughout Year 1.

## **Guidance Overview**

This document provides guidance for submission of the needs assessment and implementation plan for both Tribal MIECHV Development and Implementation grantees and Tribal MIECHV Implementation and Expansion grantees.

There are five main sections to the guidance: [Section 1](#) provides instructions for submitting the needs and readiness assessment, program goals and objectives, and program design and logic model; [Section 2](#) provides instructions for submitting an “action plan” that outlines how the grantee will implement its program as designed; [Section 3](#) provides instructions for submitting a data collection and management plan, plan for continuous quality improvement, and plan for performance measurement; [Section 4](#) provides instructions for submitting a plan for rigorous evaluation, and [Section 5](#) provides instructions for submitting an integrated timeline of activities for Years 2-5. The document also includes Appendices containing supplementary information and resources, including [key definitions](#), [Tribal MIECHV Performance Measures Numerators and Denominators](#); and [MIECHV Form 4: Quarterly Data](#).

It is important to note that many of the core requirements for both Tribal MIECHV Program grant programs are the same. Where there are differences in the guidance related to each grant program, the guidance includes specific instructions.

Grantees are expected to respond to every section of the guidance and each element listed under each section, with the goal that by responding to each section and area, grantees will have developed a comprehensive plan that will outline critical activities that are required to successfully execute their Tribal MIECHV grants. ACF will work closely with and provide ongoing technical assistance (TA) to grantees as they develop implementation plans. ACF and TA providers will provide TA tools throughout the development of implementation plans to assist in organizing and presenting requested information. Approval of the plan will be an iterative process between the grantee and ACF as part of the cooperative agreement.

Grantees will be permitted to implement program services upon approval of Sections 1, 2, 3, and 5. Grantees will be permitted to implement their rigorous evaluation activities upon approval of Section 4. As part of the non-competing continuation application for Years 3-5 of the grant, Tribal MIECHV grantees will update their implementation plans as necessary to ensure that the plan accurately reflects activities to be completed throughout the remainder of the grant.

**Section 1: Needs & Readiness Assessment, Home Visiting Program Vision, Goals, and Objectives, and Home Visiting Program Design**

**Overview**

This section will help you to describe community and organizational strengths, needs, capacity, and priorities and, based on what you discover, outline your home visiting program vision, goals and objectives, design, and logic model. The section is divided into five parts: 1) identify and assess your at-risk tribal community or communities; 2) assess your organizational capacity and readiness; 3) assess home visiting, substance abuse, and early childhood programs and systems in your at-risk tribal community; 4) program design; and 5) program logic model.

In each of the first three parts, you will be asked to reflect on the needs, strengths, and priorities that stand out and how these are likely to influence your program vision, goals, objectives, and design. In part four, you will articulate program vision, goals, objectives, and design based on the most critical identified needs, strengths, and priorities (including the program components such as evidence-based home visiting model, adaptations, enhancements, and supplements). Finally, you will present an integrated visual logic model that captures the direct relationship between identified needs, strengths, and priorities; goals and objectives; and program design.

For every numbered section below, respond to each lettered item accordingly (for example: Use numbered items as headings, lettered items as sub-headings, etc.).

**1. Identify and Assess At-Risk Tribal Community or Communities**

- A. Describe the process used to conduct your needs and readiness assessment for the community (or communities) including:
  - i. *Stakeholder Participation and Coordination with Other Needs Assessments.* Describe who participated in planning and carrying out the community needs and readiness assessment and how stakeholders were engaged and diverse perspectives ensured.
  - ii. *Needs Assessment Methodology.* Describe the methods used for gathering data (e.g., quantitative data, focus groups, surveys, etc.) including how these methods were selected and implemented, and how they complement each other.
  - iii. *Successes, Challenges, and Lessons Learned.* Please discuss the successes, challenges, and lessons learned that arose through conducting the needs and readiness assessment. What were some of the factors that facilitated the assessment process? What were some of the challenges faced, and how were they addressed? What lessons did you learn that might be relevant to future assessments that your community or organization might undertake?



B. Describe the targeted community or communities that you studied in your needs and readiness assessment

- i. Overview of targeted community or communities
  - a. Provide a general description of your service area.
  - b. Define the targeted community that was assessed for risk.
  - c. Describe the targeted community, including demographics, geography, historical and cultural factors.
  - d. Identify the “comparison” population or community against which relative needs and strengths of the targeted community were assessed (e.g., city, county, state, overall AIAN population in the U.S., U.S. as a whole)
- ii. Describe the targeted community’s established goals, visions, and priorities related to young children and families and how home visiting could fit in to these goals, vision, and priorities.
- iii. Characterize the needs and strengths of the targeted community or communities by providing data on the health and well-being of the community, as compared to the comparison population or community. If multiple targeted communities were assessed, provide information on each of these. For each targeted community, list indicators, sources of information (quantitative and qualitative), and key findings.
  - a. Premature births
  - b. Low birth weight
  - c. Infant mortality
  - d. Other risky prenatal, maternal, newborn, or child health and mental health conditions
  - e. Child maltreatment
  - f. Poverty and use of public assistance
  - g. Unemployment and underemployment
  - h. Crime, including juvenile delinquency and incarceration
  - i. Domestic or intimate partner violence
  - j. High school dropout and graduation rates
  - k. Substance use/abuse, including alcohol, tobacco, prescription drugs, illicit drugs
  - l. Other risk factors
  - m. Community strengths

C. Reflections and implications

- i. Based on the information in the table above, identify the “at-risk tribal community” or communities that will be served as part of your program. **Please note: your at-risk tribal community (or communities) could be the same as the targeted community (or communities) that**

**was assessed.** You may define an at-risk tribal community in the following ways:

- a) A tribe or tribes within a discrete geographic region (e.g., on a reservation, Tribal Jurisdictional Service Area, Alaska Native village)
  - b) Subgroups or communities of a tribe or tribes within a discrete geographic region
  - c) Members of a tribe(s) scattered throughout a larger, non-tribal geographic area interspersed with non-tribal members (e.g., AIAN living in an urban environment)
- ii. For the identified at-risk tribal community or communities, discuss the needs, strengths, and priorities that stand out and how these are likely to influence your program vision, goals, objectives, and design

## **2. Organizational Capacity and Readiness Assessment**

A. Assess your organization's capacity to respond to the identified needs of the at-risk community through a high quality, culturally appropriate, evidence-based home visiting program. Assess your organization's readiness and identify any administrative and organizational concerns that must be addressed prior to program implementation. Areas within your organization to consider include (but are not limited to) the following.

- i. Leadership and Governance
  - a. Describe the leadership or governance structure in place in your tribe or organization
  - b. Describe how home visiting programs would or do fit into the broader structure, including a current organizational chart
  - c. Describe how this structure receives input from key stakeholders
- ii. Management Practices
  - a. Discuss current management practices within your tribe or organization that are or would be applicable to your home visiting program
- iii. Human Resources
  - a. Describe organizational hiring practices and the extent to which they would or do support the ability to respond quickly and effectively to home visiting program staffing needs
- iv. Financial Resources
  - a. Describe how the organization ensures sound fiscal management practices
  - b. Describe the existing resources that are available to support home visiting program implementation (e.g., office space, IT, GSA or agency vehicles)

- c. Describe how organizational funding streams are coordinated or leveraged to streamline administrative functions
- v. Service Delivery
  - a. Describe any organizational experience implementing evidence-based programs or practices
  - b. Describe any organizational experience implementing a home visiting program
  - c. Describe existing organizational capacity and experience to deliver reflective practice and supervision
- vi. Data management infrastructure
  - a. Describe existing organizational capacity for data collection, analysis and management, as well as quality assurance and continuous quality improvement
- vii. Capacity for conducting rigorous evaluation
  - a. Describe existing organizational capacity and experience with evaluation projects using rigorous research methods. This could include capacity through subcontractors

B. Reflections and implications

- i. Based on the information above, discuss organizational needs, strengths, and priorities that stand out and how these are likely to influence your program vision, goals, objectives, and design

**3. Services and Systems Quality and Capacity Assessment.** Assess the quality and service capacity of existing programs or initiatives for maternal, infant, and early childhood home visiting and substance abuse treatment and mental health services in the at-risk tribal community, and assess the community's capacity to implement and integrate home visiting services to be provided by your program into an early childhood system.

A. Describe the capacity for home visiting services and systems in your community. For **Tribal MIECHV Implementation and Expansion grantees**, this includes the existing home visiting program you are currently implementing, as well as other existing home visiting programs in your at-risk tribal community. For **Tribal MIECHV Development and Implementation grantees**, this includes any existing home visiting programs in your at-risk tribal community.

- i. Describe the home visiting programs or initiatives that currently serve your at-risk tribal community or communities
- ii. Describe the funding sources for these programs and who administers them
- iii. Discuss how many families are currently receiving services through these programs

- iv. Describe the characteristics of individuals and families who are receiving services
  - v. Discuss which home visiting models, adaptations, enhancements, and supplements are being implemented
  - vi. Discuss the extent to which existing programs or initiatives are high-quality (i.e., are evidence-based or based on strong theory, and are implemented with fidelity)
  - vii. Describe the extent to which existing programs meet the needs of eligible families and are culturally relevant for AIAN families in the at-risk tribal community
  - viii. Describe some of the factors that limit additional investment and capacity for providing home visiting services in the at-risk tribal community
  - ix. Discuss the existing mechanisms for screening, identifying, and referring families and children to home visiting programs serving the at-risk tribal community (e.g., coordinated intake procedures)
  - x. Discuss the existing availability of qualified staff, including supervisors and home visitors, in the at-risk tribal community
  - xi. Describe the extent to which there is buy-in from community members, including Tribal Leaders and Elders, for home visiting programs in the at-risk tribal community
  - xii. Discuss the referral resources currently available to support families enrolled in home visiting programs residing in the at-risk tribal community
- B. Assess the at-risk tribal community's capacity for providing substance abuse treatment and mental health services to individuals and families in need of treatment or services and who are eligible for home visiting programs.
- i. List the existing investments in providing substance abuse treatment and mental health services through various funding streams
  - ii. Identify the numbers and characteristics of individuals and families who are receiving substance abuse treatment and mental health services in the at-risk tribal community(s)
  - iii. Discuss to what extent are the services high-quality and meet the needs of individuals and families who are eligible for home visiting services (e.g., are accessible and culturally relevant)
  - iv. Discuss what factors limit additional investment and capacity for providing needed services to individuals and families who are eligible for home visiting programs
- C. Assess the at-risk tribal community's capacity to implement and integrate home visiting services to be provided by your program into an early childhood system.

- i. Describe the existing programs, services, supports, and other resources in the at-risk tribal community or communities that serve pregnant women, expectant fathers, and children from birth to kindergarten entry and their families (including Head Start/Early Head Start, child care, health, mental health, early learning, child welfare, child abuse prevention, nutrition, housing, and other types of supportive services provided through federal, state, tribal, local, public, and private programs)
- ii. Discuss to what extent the services described above are linked in an early childhood system
- iii. Describe to what extent the community has a sustainable governance structure (e.g., early childhood advisory council) or coordinated way to plan for services for pregnant women, young children, and their families
- iv. Describe to what extent 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
- v. Describe to what extent 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)
- vi. Describe to what extent 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

D. Reflections and implications

- i. Based on the information above related to the services and systems in your at-risk community, discuss the needs, strengths, and priorities that stand out and how these are likely to influence your program vision, goals, objectives, and design

**4. Program Design**

- A. Summarize the most critical **needs, strengths, and community priorities** that emerged from your community needs and readiness assessment, organizational capacity and readiness assessment, and services and systems quality and capacity assessment
- B. Based on these, define the **vision, goals, and objectives** of your proposed program. These should reflect a direct relationship to the needs, strengths, and priorities of the at-risk tribal community or communities identified through the needs and readiness assessment laid out above

- i. Vision – a one-sentence statement describing the clear and inspirational long-term desired change resulting from your program's work
  - ii. Goals – the intended specific results of your program, should it be effective
  - iii. Objectives – the specific and measurable steps for reaching your goals
- C. Describe the **design of your proposed home visiting program**, including its key components (i.e., evidence-based home visiting model(s), proposed adaptations to home visiting models, proposed enhancements to home visiting models, and other proposed supplemental components to the program).
  - i. For each proposed program component (model, adaptation, enhancement, supplement) already in existence:
    - 1. Identify and provide a basic description of the component
    - 2. Describe how the component meets the identified needs, strengths, and priorities of the at-risk community and aligns with your organizational capacity
    - 3. Describe how the component meets your identified programmatic vision, goals, and objectives
    - 4. Describe the component's theory of change
    - 5. Describe the component's evidence of effectiveness. If no evidence of effectiveness, what is its empirical basis (from research, theory, practice, culture, and/or context)?
    - 6. Describe how the component aligns with ACF's definition of an "evidence-based home visiting model", "adaptation", "enhancement", or "supplement"
    - 7. Describe how the community was involved in the identification and selection of the component. Discuss which stakeholders (e.g., Tribal Leaders, model developers, Elders, families) were involved and how
  - ii. For each proposed program component that you plan to develop as part of Years 2-5 activities under this grant, provide a general description and overview of the component's intended purpose (i.e., how it will meet identified needs and strengths and your programmatic vision, goals, and objectives). In Section 2, you will describe the process you plan to take to develop these program components
  - iii. Provide a rationale for how all of the proposed components will work in concert to meet the needs, strengths, and priorities of the at-risk tribal community or communities identified through the needs and readiness assessment and organizational capacity assessment. Discuss how their theories of change align with or enhance one another, and how they collectively meet your proposed vision, goals, and objectives

## **5. Program Logic Model**

- A. Provide a logic model summarizing what you have articulated above. A TA tool will be provided to you to help organize this information and present it as part of Section 1 of your implementation plan.
- i. At-risk tribal community context, culture, needs, and strengths you have prioritized to address with your program
  - ii. Vision, goals, and objectives of your program
  - iii. Underlying assumptions
  - iv. Program inputs
  - v. Program design (key components)
  - vi. Program activities and outputs
  - vii. Short- and long-term outcomes

## **Section 2: Action Plan for Effective Implementation of Home Visiting Program**

### **Overview**

This section will assist you to articulate your action plan for effectively implementing your vision, goals, objectives, and program design as laid out in Section 1. Each of the sections below, including leadership and governance; community engagement; creating and maintaining a quality workforce; recruitment enrollment and engagement of families in home visiting services; implementation of a high-quality home visiting program; development, improvement, and implementation of an early childhood system; sustainability; and dissemination, will assist you in developing an action plan for successfully implementing your program in Years 2-5 of your grant.

