MATERNAL INFANT AND EARLY CHILDHOOD HOME VISITING (MIECHV) PROGRAM
ATTACHMENT B: SCOPE OF WORK

Article 1
DEFINITIONS

1.1 In this grant, the following definitions apply:

"**CQI**" means Continuous Quality Improvement, a component of the MIECHV program which requires tracking and reporting of quality improvement activities. Utah fulfills this requirement by convening a monthly CQI workgroup of CQI Representatives from each program to lead local quality improvement activities focused around a statewide goal.

"**CQI Representative**" means one identified individual from each local program who participates in monthly CQI workgroup meetings and leads local CQI efforts in alignment with the statewide goal.

"**FTE**" means full time equivalent used to determine the number of full time hours worked by employees.

"Home Visit" means a service provided by a Home Visitor to expectant parents and caregivers of young children with fidelity to an evidence-based Home Visiting Model. These voluntary services may include screening, caregiver coaching and education, connecting families to needed services, and is provided in the family's home or another location of the family's choice.

"**Home Visiting Model**" means an evidence-based home visiting program model, either Nurse-Family Partnership or Parents as Teachers.

"**Home Visitor**" means an employee of the Grantee who is trained under a Home Visiting Model and provides home visiting services to families.

"**HRSA**" means the federal Health Resources and Services Administration, a federal agency of the U.S. Department of Health and Human Services, which administers the MIECHV program .

"**IPV**" means intimate partner violence, which is physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner. An intimate partner is a person with whom one has a close personal relationship that can be characterized by the following: emotional connectedness, regular contact