For every numbered section below, respond to each lettered item accordingly (for example: Use numbered items as headings, lettered items as sub-headings, etc.).

### **1. Leadership, Governance, and Administration**

- A. Identify the lead agency for your program
- B. Describe the administrative management and structure that your program operates within, and who will be responsible for ensuring successful implementation and oversight of your program
- C. Describe who will be responsible for ensuring fiscal planning and oversight of your program is in place
- D. Provide a list of lead collaborative partners, including subcontractors, and their roles and responsibilities in the development and implementation of your program
- E. Describe the composition and use of a local advisory committee to support planning and oversight of your program, including:
  - i. Role of advisory committee and tasks it will perform
  - ii. Composition of advisory committee and how members will potentially advise and inform your program
  - iii. How often the advisory committee will meet
- F. Identify the governing body(ies) that has legal oversight, including tribal governance, tribal standing committee(s), or board of directors to which your program will report
- G. Provide an organizational chart for your program

### **2. Community Engagement**

- A. Identify community stakeholders that will be engaged throughout the development and implementation of your program, including tribal and organizational leadership, parents, Elders, and community leaders



- B. Identify partner organizations, departments, or programs not identified in Section 1 and that your program plans to engage
- C. Identify strategies for engagement with the entire community
  - i. Describe methods for engagement and outreach
  - ii. Identify existing tribal, community, and organizational resources that can be utilized and leveraged to increase community engagement

### **3. Creating and Maintaining a Quality Workforce**

- A. Describe the staff positions that are necessary for the implementation of your program, and the key competencies and activities that are required for each position. Include job descriptions for these positions and resumes of staff or proposed staff as an appendix
- B. Describe how new staff will be recruited and provide an overview and general timeline of the hiring process
- C. Describe how new employee orientation and training will be provided, including training in your program components
- D. Describe how you will provide high quality reflective, clinical, and administrative supervision
  - a. How frequently it will be provided
  - b. The format it will take (e.g., group, individual)
  - c. Who will provide it
- E. Describe how reflective practice will be supported in your program
- F. Describe how the program will support access to infant and early childhood mental health consultation and other supports
- G. Describe how you will support staff professional development
- H. Describe strategies to prepare for and address potential staff turnover

### **4. Recruitment, Enrollment and Engagement of Families**

- A. Describe strategies for identifying and recruiting families who will most benefit from your program
- B. Describe the process for enrolling families into your program
- C. Estimate the number of families to be served, including your total proposed caseload
- D. Describe your approach to engaging and retaining families, including ensuring appropriate dosage of services

### **5. Implementation of a High-Quality Program**

- A. For each existing program component (model, adaptation, enhancement, supplement) proposed as part of your program design, provide a plan for working with model developer(s) and/or developers of other program components, including:

- i. The approach to ongoing communication and working relationship with the developers to address challenges that may arise and share best practices
  - ii. How component curriculum and materials will be accessed, as well as any necessary pre-service or recurring training, licensing, affiliation, and/or certification
  - iii. What technical assistance and supports will be provided
- B. If you proposed in Section 1 to develop a program component as part of Year 2-5 activities, please describe the process through which it will be developed
  - i. Which stakeholders will be involved and how
  - ii. How you will ensure that the component meets ACF requirements and definitions
  - iii. Anticipated challenges and how they will be addressed
- C. Monitoring of fidelity of program implementation to ensure services are delivered according to the requirements of the selected program components
  - i. Describe how you will monitor, assess, and support implementation with fidelity to the chosen program components and maintain implementation quality assurance<sup>1</sup>
  - ii. Discuss anticipated challenges to maintaining quality and implementation fidelity and how you will address them

## **6. Early Childhood Systems Building**

- A. Describe how your program will accomplish the goal of meeting the needs of families from pregnancy through kindergarten entry through the development, improvement, and implementation of an early childhood system of support for families that includes your home visiting program. Discuss how your program will meet the needs of families served through collaboration with tribal and community stakeholders and partners providing services and supports such as, but not limited to:
  - i. Early care and education (Head Start/Early Head Start, child care, pre-kindergarten)
  - ii. Home visiting (including State MIECHV)
  - iii. Maternal, child, and family health
  - iv. Mental and behavioral health
  - v. Substance abuse prevention and treatment
  - vi. Domestic violence

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<sup>1</sup>The quality assurance plan you articulate in Section 3 may be one piece of this overall implementation quality assurance plan.

- vii. Child welfare, child maltreatment and injury prevention
- viii. Economic self-sufficiency
- ix. Elementary and secondary education
- x. Early intervention for developmental delays
- xi. Housing and homelessness
- xii. Other social and health services for pregnant women, expectant fathers, young children, and families

## **7. Developing Policies and Procedures**

- A. Identify topic areas of existing policies at the tribal or organizational level, such as human resources/personnel, confidentiality and privacy, etc.
- B. Identify topic areas of policies and/or procedures that will need to be revised, refined, or developed for your program
- C. Describe strategies for engaging program staff and other stakeholders in the development of your program policies and procedures manual, including administrative leadership, advisory groups, and service recipients
- D. Describe activities that will ensure the regular utilization and review of your program policies and procedures manual

## **8. Engaging in Dissemination – Telling Your Program Story**

- A. Describe your program's main goals for dissemination
- B. Describe the audiences you plan to prioritize for dissemination
- C. Discuss the types of information you think these audiences will be most interested in and how you will gather this information
- D. Provide an overview of the types of dissemination materials and products you will develop or have already developed to reach these audiences
- E. Describe your plans to disseminate the materials and products you develop
- F. Describe your plans to evaluate the successes of your dissemination efforts

## **9. Promoting Sustainability**

- A. Describe how your program will build and ensure sustainability after the grant has ended. Discuss how your program will engage with tribal or other organizational leaders, and how your program fits into and is important within the historical and cultural contexts of the community; including:
  - i. How your program's purpose aligns within and is critical to the larger tribal or organizational strategic vision for the future
  - ii. How your program demonstrates to stakeholders that it provides a vital and critical service and is important to the families and to the community

- iii. Identify the strategic linkages between your community engagement strategy and sustainability, including how will you leverage relationships and engage with advisory groups and other stakeholders
- B. Assess the current infrastructure and resources for retaining and extending home visiting services beyond the federal funding period.
- C. Identify resources that potentially may be leveraged to sustain home visiting, including collaborations with service partners, various funding streams, both public and private.

**Section 3: Plan for Data Collection and Management,  
Continuous Quality Improvement, and Performance Measurement**

**Overview**

The broad aim of this section is to support you in monitoring and improving the program design and implementation action plan you developed in Sections 1 and 2. All grantees will engage in ongoing planning, collection, and monitoring of data on program activities. The purpose of this section is for you to: 1) develop a data collection and management plan; 2) develop a plan for using data to inform program management and improvement; and 3) develop a plan for the reporting of demographic, implementation, and performance measures required by the Tribal MIECHV Program.

For every numbered section below, respond to each lettered item accordingly (for example: Use numbered items as headings, lettered items as sub-headings, etc.).

**1. Data Collection and Management Plan**

**A. Plan for data collection and entry**

- i. Describe your data collection process for Tribal MIECHV Form 1, MIECHV Form 4, and performance measurement data
  - a. Identify the persons responsible for data collection (i.e., home visitors, intake specialist, data collector, coordinator, etc.)
  - b. Identify mode of data collection (i.e., paper forms, tablet, combination of the two, etc.)
  - c. Describe whether participants will complete forms themselves, whether the data will be collected via interview or with computer assisted interviewing technology
  - d. Identify the persons responsible for data entry
  - e. Describe data entry procedures and timeframes

**B. Plan to ensure the quality of data collection and analysis**

- i. Describe procedures for training and staffing around data
  - a. The minimum qualifications or training requirements for those administering measures
  - b. The qualifications of personnel responsible for data management at the grantee and program level
  - c. The qualifications of personnel responsible for data analysis at the grantee and program level
  - d. The time estimated for the data collection-related activities for different staff positions

- e. Strategies you have for minimizing the impact of any staff turnover on data collection and analysis
- ii. Describe your approach to promoting a culture of quality within the organization and program
- iii. Discuss your policies and procedures around data collection and management
  - a. Describe your plans for documenting procedures or policies related to data collection, data entry, data management and/or data analysis
  - b. If you have developed policies and procedures already, please describe them  
Describe your plan for using, monitoring, or updating these procedures or policies
- iv. Provide a plan for data quality checks
  - a. Describe your process for verifying the validity, accuracy, completeness, consistency and uniformity of data collected in the field, including frequency of data quality checks
  - b. Describe your process for verifying the validity, accuracy, completeness, consistency and uniformity of data entry, including frequency of data quality checks
  - c. Describe process for providing feedback and improving data quality issues if they arise

C. Plan for Data Management Information System (MIS)

- i. Describe your data management information system(s)
- ii. Describe the contractor responsible for the data system (if applicable), what services are provided, and what training and TA are provided
- iii. Describe your plan for data entry/upload
- iv. Describe whether and how your data system will link with other systems
- v. Discuss the functions your system will provide (e.g., auto-calculations, reports)
- vi. Describe which staff will have access to the system, including whether different staff will have different levels of access
- vii. Identify which staff will run reports
- viii. Identify the staff responsible for making changes to the system, and describe how those changes will be made (e.g., is there a period where system locks and all changes are made? Or do changes occur on an ongoing basis?)
- ix. Discuss how data system policies will be manualized
- x. Describe how staff will be trained to use the system in an ongoing way
- xi. If applicable, identify goals for improving your existing data system

D. Plan for Data Security

- i. Describe plan for data security 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)
- ii. Discuss how staff will be trained on these topics

## **2. Plan For Using Data to Inform Program Management And Improvement**

### **A. Quality Assurance Plan**

- i. Identify data elements that you will use on an ongoing basis for quality assurance,
  - a. Describe what model-specific data you will review, such as fidelity measures
  - b. Discuss which core and flex performance measures you will review
  - c. Discuss which demographic, service utilization, and implementation data you will review
  - d. Identify other sources of data you may use for quality assurance
- ii. Describe the data analytic methods you will use to monitor program performance, such as data visualization, run charts, etc.
- iii. Discuss how often you will review these data, and who will be involved in sharing, reviewing, and acting upon the data within your program, organization, and community

### **B. Continuous Quality Improvement Plan**

- i. Discuss your program's readiness to engage in CQI, including your past experiences with CQI and the steps your program might need to take to be ready to integrate CQI into regular practice
- ii. Provide a plan to support CQI
  - a. Identify members of your CQI team
  - b. Describe members' roles and responsibilities
  - c. Describe a plan for meetings, including if CQI will be incorporated into regular staff meetings or occur in separate CQI meetings
  - d. Discuss how often your CQI team will meet

- e. Describe how the CQI team will work in an ongoing way to identify CQI opportunities and topics, including which data you will use and how you will use data

### **3. Plan for the Reporting of Required Demographic, Service Utilization, Implementation, and Performance Measurement Data**

Grantees under the Tribal MIECHV program must collect, analyze, use, and report data on program implementation and improvements for eligible families participating in the program in the legislatively-mandated benchmark areas of: I) improved maternal, newborn, and child health; II) prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency room visits; III) improvements in school readiness and child academic achievement; IV) reductions in crime or domestic violence; V) improvements in family economic self-sufficiency; and VI) improvements in the coordination and referrals for other community resources and supports. Grantees will also collect and report on demographic and service utilization and service capacity, place-based services, family engagement, and staffing data.

The data that you will collect and report include the following.

- 15 Performance Measures (will be submitted annually starting in Year 2 of the grant; definitions are provided in [Appendix C](#))
  - 12 Core Measures
    - Implementation Measures
      1. Receipt of Home Visits
      2. Home Visit Implementation Observation
      3. Reflective Supervision
    - Benchmark Measures
      4. Depression Screening (I)
      5. Substance Abuse Screening (I)
      6. Well-child Visit (I)
      7. Child Injury Prevention (II)
      8. Parent-Child Interaction (III)
      9. Developmental and Behavioral Screening (III)
      10. Screening for Intimate Partner Violence (IV)
      11. Screening for Economic Strain (V)
      12. Developmental and Behavioral Referrals (VI)
  - 3 Flex Measures
    - Grantees must select 3 measures, two from items 1-7 and one from items 8-11.
      1. Breastfeeding (I)
      2. Postpartum Health (I)
      3. Immunizations (I)
      4. Screening for Parenting Stress
      5. Safe Sleep Education (II)



6. Child Injury Prevention (II)
  7. Early Language and Literacy Activities (III)
  8. Intimate Partner Violence Referrals (VI)
  9. Depression and Parenting Stress Referrals (VI)
  10. Substance Abuse Referrals (VI)
  11. Economic Strain Referrals (VI)
- Demographic and service utilization data ([Tribal MIECHV Form 1](#)) (will be submitted annually starting in Year 2 of the grant for Development and Implementation grantees and Year 1 of the grant for Implementation and Expansion grantees)
  - Service capacity, place-based services, family engagement, and staffing data ([MIECHV Form 4](#)) (will be submitted quarterly starting in Year 2 of the grant for Development and Implementation grantees and Year 1 of the grant for Implementation and Expansion grantees)
- A. For each required element, you will be required to address the following in your plan. A TA tool will be provided to you to help organize this information and present it as part of Section 3 of your implementation plan.
- i. Target population to be assessed
  - ii. Data sources, forms, and tools
  - iii. Data time points
  - iv. Data elements to be used for computing data value
  - v. Data systems modifications needed
  - vi. Data reporting fields to be used for calculation
  - vii. Unique data reporting elements

#### **Section 4: Plan for Rigorous Evaluation of Home Visiting Program**

The evaluation activities of the Tribal MIECHV grantees occur as part of a continuous program of rigorous research within the broader MIECHV Strategic Learning Agenda. It is expected that collectively these program evaluation activities will contribute to the empirical evidence base on implementation, efficacy, effectiveness, and/or adaptation of home visiting programs in AIAN communities. Tribal MIECHV Development and Implementation grantees will propose and put into action a plan for iterative formative evaluation of home visiting in their tribal community. Tribal MIECHV Implementation and Expansion grantees will either participate in a multi-site implementation evaluation (MUSE) OR plan and conduct a local efficacy study of home visiting in their tribal community. All Implementation and Expansion grantees that choose to conduct a local efficacy study will be encouraged to participate in the multi-site implementation evaluation to the extent feasible and relevant. In the following section, the implementation plan guidance for evaluation for each set of grantees is presented separately (i.e., [Development and Implementation](#) grantees pages 27-31; [Implementation and Expansion](#) grantees pages 32-38).

## **EVALUATION GUIDANCE FOR TRIBAL MIECHV DEVELOPMENT AND IMPLEMENTATION GRANTS**

### **Overview**

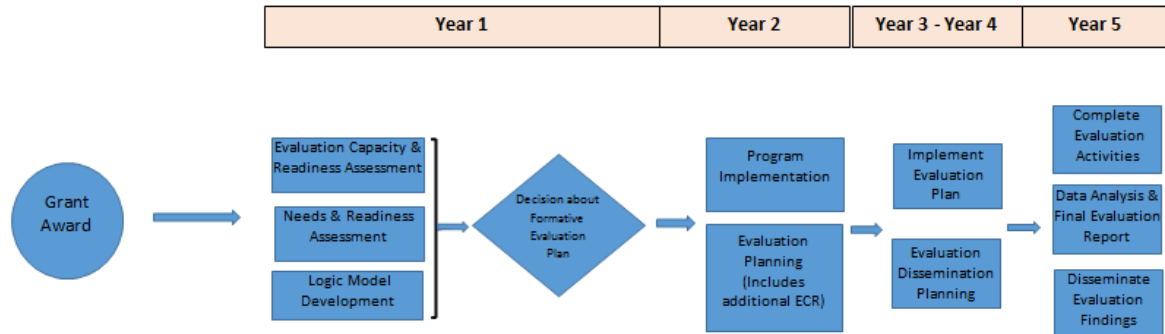
Grantees will propose a plan for participating in ongoing program evaluation activities that addresses locally relevant questions that emerge from their needs and readiness for home visiting assessment. It is expected that these evaluations will contribute to building the knowledge base around successful strategies for implementing, adopting, providing, and sustaining high-quality, evidence-based home visiting services to AIAN populations. The grantee's evaluation plan will be grounded in the grantee's logic model for home visiting and an Evaluation Capacity and Readiness (ECR) assessment. Upon review of the logic model and ECR, grantees will consider evaluation approaches that clarify and/or test the relationships between elements within the logic model. For example, design and development studies help answer questions about how activity components influence outputs and how outputs influence immediate outcomes. Efficacy studies help answer questions about, how a particular intervention when implemented in a particular context effects specific immediate and proximal outcomes for a particular group of participants. ACF will provide technical assistance to support grantees in developing and implementing an evaluation plan, design and measurement strategy that is grounded in their ECR and that best fits their local question(s). For more information on types of research and evaluation, see The Administration for Children and Families Common Framework for Research and Evaluation, available at <http://www.acf.hhs.gov/programs/opre/resource/the-administration-for-children-families-common-framework-for-research-and-evaluation>.

### **Timeline of Evaluation Activities**

The Development and Implementation grants process map (below) provides a visual representation of the evaluation activities for the Development and Implementation grants for the five year grant cycle. Some of the included activities are not exclusively evaluation-related activities, such as logic model development and needs and readiness assessment. A stage-like progression of iterative planning and technical assistance that includes reflection and revision based on local experience will be followed. In Year 1, you will describe your plan for engaging the community, tribal, and organizational leadership in the development and oversight of the evaluation. You will also develop a logic model that represents your expectations regarding home visiting in their community, conduct a needs and readiness assessment, and participate in an evaluation capacity and readiness (ECR) assessment. You will then make a decision about your formative evaluation priorities. In Year 2, you will plan your formative evaluations, with continued ECR assessment. You will choose a focus for your evaluation and describe planned evaluation activities, including a specification of evaluation question(s) and design, measurement plans, the plan for data collection and management, the data analysis plan, the planned strategy for tribal oversight, the plan for protection of human subjects, and a timeline of evaluation activities to occur during Years 3-4. In Years 3 and 4, you will implement your evaluation, adjust as needed, and begin planning for the dissemination of your evaluation.

Early in Year 5, you will complete evaluation activities. You will then conduct data analysis, complete their final evaluation report, and disseminate evaluation findings.

DEVELOPMENT AND IMPLEMENTATION GRANTS EVALUATION ACTIVITIES PROCESS MAP



**Developing the Evaluation Plan.** You will develop the following information regarding your evaluation plan. For every numbered section below, respond to each lettered item accordingly (for example: Use numbered items as headings, lettered items as sub-headings, etc.).

Years 1- 2

1. Plan for Collaboratively Building a Knowledge Base for Home Visiting and its Impact with AIAN Populations (2-3 paragraphs)
  - a. Strategy for community participation in and Tribal oversight of evaluation plans and activities
2. Logic Model – visual and verbal description (1 page graphic and 5 paragraphs)
3. Summary of and reflection on ECR (3-5 paragraphs)
4. Summary of potential evaluation questions that have been considered, including the advantages and challenges for each. If you considered expanding a piece or pieces of the logic model to examine components more closely, describe this here. () (5-7 paragraphs)
5. Choice of evaluation focus and rationale for it being the priority with clear links to logic model, needs and readiness assessment, ECR assessment. The evaluation focus may involve one ‘big’ question with data collection over years or staged questions that are modified over time based on plan/decisions . (3-5 paragraphs)

## 6. Evaluation Design

## a. Evaluation question(s) to be addressed

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

Evaluation Question(s):	
<b>R</b>	<i>The relationship(s) in logic model that will be studied</i>
<b>E</b>	<i>The elements you plan to measure to understand the relationship(s)</i>
<b>P</b>	<i>The prediction for how you think the relationship(s) will work</i>

## b. Based upon the evaluation question(s) above, clearly state the hypothesis (hypotheses) that you mean to explore.

## c. Evaluation approach and method(s)

- i. Rationale and considerations for proposed evaluation approach to address evaluation questions
- ii. Evaluation Diagram: Please briefly diagram in a visual form how your evaluation approach will help clarify and/or explain aspects of your logic model.
- iii. Describe your expected sample.

## d. Planned quantitative and/or qualitative measures and instruments (please provide in a table format)

Measure/Instrument & Source Information	Logic Model element to be measured (e.g., input, activity, output, outcome )

## e. Data collection process

- 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)

## f. Data collection schedule (provide detailed timeline) Analysis plan

- i. Describe your analysis plan for answering each of your research questions/hypotheses.
- ii. 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.

- iii. 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.
- iv. If you will be utilizing a consultant for your data analysis, please describe your plan for the data analysis consultation process.

#### 7. 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

#### 8. Data Collection 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)

#### 9. 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 (modify table as needed):

Evaluation Task	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year	Month/ Year

<b>Evaluation planning</b>								
<b>Tribal oversight and IRB approval</b>								
<b>Instrument development</b>								
<b>Staff recruitment and training</b>								
<b>Data collection</b>								
<b>Administration of instruments</b>								
<b>Data analysis</b>								
<b>Reporting</b>								

c. Budget for evaluation activities described in above table

#### Years 3-4

10. Planned Evaluation Dissemination Activities. This will be submitted early in Year 3, then reviewed and revised early in Year 4, and then reviewed and revised at the beginning of Year 5.

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

<input checked="" type="checkbox"/>	<b>Dissemination Activity</b>
<input type="checkbox"/>	Internal newsletter/publication
<input type="checkbox"/>	External newsletter/publication
<input type="checkbox"/>	Conference presentations/posters
<input type="checkbox"/>	Tribal Organization Publication
<input type="checkbox"/>	Website publication
<input type="checkbox"/>	Peer reviewed evaluation journal

11. Review and Revision of Evaluation Plan. During implementation of the evaluation, reflection and review of plans will occur. Revision will occur on an ad hoc basis as needed.

#### Year 5

12. Submit Final Report

#### **EVALUATION GUIDANCE FOR TRIBAL MIECHV IMPLEMENTATION AND EXPANSION GRANTS**

## **Overview**

Implementation and Expansion grantees will either participate in a multi-site implementation evaluation (MUSE) OR plan and conduct a local efficacy study of home visiting in their tribal community that involves 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 (EFFICACY). All Implementation and Expansion grantees that choose to conduct a local efficacy study will be encouraged to participate in the multi-site implementation evaluation to the extent feasible and relevant as well (EFFICACY+MUSE). ACF will provide technical assistance to support grantees as appropriate across these three options.

## **Timeline of Evaluation Activities**

The Implementation and Expansion grants process map (below) provides a visual representation of the evaluation activities for the Implementation and Expansion grants for the five year grant cycle. Some items in the map represent activities that are not exclusively evaluation-related activities, such as logic model development and needs assessment.

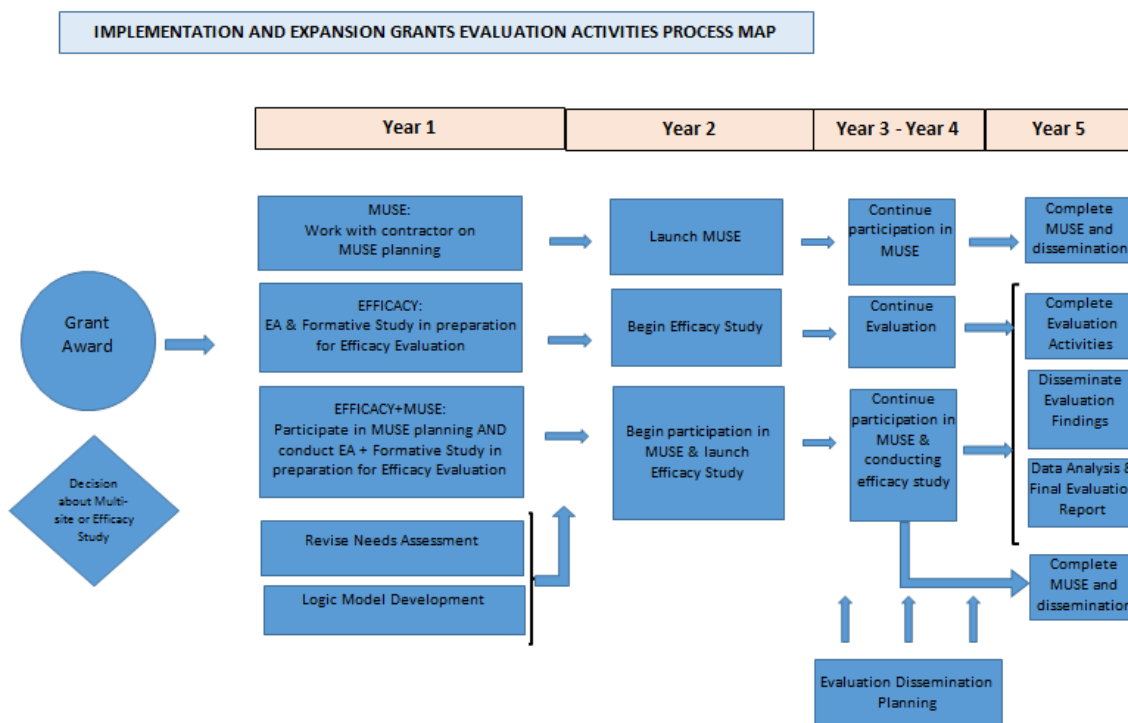
In Year 1, all grantees will describe their plan for engaging the community, tribal, and organizational leadership in the development and oversight of the evaluation. You will also develop a logic model that represents your expectations regarding home visiting in your community and revise your needs assessment. Evaluation timeline activities for Implementation and Expansion grantees are described below.

In Year 1, MUSE and EFFICACY+MUSE grantees will work with the ACF contractor on the multi-site implementation evaluation. In Year 2, these grantees will launch the multi-site evaluation. In Years 3 and 4, MUSE and EFFICACY+MUSE grantees will continue participation in the multi-site evaluation. Early in Year 5, all grantees will complete evaluation activities.

In Year 1, EFFICACY and EFFICACY+MUSE grantees will participate in an evaluability assessment (EA) to determine formative evaluation steps appropriate to prepare for and refine their proposed efficacy study. In Year 2, EFFICACY and EFFICACY+MUSE grantees will refine plans for their efficacy study and initiate implementation of their study. During Year 2, EFFICACY and EFFICACY+MUSE grantees will refine and describe planned evaluation activities, including a re-specification of evaluation question(s) and design, measurement plans, the plan for data collection and management, the data analysis plan, the planned strategy for tribal oversight, the plan for protection of human subjects, and a timeline of evaluation activities to occur. In Years 3 and 4, EFFICACY and EFFICACY+MUSE grantees will continue implementing their efficacy study and begin planning for the dissemination of their evaluation. Early in Year 5, all grantees will complete evaluation activities. During Year 5, EFFICACY and EFFICACY+MUSE



grantees will conduct data analysis, complete their final evaluation report, and disseminate evaluation findings.



**MUSE and EFFICACY+MUSE Participation.** The details for the multi-site implementation evaluation will not be addressed in this guidance, as grantees will work with the contractor for this study to develop any necessary plans.

**EFFICACY and EFFICACY+MUSE: Re-fining the Evaluation Plan.** Grantees choosing this option will plan and conduct a local efficacy study of home visiting in your tribal community that involves 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.

You will develop the following information regarding your evaluation plan. *Efficacy study grantees will need to write a rationale for your study based in the literature, will use the PICO model for your evaluation question, as well as include information on additional research questions and data plans (e.g., qualitative component).*

**Developing the Evaluation Plan.** You will develop the following information regarding your evaluation plan. For every numbered section below, respond to each lettered item accordingly (for example: Use numbered items as headings, lettered items as sub-headings, etc.).

1. Plan for Collaboratively Building a Knowledge Base for Home Visiting and its Impact with AIAN Populations (2-3 paragraphs)
  - a. Strategy for community participation in and Tribal oversight of evaluation plans and activities
2. Logic Model – visual and verbal description of overall home visiting logic model as well as components to be studied in evaluation (1 page graphic and 5 paragraphs)
3. Summary of and Reflection on Evaluability Assessment (3-5 paragraphs)
4. Rationale for efficacy study (with clear links to a specific review of home visiting literature (as well as other empirical and theoretical justification), logic model, needs and readiness assessment, EA assessment). (3-5 pages)
5. Efficacy Study Design
  - a. Evaluation question(s) to be addressed

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

<b>Evaluation Question(s):</b>	
<b>P</b>	<i>The target population and their prioritized needs.</i>
<b>I</b>	<i>The intervention, program, or program component to be evaluated.</i>
<b>C</b>	<i>The comparison that will be made to understand the impact of the program.</i>
<b>O</b>	<i>The intended outcomes you want to see achieved.</i>

- b. Based upon the evaluation question(s) above, clearly state the hypothesis (hypotheses) that you mean to test.
- 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.

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

iii. Sample size(s)

d. Planned measures and instruments (please provide in a table format)

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

e. Data sources (see table below for 5 l., m. & n.)

f. Data collection process (see table below for 5 l., m. & n.)

v. 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 5 l., m. & n.)

<b>Input, Activity, Output, or Outcome</b>	<b>Measure/ Indicator</b>	<b>Data Source</b>	<b>Measurement Interval</b>	<b>Data Collection Method</b>	<b>Person Responsible</b>
	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

- vi. Describe your analysis plan for answering each of your research questions/hypotheses.
- vii. 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.
- viii. 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.
- ix. If you will be utilizing a consultant for your data analysis, please describe your plan for the data analysis consultation process.

## 6. 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

## 7. 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)

## 8. 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:

<b>Evaluation Task</b>	<b>Month/ Year</b>	<b>Month/ Year</b>	<b>Month/ Year</b>	<b>Month/ Year</b>	<b>Month/ Year</b>	<b>Month/ Year</b>	<b>Month/ Year</b>	<b>Month/ Year</b>
<b>Evaluation planning</b>								
<b>Tribal oversight and IRB approval</b>								
<b>Instrument development</b>								
<b>Staff</b>								

<b>recruitment and training</b>								
<b>Data collection</b>								
<b>Administration of instruments</b>								
<b>Data analysis</b>								
<b>Reporting</b>								

c. Budget for evaluation activities described in above table

Years 3-5

9. Planned Evaluation Dissemination Activities. This will be submitted early in Year 3, then reviewed and revised early in Year 4, and then reviewed and revised at the beginning of Year 5.

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

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

10. Review and Revision of Evaluation Plan. During implementation of the evaluation, reflection and review of plans will occur. Revision will occur on an ad hoc basis as needed.

Year 5

12. Submit Final Report

## **Section 5: Integrated Years 2-5 Timeline**

### **Overview**

In this section, you will provide a comprehensive timeline that reflects the major milestones that have been identified in each of Sections 2-4 and that will be executed in years 2-5 of the grant. Technical assistance tools will be provided to you to help develop and organize the timeline and submit it as part of your implementation plan.

1. Program component development
2. Leadership, governance, and administration plans
3. Community engagement activities
4. Recruitment, enrollment and engagement of families in home visiting services
5. Implementation of a high-quality home visiting program
6. Meeting the needs of families from pregnancy through kindergarten entry through the development, improvement, and implementation of an early childhood system
7. Developing, refining, or updating policies and procedures for your home visiting program, including the development of a policies and procedures manual
8. Development and implementation of dissemination activities into your program
9. Sustainability planning
10. Development of a data collection and management infrastructure
11. Data system development and management
12. Quality assurance activities
13. Continuous quality improvement activities
14. Collection, analysis, and reporting of required data
15. Rigorous evaluation planning and implementation activities

## **Appendix A – Definitions of Key Terms in Implementation Plan Guidance**

- **Adaptation**
  - For the purposes of the Tribal MIECHV program, an acceptable adaptation of an evidence-based model or promising approach includes changes to the model that have not been tested with rigorous impact research and are determined by the model developer to alter core components related to program impacts, are aligned with Tribal MIECHV program requirements, and are agreed to by the model developer and ACF in partnership with the grantee.
- **Administrative supervision**
  - For the purposes of the Tribal MIECHV program, administrative supervision is the oversight of tribal, federal, state, and agency regulations, program policies and procedures, quality assurance and safety. Administrative supervision is aimed at monitoring an employee's productivity and performance.
- **Advisory committee**
  - For the purposes of the Tribal MIECHV program, a local advisory committee is comprised of community members from the program's service area and provides input on a variety of program and evaluation activities. Advisory committees are created to ensure that the program is in touch with the community's needs and incorporates the community's perspective in program operations and evaluation activities. Advisory committees should meet on a regular basis and perform a number of valuable functions, including providing input on needs assessment, performance measurement, continuous quality improvement, evaluation, and dissemination activities; defining program vision, goals, objectives, and design; and helping shape many core functions and activities of the program.
- **At-risk tribal community**
  - For the purposes of the Tribal MIECHV program, in order to reflect the diverse circumstances of tribal populations, ACF takes a broad and inclusive view of what constitutes an at-risk tribal community. Grantees may define an at-risk tribal community in the following ways:
    - A tribe or tribes within a discrete geographic region (e.g., on a reservation, Tribal Jurisdictional Service Area, Alaska Native village) could be considered an at-risk tribal community;
    - Subgroups or communities of a tribe or tribes within a discrete geographic region could be considered an at-risk tribal community; or
    - Members of a tribe(s) could live scattered throughout a larger, non-tribal geographic area interspersed with non-tribal members (e.g., AIAN living in an urban environment) and be considered an at-risk tribal community.
- **Clinical supervision or Consultation**



- For the purposes of the Tribal MIECHV program, clinical supervision is case-focused and supports a practitioner in reviewing, discussing and evaluating cases, including treatment planning, implementation of intervention strategies and progress of clients. Clinical supervision may or may not be reflective.
- Continuous quality improvement
  - For the purposes of the Tribal MIECHV program, an effectively implemented system of continuous quality improvement (CQI) within a home visiting program supports the ongoing use of performance and implementation data to optimize program outcomes, facilitate cultural and contextual adaptations of evidence-based models to meet community and program needs, identify and disseminate best practices, and test new approaches in home visiting that can increase efficiency and enhance effectiveness of programs. To maximize the utility of data for decision-making and learning, grantees under this FOA will build capacity for rapid-cycle continuous quality improvement and testing of improvement strategies through use of run charts and other tools.
- Culture of quality
  - For the purposes of the Tribal MIECHV program, culture of quality is defined as an organization that has the systems and structure in place to support continuous quality improvement and actively engages in continuous quality improvement processes and data-driven decision making. Continuous quality improvement drives the organization's culture of quality and must be aligned with the organization's mission, vision, and strategic plan and linked to organizational and individual performance.
- Data source characteristics
  - Grantees under this FOA should consider the following in planning for and conducting needs and readiness assessments:
    - *Recency or timeliness of data:* Data sources are updated on different schedules, some annually and others much less frequently. The most recently updated data sources may be preferred to more outdated sources, even if the estimates may be less precise.
    - *Geographic boundaries of data:* Grantees have discretion in how they geographically define 'community(ies)'. However, whenever possible, needs assessment data should be aggregated at the same or similar geographic level (e.g., tribal reservations, counties, cities, neighborhoods, zip codes, census tracts, etc.) as the communities being described. Thus, when choosing between data sources, grantees should make careful note of the geographic units for which the data are available.
    - *Stability of data:* While it may be possible to disaggregate some national, tribal, and state data into community level data, this does not mean that the data indicators will be stable or reliable at that level. For many assessments, the sub-sample of residents from a specific community will

be too small to be a trustworthy representation of the characteristic of that community and its residents.

- Dissemination
  - Dissemination is an intentional process to move new information relevant to policy, practice, and research from your home visiting program to well-defined multiple early childhood and tribal audiences for a particular purpose. The dissemination cycle includes planning, identifying content, materials development, and dissemination and evaluation.
- Early childhood system
  - For the purposes of the Tribal MIECHV program, an early childhood system brings together health, early care and education, and family support program partners, as well as tribal and community leaders, families, and other stakeholders to achieve agreed-upon goals for thriving children and families. An early childhood system aims to: reach all children and families as early as possible with needed services and supports; reflect and respect the strengths, needs, values, languages, cultures, and communities of children and families; ensure stability and continuity of services along a continuum from pregnancy to kindergarten entry; genuinely include and effectively accommodate children with special needs; support continuity of services, eliminate duplicative services, ease transitions, and improve the overall service experience for families and children; value parents and community members as decision makers and leaders; and catalyze and maximize investment and foster innovation.
- Eligible family
  - The MIECHV legislation (Section 511(k)(2) of the Social Security Act) states that an eligible family in MIECHV means a woman who is pregnant, and the father of the child if the father is available; or a parent or primary caregiver of a child aged birth through kindergarten entry, including grandparents or other relatives of the child, foster parents who are serving as the child's primary caregiver, and non-custodial parents who have an ongoing relationship with, and at times provide physical care for, the child. Section 511(d)(4) of the Act further requires that MIECHV grantees give priority to serving high-risk groups including: eligible families who reside in at-risk tribal communities in need of such services, as identified in the needs assessment; low-income eligible families; eligible families who are pregnant women who have not attained age 21; eligible families that have a history of child abuse or neglect or have had interactions with child welfare services; eligible families that have a history of substance abuse or need substance abuse treatment; eligible families that have users of tobacco products in the home; eligible families that are or have children with low student achievement; eligible families with children with developmental delays or disabilities; and eligible families who, or that include individuals who, are serving or 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.

- Enhancement
  - For the purposes of the Tribal MIECHV program, an acceptable enhancement of an evidence-based model or promising approach includes changes or additions to the model that have not been tested with rigorous impact research but are determined by the model developer not to alter the core components related to program impacts, are aligned with Tribal MIECHV program requirements, and are agreed to by the model developer and ACF in partnership with the grantee.
- Evaluation
  - Program evaluation is the use of quantitative and qualitative 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. For more information on types of research and evaluation, see The Administration for Children and Families Common Framework for Research and Evaluation available at <http://www.acf.hhs.gov/programs/opre/resource/the-administration-for-children-families-common-framework-for-research-and-evaluation>.
- Evidence-based home visiting model
  - For the purposes of the Tribal MIECHV program, the term evidence-based home visiting model is used to describe both models that meet the HHS criteria for evidence of effectiveness in tribal communities and models that are considered promising approaches. Grantees under the Tribal MIECHV program may choose to implement both models that meet the HHS criteria for evidence of effectiveness in AIAN communities and promising approaches. HHS uses Home Visiting Evidence of Effectiveness (HomVEE, <http://homvee.acf.hhs.gov/>) 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 models that target families with pregnant women and children from birth to kindergarten entry. There is currently one model that meets the HHS criteria for evidence of effectiveness in AIAN communities. All other home visiting models, including those that have been designated by HHS as meeting criteria for evidence of effectiveness for the general population through the HomVEE review, are currently considered promising approaches for use with AIAN populations.
  - The home visiting models that Tribal MIECHV grantees select must be research-based and grounded in relevant empirically based knowledge, target outcomes specified in the authorizing legislation, be associated with (or developed by or in partnership with) a national organization or institution of higher education, and have comprehensive home visiting program standards that ensure high quality service delivery and continuous program quality improvement. Grantees may

incorporate cultural and contextual adaptations or enhancements to their selected models, and must ensure fidelity of implementation of selected home visiting models, adaptations, and enhancements.

- Fidelity
  - For the purposes of the Tribal MIECHV program, fidelity constitutes a grantee's adherence to model developer requirements for high-quality implementation as well as any affiliation, certification, or accreditation required by the model developer, if applicable. These requirements include all aspects of initiating and implementing a home visiting model, including, but not limited to, recruiting and retaining clients, providing initial and ongoing training, supervision, and professional development for staff, establishing a management information system to track data related to service delivery and model fidelity, and developing an integrated resource and referral network to support client needs. Changes to a model that alter the core components related to program outcomes (otherwise known as drift) could impair fidelity and undermine the program's effectiveness. Tribal MIECHV grantees will therefore work in close partnership with communities, model developers and ACF to identify, develop, and implement the cultural and contextual enhancements and adaptations that will support optimal fit between the model and the community without compromising the potential impact of the services.
- Infant and early childhood mental health consultation
  -
- Home visiting program
  - For purposes of the Tribal MIECHV program, a home visiting program:
    - Includes home visiting as the primary service delivery strategy (excluding programs with infrequent or supplemental home visiting);
    - Is offered on a voluntary basis to eligible families in at-risk tribal communities; and
    - Targets outcomes specified in the MIECHV legislation, including: improved maternal and child health; prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or

domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports.

- Needs and readiness assessment
  - For the purposes of the Tribal MIECHV program, a thorough needs and readiness assessment has two major components: an assessment of community needs and an analysis of community readiness and capacity of organizations and programs to meet these needs.
- Professional development
  - For the purposes of the Tribal MIECHV program professional development is any learning experience delivered to develop and strengthen staff knowledge and skills that are needed to perform job duties.
- Quality Assurance
  - For the purposes of the Tribal MIECHV program, Quality Assurance (QA) is defined as a way to warrant that predefined standards are met. QA is the first step toward quality improvement.
- Reflective practice
  - For the purposes of the Tribal MIECHV program, reflective practice refers to work approaches that are characterized by trust, support and growth. Reflective practice includes self-awareness, careful and continual observation, and respectful, flexible responses among colleagues and with clients.
- Reflective supervision
  - For the purposes of the Tribal MIECHV program, reflective supervision is a distinctive form of competency-based professional development that is provided to multidisciplinary early childhood home visitors who are working to support very young children's primary caregiving relationships. Reflective supervision is a practice that acknowledges that infants and toddlers have unique developmental and relational needs and that all early learning occurs in the context of relationships. Reflective supervision is distinct from administrative supervision and clinical supervision due to the shared exploration of the parallel process, that is, attention to all of the relationships is important, including the relationships between home visitor and supervisor, between home visitor and parent, and between parent and infant/toddler. Reflective supervision supports professional and personal development of home visitors by attending to the emotional content of their work and how reactions to the content affect their work. In reflective supervision, there is often greater emphasis on the supervisor's ability to listen and wait, allowing the supervisee to discover solutions, concepts and perceptions on his/her own without interruption from the supervisor.

- Rigorous program evaluation
  - For the purposes of the Tribal MIECHV program, rigorous program evaluation is the use of 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, P.H., Freeman, H.E., and Lipsey, M.W. (2004)). The most appropriate research methods to use for evaluation depend on the question being addressed. It is important to note that no specific evaluation type is more rigorous than another. Descriptive studies, quasi-experimental studies, and experimental studies can all be rigorous. Rigorous program evaluation incorporates the following features:
    - *Credibility/Internal Validity*: Ensuring what is intended to be evaluated is actually what is being evaluated; making sure that descriptions of phenomena or experience being studied are accurate and recognizable to others; ensuring that the method(s) used is the most definitive and compelling approach that is available and feasible for the question being addressed. If conclusions about program efficacy are being examined, the limitations of non-experimental designs are carefully considered.
    - *Applicability/External Validity*: Generalizability of findings beyond the current project (i.e., when findings fit into contexts outside the study situation). Ensuring the population being studied represents one or more of the populations being served by the program.
    - *Consistency/Reliability*: When processes and methods are consistently followed and clearly described so that someone else could replicate the approach and other studies can confirm what is found.
    - *Neutrality*: Producing results that are as objective as possible and acknowledge the bias and limitations brought to the collection, analysis, and interpretation of results.
- Supplement
  - For the purposes of the Tribal MIECHV program, an acceptable supplement to an evidence-based model or promising approach is the addition of a supportive or complementary curriculum or strategy to an evidence-based home visiting model. The supplement may or may not have been tested with rigorous impact research, but must be determined by the model developer not to alter the core components related to program impacts, aligned with Tribal MIECHV program requirements, and agreed to by the model developer and ACF in partnership with the grantee.
- Tribal MIECHV Performance Measurement System
  - This redesigned system, developed by ACF following consultation with existing Tribal MIECHV grantees and other stakeholders, will support grantees to collect, analyze, and use data on program implementation and improvements for the

eligible families participating in the program in the legislatively-mandated benchmark areas of: 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 B: MIECHV Form 4: Quarterly Data**

**OMB Control Number 0906-0016**

**Expiration data 03/31/2019**

**Service Utilization Instructions and Forms**

**U.S. Department of Health and Human Services**

**Health Resources and Services Administration**

**Administration for Children and Families**

**DGIS-HV FORM: MIECHV Quarterly Data**

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and Tribal MIECHV grantees are required to submit the information outlined below on a quarterly basis.

Quarterly reporting periods are defined as follows. Reports are due 60 days after the end of each reporting period:

- Q1 - October 1-December 31;
- Q2 - January 1-March 31;
- Q3 – April 1-June 30;
- Q4 – July 1-September 30

Definitions for key terms are included in Appendix A. Please carefully consult key term definitions before completing this form.

**Grant Number(s):** \_\_\_\_\_



**Section A:****Table A.1: Program Capacity**

Column A	Column B	Column C	Column D	Column E
Number of New Households Enrolled	Number of Continuing Households	Current Caseload (A+B) (Auto-Calculate)	Maximum Service Capacity	Capacity Percentage (C÷D) (Auto-Calculate)

**Table A.2: Place-Based Services**

Add a row for each additional community served during the reporting period.

Column A	Column B	Column C
Community	Zip Codes within Community	Number of Households Served
<b>Total</b>		<b>Sum of Column C (all rows)</b>

**Table A.3: Family Engagement**

Column A <sup>2</sup>	Column B	Column C	Column D	Column E <sup>3</sup>	Column F
Number of Households Currently Receiving Services	Number of Households who Completed Program	Number of Households who Stopped Services Before Completion	Other	Total (A+B+C+D) (Auto-Calculate)	Attrition Rate (C÷E) (Auto-Calculate)

**Table A.4.1: Staff Recruitment and Retention**

Column A	Column B	Column C	Column D	Column E	Column F	Column G	Column H	Column I
Number of New FTE MIECHV Home Visitors	Number of Continuing FTE MIECHV Home Visitors	Number of FTE MIECHV Home Visitors (A+B) (Auto-Calculate)	Number of New FTE MIECHV Supervisors	Number of Continuing FTE MIECHV Supervisors	Number of FTE MIECHV Supervisors (D+E) (Auto-Calculate)	Number of New FTE MIECHV Other Staff	Number of Continuing FTE MIECHV Other Staff	Number of FTE MIECHV Other Staff (G+H) (Auto-Calculate)

**Table A.4.2: Staff Vacancies**

Column A	Column B	Column C	Column D
Number of Vacant FTE MIECHV Home Visitors	Number of Vacant FTE MIECHV Supervisors	Number of Vacant FTE MIECHV Other Staff	Number of FTE MIECHV Staff Vacancies (A+B+C) (Auto-Calculate)

<sup>2</sup> Validation: Column A should equal Table A.1. columns A and B<sup>3</sup> Validation: Column E should equal Table A.2 sum of all rows in Column C

#### **Form 4: Definitions of Key Terms**

**Capacity Percentage:** Capacity percentage is a calculated indicator that results from dividing the current caseload by the maximum service capacity and multiplying by 100.

**Community:** A community is a geographically distinct area that is defined by the MIECHV grantee. Communities should be areas that hold local salience and can be defined as a neighborhood, town, city, or other geographic area. Services provided within a particular community should be distinguishable from other communities.

**Completed Program:** The number of households who completed the program refers to families who have completed the program or transitioned to another program according to home visiting model-specific definitions and criteria during the quarterly reporting period.

**Continuing Household:** A household, including a pregnant woman, female caregiver, and/or male caregiver who were signed up and actively enrolled in the home visiting program prior to the beginning of the quarterly reporting period and continues enrollment through the reporting period. The household may include multiple caregivers depending on model-specific definitions.

**Continuing FTE Home Visitor/Supervisor/Other Staff:** A full time equivalent home visitor(s)/supervisor(s)/other staff who was employed by a contracted local implementing agency in the previous quarterly reporting period. Grantees should only report the proportion of the FTE that is supported by MIECHV grant funds.

**Current Caseload:** The number of households actively enrolled at the end of the quarterly reporting period. All members of one household represent a single caseload slot.

**Currently Receiving Services:** The number of households currently receiving services refers to households that are participating in services at the end of the quarterly reporting period.

**Maximum Service Capacity:** The highest number of households that could potentially be enrolled at the end of the quarterly reporting period if the program were operating with a full complement of hired and trained home visitors.

Note: The maximum service capacity is equivalent to the caseload of family slots indicated in your Notice of Award.

**Caseload of Family Slots:** The highest number of families (or households) that could potentially be enrolled at any given time if the program were operating with a full complement of hired and trained home visitors. Family slots are those enrollment slots served by a trained home visitor implementing services with fidelity to the model for whom at least 25% of his/her personnel costs (salary/wages including benefits) are paid for with MIECHV funding. All members of one family or household represent a single caseload slot. The count of slots should be distinguished from the cumulative number of enrolled families during the grant period. It is known that the caseload of family slots may vary by federal fiscal year pending variation in available funding in each fiscal year. Applicants should remember that inability to meet proposed caseloads may result in deobligated funds, which may impact future funding.

**New Household:** A household, including a pregnant woman, female caregiver, and/or male caregiver who signs up to participate in the home visiting program at any time during the quarterly reporting period and continues enrollment through the reporting period. The household may include multiple caregivers depending on model-specific definitions.

**New FTE Home Visitors/Supervisors/Other Staff:** A full time equivalent home visitor(s)/supervisor(s)/other staff who begins employment with a contracted local implementing agency during the quarterly reporting period. Grantees should only report the proportion of the FTE that is supported by MIECHV grant funds.

**Stopped Services before Completion:** The number of households who stopped services before completion refers to households who left the program or were lost to follow-up for any reason prior to completion.

Appendix C - Tribal MIECHV Performance Measures Numerators and Denominators					
Area		Construct	Indicator	Numerator	Denominator
Core Measures					
1	Implementation	Receipt of Home Visits	Percentage of recommended home visits received by families enrolled in the home visiting program during the reporting period	Number of home visits received by families during the reporting period	Number of home visits families should receive according to model developer fidelity requirements during the reporting period
2	Implementation	Home Visit Implementation Observation	Percentage of recommended home visits where home visitors are observed for implementation quality and receive feedback from their supervisors during the reporting period	Number of home visits where home visitors are observed for implementation quality and receive feedback from their supervisors during the reporting period	Number of home visits where home visitors should receive an observation according to model developer guidelines during the reporting period
3	Implementation	Reflective Supervision	Percentage of recommended individual and/or group reflective supervision sessions received by home visitors during the reporting period	Number of individual and/or group reflective supervision sessions received by home visitors during the reporting period	Number of individual and/or group reflective supervision sessions that home visitors should receive during the reporting period
4	I - Maternal and Newborn Health	Depression Screening	Percent of primary caregivers enrolled in HV who are screened for depression using a validated tool within 3 months of enrollment (for those not enrolled prenatally) by 3 months post- delivery (for those enrolled prenatally) and at least annually thereafter	For those not enrolled prenatally, number of primary caregivers enrolled in HV who are screened for depression within the first three months since enrollment; for those enrolled prenatally, the number of primary caregivers screened for depression by three months post- delivery; or annually after the first year of enrollment	Number of primary caregivers not enrolled prenatally who are enrolled in HV for at least three months; the number of mothers enrolled prenatally who have reached 3 months post-delivery
5	I - Maternal and Newborn Health	Substance Abuse Screening	Percent of primary caregivers enrolled in HV who are screened for substance abuse using a validated tool within 3 months of enrollment and at least annually thereafter	Number of primary caregivers enrolled in HV who are screened for substance abuse using a validated tool within 3 months of enrollment and annually after the first year of enrollment	Number of primary caregivers enrolled in HV for at least three months
6	I - Maternal and Newborn Health	Well Child Visit	Percent of the AAP-recommended number of well-child visits received by children enrolled in home visiting during the reporting period	Number of AAP-recommended well-child visits received by children (index child) enrolled in home visiting during the reporting period	Number of AAP-recommended well-child visits children (index child) enrolled in home visiting should receive during the reporting period
7	II - Child Maltreatment, Injuries and ED Visits	Child Injury Prevention	Percentage of primary caregivers enrolled in home visiting who are provided with training on prevention of child injuries	Number of primary caregivers enrolled in home visiting who are provided with training on prevention of infant and child injuries during the reporting period	Number of primary caregivers enrolled in home visiting
8	III – School	Parent-Child	Percent of primary caregivers enrolled in HV who receive an	Number of primary caregivers enrolled	Number of primary caregivers

Appendix C - Tribal MIECHV Performance Measures Numerators and Denominators					
	Area	Construct	Indicator	Numerator	Denominator
	<b>Readiness and Achievement</b>	Interaction	observation of caregiver-child interaction by the home visitor using a validated tool.	in HV who receive an observation of caregiver-child interaction by the home visitor using a validated tool	enrolled in HV with children reaching the end of the desired age range specified by the tool or HV model
9	<b>III – School Readiness and Achievement</b>	Developmental Screening	Percentage of children enrolled in HV screened at least annually for developmental delays using a validated* parent-completed tool	Number of children (index child) enrolled in HV with at least one documented developmental screening during the reporting period.	Number of children (index child) enrolled in HV during the reporting period that required a screening
10	<b>IV - Crime or Domestic Violence</b>	IPV Screening	Percentage of primary caregivers enrolled in HV who are screened for intimate partner violence using a validated* tool within 6 months of enrollment and at least annually thereafter	Number of primary caregivers enrolled in HV who are screened for IPV using a validated tool within 6 months of enrollment and annually after the first year of enrollment	Number of primary caregivers enrolled in HV for at least 6 months
11	<b>V - Family Economic Self-Sufficiency</b>	Screening for Economic Strain	Percentage of primary caregivers who are screened for unmet basic needs (poverty, food insecurity, housing insecurity, etc.) within 3 months of enrollment and at least annually thereafter	Number of primary caregivers who are screened for unmet basic needs within 3 months of enrollment and annually after the first year of enrollment	Number of primary caregivers enrolled in home visiting for at least 3 months
12	<b>VI- Coordination and Referrals</b>	Completed Developmental Referrals	Percentage of children enrolled in home visiting with positive screens for developmental delays (measured using a validated* tool) who receive a timely referral for services and a follow up	Number of children (index child) enrolled in HV who received referral information to early intervention services (and met the conditions specified in the denominator) and for whom the HV program followed up on the referral within 45 days	Number of children (index child) enrolled in HV during the reporting period with positive screens for developmental delays (measured using a validated tool)
<b>Flex Measures (select 2 from 1-7 and 1 from 8-11)</b>					
1	<b>I - Maternal and Newborn Health</b>	Breastfeeding	Percentage of women enrolled prior to child's birth who initiate breastfeeding	Number of women enrolled prenatally who initiate breastfeeding	Number of women enrolled prenatally who gave birth within the reporting period
2	<b>I - Maternal and Newborn Health</b>	Postpartum Care	Percent of mothers enrolled in HV prenatally or within 30 days after delivery who received a postpartum visit with a health care provider within 8 weeks (56 days) of delivery.	Number of mothers enrolled in HV prenatally or within 30 days after delivery who received a postpartum visit with a health care provider within 8 weeks (56 days) of delivery	Number of mothers who enrolled in HV prenatally or within 30 days after delivery and remained enrolled for at least 8 weeks (56 days) after delivery
3	<b>I - Maternal and Newborn Health</b>	Immunizations	Percent of children enrolled in home visiting who receive all AAP-recommended immunizations during the reporting period	Number of children (index child) enrolled in HV who receive all AAP-recommended immunizations during the reporting period	Number of children (index child) enrolled in HV during the reporting period
4	<b>II - Child Maltreatment,</b>	Screening for Parenting Stress	Percentage of primary caregivers who are screened for parenting stress using a validated* tool within 3 months of enrollment and at	For those not enrolled prenatally, number of primary caregivers enrolled	Number of primary caregivers not enrolled prenatally who are enrolled

Appendix C - Tribal MIECHV Performance Measures Numerators and Denominators					
	Area	Construct	Indicator	Numerator	Denominator
	<b>Injuries and ED Visits</b>		least annually thereafter	in HV who are screened for parenting stress within the first three months since enrollment; for those enrolled prenatally, the number of primary caregivers screened for parenting stress by three months post- delivery; or annually after the first year of enrollment	in HV for at least three months; the number of mothers enrolled prenatally who have reached 3 months post-delivery
5	<b>II - Child Maltreatment, Injuries and ED Visits</b>	Safe Sleep	Percentage of primary caregivers educated about the importance of putting infants to sleep on their backs, without bed-sharing and soft-bedding	Number of primary caregivers educated about the importance of putting infants to sleep on their backs, and without bed-sharing and soft-bedding during the reporting period	Number of primary caregivers enrolled in home visiting during the reporting period who are either pregnant or have a child under 12 months of age
6	<b>II - Child Maltreatment, Injuries and ED Visits</b>	Child Injury	Rate of injury-related visits to the Emergency Department (ED) or urgent care since enrollment among children enrolled in HV	Number of parent-reported nonfatal injury-related visits to the Emergency Department (ED) or urgent care since enrollment among children (index child) enrolled in HV	Number of children (index child) enrolled in HV during the reporting period
7	<b>III – School Readiness and Achievement</b>	Early Language and Literacy Activities	Percent of children enrolled in HV with a caregiver who reported that during a typical week the caregiver or a family member read, told stories, and/or sang songs with their child every day	Number of children (index child) enrolled in HV with a caregiver who reported that during a typical week the caregiver or a family member read, told stories, and/or sang songs with their child every day.	Number of children (index child) enrolled in HV during the reporting period
8	<b>VI- Coordination and Referrals</b>	Completed IPV referrals	Percentage of primary caregivers screening positive for intimate partner violence who receive a timely referral for services and a follow up	Number of primary caregivers enrolled in HV who received referral information to appropriate services (and met the conditions specified in the denominator) and for whom the HV program followed up on the referral within 45 days	Number of primary caregivers enrolled in HV with positive screens for IPV (measured using a validated tool)
9	<b>VI- Coordination and Referrals</b>	Completed Depression and Parenting Stress Referrals	Percent of primary caregivers screening positive for depression or parenting stress using a validated* tool who receive a timely referral for services and a follow up	Number of primary caregivers enrolled in HV who received referral information to appropriate services (and met the conditions specified in the denominator) and for whom the HV program followed up on the referral within 45 days	Number of primary caregivers enrolled in HV who had a positive screen for depression or parenting stress (measured using a validated tool)
10	<b>VI- Coordination</b>	Completed	Percent of primary caregivers screening positive for substance	Number of primary caregivers enrolled	Number of primary caregivers

Appendix C - Tribal MIECHV Performance Measures Numerators and Denominators					
	Area	Construct	Indicator	Numerator	Denominator
	<b><i>and Referrals</i></b>	Substance Abuse Referrals	abuse using a validated* tool who receive a timely referral for services and a follow up	in HV who received referral information to appropriate services (and met the conditions specified in the denominator) and for whom the HV program followed up on the referral within 45 days	enrolled in HV who had a positive screen for substance abuse (measured using a validated tool)
11	<b><i>VI- Coordination and Referrals</i></b>	Completed Economic Strain Referrals	Percent of primary caregivers with unmet basic needs who receive a timely referral for services and a follow up	Number of primary caregivers enrolled in HV who received referral information to appropriate services (and met the conditions specified in the denominator) and for whom the HV program followed up on the referral within 45 days	Number of primary caregivers enrolled in HV who had a positive screen for unmet basic needs

**TRIBAL MATERNAL, INFANT, AND EARLY CHILDHOOD HOME  
VISITING PROGRAM**

**FORM 1**

**DEMOGRAPHIC AND SERVICE UTILIZATION DATA**



**SECTION A: PARTICIPANT DEMOGRAPHICS AND SERVICE UTILIZATION****A.1: Participant Demographics during Reporting Period (Newly Enrolled and Continuing)****Table 1. Unduplicated Count of Adult Participants and Index Children Served by Tribal MIECHV Home Visitors during Reporting Period (Newly Enrolled and Continuing)**

	Number Newly Enrolled	Number Continuing	Total
<b>Adult Participants</b>			
Pregnant Women			
Female Caregivers			
Male Caregivers			
<b>All Adult Participants (Auto Calculate)</b>			
<b>Index Children</b>			
Female Index Children			
Male Index Children			
<b>All Index Children (Auto Calculate)</b>			

**Table 1(a). Female Caregivers in the Current Reporting Period who Were Counted as Pregnant Women in the Prior Reporting Period**

<b>Adult Participants</b>	<b>Number</b>
<b>Number of Female Caregivers in the Current Reporting Period who Were Counted as Pregnant Women in the Prior Reporting Period</b>	

**Table 2. Unduplicated Count of Households Served by Tribal MIECHV Home Visitors (Newly Enrolled and Continuing)**

Households	Number Newly Enrolled	Number Continuing	Total
<b>Number of Households</b>			

**Table 3. Adult Participants by Current Educational Status (Newly Enrolled and Continuing)**

Adult Participants	Student/trainee	Not a student/trainee	Unknown/Did not Report	Total
Newly Enrolled Pregnant Women				
Newly Enrolled Female Caregivers				
Newly Enrolled Male Caregivers				
<b>All Newly Enrolled Adults (Auto Calculate)</b>				
Continuing Pregnant Women				
Continuing Female Caregivers				
Continuing Male Caregivers				
<b>All Continuing Adults (Auto Calculate)</b>				
<b>All Adult Participants (Auto Calculate)</b>				

**Table 4. Adult Participants by Employment Status (Newly Enrolled and Continuing)**

<b>Adult Participants</b>	<b>Employed Full Time</b>	<b>Employed Part-Time</b>	<b>Not employed</b>	<b>Unknown/Did not Report</b>	<b>Total</b>
Newly Enrolled Pregnant Women					
Newly Enrolled Female Caregivers					
Newly Enrolled Male Caregivers					
<b>All Newly Enrolled Adults (Auto Calculate)</b>					
Continuing Pregnant Women					
Continuing Female Caregivers					
Continuing Male Caregivers					
<b>All Continuing Adults (Auto Calculate)</b>					
<b>All Adult Participants (Auto Calculate)</b>					

**Table 5. Household Income in Relation to Federal Poverty Guidelines (Newly Enrolled and Continuing)**

<b>Households</b>	<b>Newly Enrolled Households</b>	<b>Percent</b>	<b>Continuing Households</b>	<b>Percent</b>	<b>Total Households</b>	<b>Percent</b>
50% and under						
51-100%						
101-133%						
134-200%						
201-300%						
>300%						
Unknown/Did not Report						
<b>All Households (Auto Calculate)</b>		<b>100</b>		<b>100</b>		<b>100</b>

**Table 6. Index Children by Age (Newly Enrolled and Continuing)**

<b>Index Children</b>	<b>Under 12 months</b>	<b>12-24 months</b>	<b>25-36 months</b>	<b>37-60 months</b>	<b>60-72 months</b>	<b>Unknown /Did not Report</b>	<b>Total</b>
Newly Enrolled Female Index Children							
Newly Enrolled Male							

Index Children							
<b>All Newly Enrolled Index Children (Auto Calculate)</b>							
Continuing Female Index Children							
Continuing Male Index Children							
<b>All Continuing Index Children (Auto Calculate)</b>							
<b>All Index Children (Auto Calculate)</b>							

**Table 7. Adult Participants by Housing Status (Newly Enrolled and Continuing)**

Adult Participants	Not Homeless	Homeless				Unknown/ Did not Report	Total
	Not Homeless	Homeless and sharing housing	Homeless and living in an emergency or transitional shelter	Homeless with some other arrangement	Total Homeless (Auto Calculate)		
Newly Enrolled Pregnant Women							
Newly Enrolled Female Caregivers							
Newly Enrolled Male Caregivers							
<b>All Newly Enrolled Adult Participants (Auto Calculate)</b>							

Continuing Pregnant Women							
Continuing Female Caregivers							
Continuing Male Caregivers							
<b>All Continuing Adult Participants (Auto Calculate)</b>							
<b>All Adult Participants (Auto Calculate)</b>							

**Table 8. Adult Participants and Index Children by Type of Health Insurance Coverage (Newly Enrolled and Continuing)**

	Not Insured			Insured					
	Has access to IHS, CHS, or UIHP facility	Does not have access to IHS, CHS, or UIHP facility	Total Not Insured (Auto Calculate)	Medicaid or CHIP	TriCare	Private Insurance	Unknown/ Did not Report	Total Insured (Auto Calculate)	Total
<b>Adult Participants</b>									
Newly Enrolled Pregnant Women									
Newly Enrolled Female Caregivers									
Newly Enrolled Male Caregivers									
<b>All Newly Enrolled Adult Participants (Auto Calculate)</b>									
Continuing Pregnant Women									
Continuing									

Female Caregivers									
Continuing Male Caregivers									
<b>All Continuing Adult Participants (Auto Calculate)</b>									
<b>All Adult Participants (Auto Calculate)</b>									
<b>Index Children</b>									
	<b>Has access to IHS, CHS, or UIHP facility</b>	<b>Does not have access to IHS, CHS, or UIHP facility</b>	<b>Total Not Insured (Auto Calculate)</b>	<b>Medicaid or CHIP</b>	<b>TriCare</b>	<b>Private Insurance</b>	<b>Unknown/ Did not Report</b>	<b>Total Insured (Auto Calculate)</b>	<b>Total</b>
Newly Enrolled Female Index Children									
Newly Enrolled Male Index Children									
<b>All Newly Enrolled Index Children (Auto Calculate)</b>									
Continuing Female Index Children									
Continuing Male Index Children									
<b>All Continuing Index Children (Auto Calculate)</b>									
<b>All Index Children (Auto</b>									

Calculate)									
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**A.1 NOTES:**

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**A.2: Participant Demographics during Reporting Period (Newly Enrolled Only)****Table 9. Adult Participants by Age (Newly Enrolled)**

<b>Adult Participants</b>	<b>≤17</b>	<b>18-19</b>	<b>20-21</b>	<b>22-24</b>	<b>25-29</b>	<b>30-34</b>	<b>35-44</b>	<b>45-54</b>	<b>55-64</b>	<b>≥65</b>	<b>Unknown /Did not Report</b>	<b>Total</b>
Pregnant Women												
Female Caregivers												
Male Caregivers												
<b>All Adults (Auto Calculate)</b>												

**Table 10. Participants by Ethnicity (Newly Enrolled)**

<b>Participants</b>	<b>Hispanic or Latino</b>	<b>Not Hispanic or Latino</b>	<b>Unknown/Did not Report</b>	<b>Total</b>
Pregnant Women				
Female Caregivers				
Male Caregivers				
<b>All Adults (Auto Calculate)</b>				
Female Index Children				
Male Index Children				
<b>All Index Children (Auto Calculate)</b>				

**Table 11. Participants by Race (Newly Enrolled)**

<b>Participants</b>	<b>American Indian or Alaska Native</b>	<b>Asian</b>	<b>Black or African American</b>	<b>Native Hawaiian or Other Pacific Islander</b>	<b>White</b>	<b>More than one race including AI/AN</b>	<b>More than one race not including AI/AN</b>	<b>Unknown/Did not Report</b>	<b>Total</b>
Pregnant Women									
Female Caregivers									
Male Caregivers									
<b>All Adults (Auto Calculate)</b>									
Female Index Children									
Male Index Children									
<b>All Index</b>									

<b>Children (Auto Calculate)</b>									
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**Table 12. Adult Participants by Marital Status (Newly Enrolled)**

<b>Adult Participants</b>	<b>Single</b>	<b>Legally Married</b>	<b>Not married but living together with partner</b>	<b>Separated/Divorced/ Widowed</b>	<b>Unknown/Did not Report</b>	<b>Total</b>
Pregnant Women						
Female Caregivers						
Male Caregivers						
<b>All Adults (Auto Calculate)</b>						

**Table 13. Adult Participants by Educational Attainment (Newly Enrolled)**

<b>Adult Participants</b>	<b>Less than HS diploma</b>	<b>HS Diplo ma/ GED</b>	<b>Some college/ training</b>	<b>Technical training or certification</b>	<b>Associate's Degree</b>	<b>Bachelor's Degree or higher</b>	<b>Other</b>	<b>Unknown /Did not Report</b>	<b>Total</b>
Pregnant Women									
Female Caregivers									
Male Caregivers									
<b>All Adults (Auto Calculate)</b>									

**Table 14. Primary Language Spoken at Home of Index Children (Newly Enrolled)**

<b>Index Children</b>	<b>Number Newly Enrolled</b>	<b>Percent</b>
English		
Spanish		
Any Native American Language		
Other		
Unknown/Did Not Report		
<b>All Index Children (Auto Calculate)</b>		<b>100</b>

**Table 15. Secondary Language Spoken at Home of Index Children (Newly Enrolled)**

<b>Index Children</b>	<b>Number Newly Enrolled</b>	<b>Percent</b>
English		
Spanish		



Any Native American Language		
Other		
None		
Unknown/Did Not Report		
<b>All Index Children (Auto Calculate)</b>		<b>100</b>

**Table 16. Priority Population Household Characteristics (Newly Enrolled)**

Households	Yes	No	Unknown/Did not Report	Total
1. Low income household				
2. Household contains an enrollee who is pregnant and under age 21				
3. Household has a history of child abuse or neglect or has had interactions with child welfare services				
4. Household has a history of substance abuse or needs substance abuse treatment				
5. Someone in the household uses tobacco products in the home				
6. Someone in the household has attained low student achievement or has a child with low student achievement				
7. Household has a child with developmental delays or disabilities				
8. Household includes individuals who are serving or formerly served in the US armed forces				

**A.2 NOTES:**

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**A.3: Participant Service Utilization during Reporting Period****Table 17. Number of Home Visits**

Home Visits	Number
Total Number of Home Visits Completed	

**Table 18. Family Engagement by Household (Newly Enrolled and Continuing)**

Households	Number of Newly Enrolled Households	Number of Continuing Households	All Households (Auto Calculate)
Currently receiving services			
Completed program			
Stopped services before completion			
Enrolled but not currently receiving services/Other			
Unknown/Did not Report			
<b>All Categories (Auto Calculate)</b>			

**Table 19: Unduplicated Count of Households by Evidence-Based Home Visiting Model**

Home Visiting Model (Select One per Row – Add Rows for Additional Models)	Households
<b>All Models (Auto Calculate)</b>	

**A.3 NOTES:**

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**SECTION B: PROGRAM STAFF DEMOGRAPHICS****Table 20. Program Staff by Age**

Program Staff	≤29	30-39	40-49	50-64	≥65	Unknown/ Did not Report	Total
Home Visitors							
Project Directors/ Managers/Coordinators							
<b>All Staff (Auto Calculate)</b>							

**Table 21. Program Staff by Gender**

Program Staff	Female	Male	Unknown/Did not Report	Total
Home Visitors				
Project Directors/ Managers/Coordinators				
<b>All Staff (Auto Calculate)</b>				

**Table 22. Program Staff by Ethnicity**

Program Staff	Hispanic or Latino	Not Hispanic or Latino	Unknown/Did not Report	Total
Home Visitors				
Project Directors/ Managers/Coordinators				
<b>All Staff (Auto Calculate)</b>				

**Table 23. Program Staff by Race**

Program Staff	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More than one race including AI/AN	More than one race not including AI/AN	Unknown/ Did not Report	Total
Home Visitors									
Project Directors/ Managers/ Coordinators									
<b>All Staff (Auto Calculate)</b>									

**Table 24. Program Staff by Educational Attainment**

<b>Program Staff</b>	<b>Less than HS Diploma</b>	<b>HS Diploma /GED</b>	<b>Some college/ training</b>	<b>Technical training or certification</b>	<b>Associate's Degree</b>	<b>Bachelor's Degree</b>	<b>Master's Degree or Higher</b>	<b>Other</b>	<b>Unknown/ Did Not Report</b>	<b>Total</b>
Home Visitors										
Project Directors/ Managers /Coordinators										
<b>All Staff (Auto Calculate)</b>										

**Table 25. Unduplicated Count of Home Visiting Staff Full Time Equivalents**

<b>Home Visiting Program Staff</b>	<b>Number</b>
Number of FTE Home Visitors	
Number of FTE Project Directors /Managers/Coordinators	
<b>All Tribal MIECHV Staff FTE (Auto Calculate)</b>	

**SECTION B NOTES:**

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## INSTRUCTIONS AND DEFINITIONS OF KEY TERMS

## **Tribal MIECHV Form 1 Instructions**

Data for Tribal MIECHV Form 1: Demographic and Service Utilization Data should be collected at enrollment (as defined by grantee or per model developer guidelines) for newly enrolled participants/households and once during the reporting period (as determined by grantee) for continuing participants/households. Grantees may determine the method of and individuals responsible for data collection based on their own policies and procedures, and as guided by model developers and in consultation with ACF. Technical assistance is available to grantees to determine the method and timing of data collection and to ensure high quality data collection and reporting.

The form is organized into two sections. Section A includes Participant Demographics and Service Utilization and contains three sub-sections (A.1: Participant Demographics during Reporting Period (Newly Enrolled and Continuing); A.2: Participant Demographics during Reporting Period (Newly Enrolled Only); and A.3 Participant Service Utilization during Reporting Period (Newly Enrolled and Continuing)) and requests demographic and service utilization data for program participants and households, which will be used to help ACF better understand the population receiving services from Tribal MIECHV grantees and the degree to which they are using services. Section B includes Program Staff Demographics and requests information on demographics of program staff, which will be used by ACF to better understand the Tribal MIECHV workforce. All information is collected to support improved knowledge of Tribal MIECHV grantee programs and guide technical assistance provided through the cooperative agreement.

After each sub-section, the form includes a “Notes” field. Grantees should use this field to explain the reasons for missing data if more than 10 percent of data are missing (i.e., Unknown/Did Not Report) for a particular data element, and to provide any other contextual information that may be helpful to ACF in understanding the data reported. For each explanation of missing data, include the Table number for ease of reference.

**Definitions:** The following table includes definitions for key terms listed in Tribal MIECHV Form 1 Tables.

Table Number	Field or Item	Definitions
<b>General Definitions</b>		
N/A	<b>Reporting Period</b>	The most recent 12-month budget period during which a Tribal MIECHV grantee provided home visiting services.
N/A	<b>Tribal MIECHV Home Visitor</b>	A home visitor for whom at least 25 percent of his/her personnel costs (salary, wages, and benefits) are paid for with Tribal MIECHV funding.
N/A	<b>Adult Participant</b>	An adult (pregnant woman, female caregiver, male caregiver) who participates in the home visiting program during the reporting period and was served by a Tribal MIECHV home visitor. This could include teenage participants who have not yet reached age 18 but who meet the definition of either a pregnant woman, female caregiver, or male caregiver.
N/A	<b>Household</b>	Adult(s) who are caregivers for the same index child(ren) who participate in the home visiting program during the reporting period and were served by a Tribal MIECHV home visitor. A household may include one or multiple adult participants depending on model-specific definitions.
N/A	<b>Newly Enrolled (Adult Participant or Household)</b>	A participant or household who participates in the home visiting program for the first time at any time during the reporting period.
N/A	<b>Continuing (Adult Participant or Household)</b>	A participant or household who participated in the home visiting program prior to the beginning of the reporting period and continues enrollment during the reporting period. This includes any participants who had been enrolled in any prior reporting period, became inactive, and then enrolled again in the reporting period.
N/A	<b>Pregnant Woman (Adult Participant)</b>	A female participant who participated in the program while pregnant at any time during the reporting period.
N/A	<b>Female Caregiver (Adult Participant)</b>	A female participant who participated in the program during the reporting period and is considered a primary caregiver of the index child (e.g., biological mother, adoptive mother, foster mother, grandmother). If a woman has been pregnant at any time during the reporting period, she should be considered a Pregnant Woman (not Female Caregiver).
N/A	<b>Male Caregiver (Adult Participant)</b>	A male participant who participated in the program during the reporting period and is considered a primary caregiver of the index child (e.g., expectant father, biological father, step-father, foster parent, partner).
N/A	<b>Index Child</b>	The target child (male or female) in an individual household who is under the care of the participant. More than one index child can be identified (e.g., in the case of twins, triplets, or per model developer

		guidelines). Thus, there could be more than one female or male index child in a given household. A single child could have multiple primary caregivers reported in Tribal MIECHV Form 1.
<b>A.1 Participant Demographics During Reporting Period (Newly Enrolled and Continuing)</b>		
<b>1 (a)</b>	<b>Female Caregivers in the Current Reporting Period who Were Counted as Pregnant Women in the Prior Reporting Period</b>	Those continuing participants who are counted as female caregivers in the reporting period who were counted as pregnant women in the most recent prior reporting period.
<b>3</b>	<b>Adult Participants by Educational Status (Newly Enrolled and Continuing)</b>	<p><b>Student/trainee:</b> a participant who is considered a full- or part-time student or trainee by the educational institution or training program he/she is attending during the reporting period.</p> <p><b>Not a student/trainee:</b> a participant who is not enrolled in any type of educational or training programs during the reporting period.</p>
<b>4</b>	<b>Adult Participants by Employment Status (Newly Enrolled and Continuing)</b>	<p><b>Employed:</b> a participant who works for pay during the reporting period.</p> <p><b>Employed Full Time:</b> an employee who works an average of at least 30 hours per week, as per <a href="https://www.healthcare.gov/glossary/full-time-employee/">https://www.healthcare.gov/glossary/full-time-employee/</a></p> <p><b>Employed Part Time:</b> an employee who works an average of less than 30 hours per week</p> <p><b>Not Employed:</b> a participant who is not working for pay (e.g. students, stay-at-home parents, and those actively seeking work but currently not employed)</p>
<b>5</b>	<b>Household Income in Relation to Federal Poverty Guidelines (Newly Enrolled and Continuing)</b>	<p>The appropriate category for a given household will depend both on household income and on the number of household members (<i>both home visiting participants and non-participants</i>). Household income refers to the annual gross income for the household as defined in programmatic guidance, recorded at enrollment and annually thereafter.</p> <p><b>Federal Poverty Guidelines:</b> Annual income data can be estimated from monthly data (monthly income x 12). The Federal Poverty Guidelines are updated each year. See <a href="https://aspe.hhs.gov/poverty-guidelines">https://aspe.hhs.gov/poverty-guidelines</a> for the guidelines (updated every year).</p>



7	<b>Adult Participants by Housing Status (Newly Enrolled and Continuing)</b>	<p><b>Homeless:</b> participants who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the McKinney-Vento Homeless Assistance Act). Report the participant as homeless if they were homeless for one or more days during the month prior to data collection.</p> <p><b>Fixed nighttime residence:</b> stationary, permanent, and not subject to change.</p> <p><b>Regular nighttime residence:</b> used on a predictable, routine, or consistent basis.</p> <p><b>Adequate nighttime residence:</b> sufficient for meeting both the physical and psychological needs typically met in home environments.</p> <p><b>Homeless and sharing housing:</b> individuals who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason</p> <p><b>Homeless and living in an emergency or transitional shelter:</b> individuals who are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement</p> <p><b>Homeless with some other arrangement:</b> individuals who are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; individuals who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); individuals who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.</p> <p>For more: <a href="http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/family/family/Homelessness/hmls/definition/definition-legal.html">http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/family/family/Homelessness/hmls/definition/definition-legal.html</a></p>
8	<b>Adult Participants and Index Children by Type of Health Insurance Coverage (Newly Enrolled and Continuing)</b>	<p><b>Not Insured:</b> “Not insured” indicates that the individual is currently not covered by any source of insurance. This table is intended to capture insurance status, and for those not insured: access to Indian Health Services, UIHP or CHS health services. For example, receipt of care provided by the Indian Health Service or another safety net health care provider such as a Federally Qualified Health Center does not constitute insurance coverage. The not insured categories are mutually exclusive.</p> <p><b>Not insured but has access to Indian Health Services, Contract Health Services, or Urban Indian Health Program facility:</b> The Indian Health Service is funded each year through appropriations by the U.S.</p>

		<p>Congress. The Indian Health Service is not an entitlement program, such as Medicare or Medicaid. The Indian Health Service is not an insurance program. The Indian Health Service is not an established benefits package. Two types of services are provided by the Indian Health Service: (1) Direct health care services, which are provided by an IHS facility, or (2) contract health services (CHS), which are provided by a non-IHS facility or provider through contracts with the IHS. CHS are provided principally for members of federally recognized tribes who reside on or near the reservation established for the local tribe(s) in geographic areas called contract health service delivery areas (CHSDAs). The eligibility requirements are stricter for CHS than they are for direct care.</p> <p>In addition, the IHS Urban Indian Health Program (UIHP) supports contracts and grants to 34 urban health programs funded under Title V of the Indian Health Care Improvement Act. Approximately 100,000 American Indians use 23 Title V Urban Indian health programs and are not able to access hospitals, health clinics, or contract health services administered by IHS and tribal health programs because they either do not meet IHS eligibility criteria or reside outside of IHS and tribal service areas.</p> <p>A member of a Federally recognized tribe may obtain care at any IHS hospital or clinic if the facility has the staff and capability to provide the medical care. One of the additional requirements for CHS is that the patient must reside in certain areas. One way to meet the residency requirement is to live on the reservation of any Federally recognized tribe. Another way to meet the residency requirement is to reside within the contract health service delivery area (CHSDA) for the patient's tribe.</p> <p>Many, or even most, people who move away from their home reservations are not eligible for CHS since they would be moving away from the CHSDA in which they have eligibility. Some programs or portions of programs are tribally operated instead of being operated by the Federal Government through the IHS. Some tribally operated hospitals or clinics restrict services to members of their own tribe. Consequently, although a patient may be a member of a Federally recognized tribe they may not be provided medical care at a tribally operated hospital or clinic.</p> <p>For more: <a href="https://www.ihs.gov/forpatients/faq">https://www.ihs.gov/forpatients/faq</a></p> <p><b>Insured:</b> The health insurance coverage categories are mutually exclusive.</p> <p><b>Medicaid or CHIP:</b> "Medicaid" is a joint federal and state program that helps with medical costs for some people with limited income and resources. (<a href="https://www.medicare.gov/your-medicare-costs/help-paying-">https://www.medicare.gov/your-medicare-costs/help-paying-</a></p>
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		<p><a href="#">costs/medicaid/medicaid.html</a>) “CHIP”, the Children’s Health Insurance Program is a joint federal and state program that provides health coverage to eligible children. (<a href="https://www.medicaid.gov/chip/chip-program-information.html">https://www.medicaid.gov/chip/chip-program-information.html</a>)</p> <p><b>TriCare</b> is the health care program for uniformed service members (includes active duty and retired members of the U.S. Army, U.S. Air Force, U.S. Coast Guard, U.S. Marine Corps, U.S. Navy, Commissioned Corps of the U.S. Public Health Service, Commissioned Corps of the National Oceanic and Atmospheric Association), and their families. (<a href="http://tricare.mil/About.aspx?utm_source=footer&amp;utm_medium=organic&amp;utm_campaign=about-us">http://tricare.mil/About.aspx?utm_source=footer&amp;utm_medium=organic&amp;utm_campaign=about-us</a>)</p> <p><b>Private Insurance</b> includes supplemental insurance that is provided to an individual by a private insurer (whether purchased by an individual for him/herself and family, a Tribe for tribal members, or an employer for employees).</p>
<b>A.2: Participant Demographics during Reporting Period (Newly Enrolled Only)</b>		
<b>10</b>	<b>Participants by Ethnicity (Newly Enrolled)</b>	<p><b>Hispanic or Latino:</b> individuals of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.</p> <p>The responses regarding ethnicity should reflect what the individual considers herself/himself to be and are not based on percentages of ancestry.</p>
<b>11</b>	<b>Participants by Race (Newly Enrolled)</b>	<p><b>White:</b> individuals having origins in any of the original peoples of Europe, the Middle East, or North Africa.</p> <p><b>Black or African American:</b> individuals having origins in any of the Black racial groups of Africa.</p> <p><b>American Indian and Alaska Native:</b> A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.</p> <p><b>Asian:</b> individuals having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.</p> <p><b>Native Hawaiian and Other Pacific Islander:</b> individuals having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</p>

		<p><b>More than one race:</b> individuals who considers himself/herself to be of more than one race as defined above.</p> <p>The responses regarding race should reflect what the individual considers herself/himself to be and are not based on percentages of ancestry. If ethnicity and race are unknown or not reported for some participants, enter that count in the respective “Unknown/Did not Report” columns.</p>
12	<b>Adult Participants by Marital Status (Newly Enrolled)</b>	<p>If more than one adult participant is enrolled in the program in a single household, provide the status for all adult participants. For example, if a pregnant woman is enrolled with her spouse in the program, both participants would be counted under the married category.</p> <p><b>Single:</b> individuals who have never married.</p> <p><b>Legally Married:</b> individuals that have wed in manner legally recognized by their jurisdiction.</p> <p><b>Not Married but living together with partner:</b> individuals living with a partner but not considered legally married.</p> <p><b>Separated/Divorced/Widowed:</b> “Separated” refers to married individuals who are not living with their spouse due to marital discord. “Divorced” indicates individuals who reported being divorced and have not remarried. “Widowed” indicates individuals whose last marriage ended with the death of their spouse and they have not remarried.</p> <p><a href="https://www.census.gov/prod/2003pubs/c2kbr-30.pdf">https://www.census.gov/prod/2003pubs/c2kbr-30.pdf</a></p>
13	<b>Adult Participants by Educational Attainment (Newly Enrolled)</b>	<p><b>Less than high school diploma:</b> includes individuals who are older than high school age and who did not complete their high school education. For example, a 23 year old mother who did not finish high school would be included in this category because she is not of high school age and did not finish her high school education.</p> <p><b>High school diploma/GED:</b> includes individuals who completed their high school education or received a GED.</p> <p><b>Some college/training:</b> includes individuals who are currently enrolled in an undergraduate degree or taking undergraduate coursework, or participate in a training program, and those who attended in the past</p>

		<p>but did not obtain a degree or certification.</p> <p><b>Technical training or certification:</b> includes individuals who received technical training or certification in the past.</p> <p><b>Associate's Degree:</b> includes individuals who obtained an Associate's Degree.</p> <p><b>Bachelor's Degree or higher:</b> includes individuals who obtained a Bachelor's Degree or higher (e.g. Master's Degree, graduate-level courses).</p> <p><b>Other:</b> includes those individuals who did not fall into the other specified categories.</p>
14	Primary Language Spoken at Home of Index Children (Newly Enrolled)	<p><b>Primary language:</b> the language spoken in the home the majority of the time.</p> <p><b>Any Native American language:</b> includes any language indigenous to an American Indian or Alaska Native tribe or community.</p>
15	Secondary Language Spoken at Home of Index Children (Newly Enrolled)	<p><b>Secondary language:</b> a language spoken in the home the minority of the time.</p> <p><b>Any Native American language:</b> includes any language indigenous to an American Indian or Alaska Native tribe or community..</p>
16	Priority Population Household Characteristics (Newly Enrolled)	<p>Categories are not mutually exclusive. A household can be counted in more than one category.</p> <p><b>Low-Income household:</b> A household with an income determined to be below the official poverty line defined by the Census Bureau. This is updated every year online: <a href="https://aspe.hhs.gov/poverty-guidelines">https://aspe.hhs.gov/poverty-guidelines</a></p> <p><b>Household contains an enrollee who is pregnant and under age 21:</b> A household where a primary caregiver is a pregnant woman under 21 years old at time of enrollment.</p> <p><b>Household has a history of child abuse or neglect or has had interactions with child welfare services:</b> Based on participant self-report, a household where an adult participant or index child has a history of abuse or neglect and has had involvement with child welfare services either as a child or as an adult.</p>

		<p><b>Household has a history of substance abuse or needs substance abuse treatment:</b> Based on self-report, a household with at least one adult participant who has a history of substance abuse or who has been identified as needing substance abuse services through a substance abuse screening administered upon enrollment.</p> <p><b>Someone in the household uses tobacco products in the home:</b> Based on self-report, a household with at least one adult participant who uses tobacco products in the home or who has been identified as using tobacco through a substance abuse screening administered during intake. Tobacco use is defined as combustibles (cigarettes, cigars, pipes, hookahs, bidis), non-combustibles (chew, dip, snuff, snus, and dissolvables), and electronic nicotine delivery systems (ENDS).</p> <p><b>Someone in the household has attained low student achievement or has a child with low student achievement:</b> Based on participant self-report, a household where an adult participant has perceived themselves or their child(ren) (index child or another child in the household) as having low student achievement.</p> <p><b>Household has a child with developmental delays or disabilities:</b> Based on participant self-report or home visitor/staff observation, a household with a child or children (index child or another child in the household) suspected of having a developmental delay or disability.</p> <p><b>Household includes individuals who are serving or formerly served in the US armed forces:</b> Based on participant self-report, a household that includes individuals who are serving or formerly served in the U.S. Armed Forces (Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard and Reserve), including such families that have members of the Armed Forces who have had multiple deployments outside of the United States. For this criterion, the definition includes a military member's dependent acquired through marriage, adoption, or other action during the course of a member's current tour of assigned duty.</p>
<b>A.3: Participant Service Utilization during Reporting Period (Newly Enrolled and Continuing)</b>		
<b>18</b>	<b>Family Engagement by Household (Newly Enrolled and Continuing)</b>	<p><b>Currently receiving services:</b> refers to a household that is participating in services at the end of the reporting period.</p> <p><b>Completed program:</b> refers to a household that completed the program according to model-specific definitions and criteria, or grantee-defined criteria if the model does not provide guidance, during the reporting period.</p>

		<p><b>Stopped services before completion:</b> refers to a household that left the program for any reason prior to completion.</p> <p><b>Enrolled but not currently receiving services/Other:</b> refers to those households that do not fall into the previous categories and may include unreachable participants (i.e. the family is not regularly participating but did not actively sever ties, etc.)</p> <p><u>Please provide additional information about household reason for stopping services before completion, or for being enrolled but not currently receiving services/other in the A.3 Notes section.</u></p>
<b>SECTION B: PROGRAM STAFF DEMOGRAPHICS</b>		
<b>All Tables in Section B</b>		<p><b>Home Visitors:</b> A home visitor employed by the Tribal MIECHV program, regardless of the percentage of his/her personnel costs paid for with Tribal MIECHV funding.</p> <p><b>Project Directors/Managers/Coordinators:</b> Staff that play a key oversight role for the Tribal MIECHV grant, regardless of the percentage of his/her personnel costs paid for with Tribal MIECHV funding.</p>
<b>22</b>	<b>Program Staff by Ethnicity</b>	<p><b>Hispanic or Latino:</b> individuals of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.</p> <p>The responses regarding ethnicity should reflect what the individual considers herself/himself to be and are not based on percentages of ancestry.</p>
<b>23</b>	<b>Program Staff by Race</b>	<p><b>White:</b> individuals having origins in any of the original peoples of Europe, the Middle East, or North Africa.</p> <p><b>Black or African American:</b> individuals having origins in any of the Black racial groups of Africa.</p> <p><b>American Indian and Alaska Native:</b> A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.</p> <p><b>Asian:</b> individuals having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.</p> <p><b>Native Hawaiian and Other Pacific Islander:</b> individuals having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</p>

		<p><b>More than one race:</b> individuals who considers himself/herself to be of more than one race as defined above.</p> <p>The responses regarding race should reflect what the individual considers herself/himself to be and are not based on percentages of ancestry. If ethnicity and race are unknown or not reported for some participants, enter that count in the respective “Unknown/Did not Report” columns.</p>
24	Program Staff by Educational Attainment	<p><b>Less than high school diploma:</b> includes individuals who are older than high school age and who did not complete their high school education.</p> <p><b>High school diploma/GED:</b> includes individuals who completed their high school education or received a GED.</p> <p><b>Some college/training:</b> includes individuals who are currently enrolled in an undergraduate degree or taking undergraduate coursework, or participate in a training program, and those who attended in the past but did not obtain a degree or certification.</p> <p><b>Technical training or certification:</b> includes individuals who received technical training or certification in the past.</p> <p><b>Associate’s Degree:</b> includes individuals who obtained an Associate’s Degree.</p> <p><b>Bachelor’s Degree:</b> includes individuals who obtained a Bachelor’s Degree.</p> <p><b>Master’s Degree or Higher:</b> includes individuals who obtained a Master’s Degree or higher (e.g., PhD, MD, JD).</p> <p><b>Other:</b> includes those individuals who did not fall into the other specified categories.</p>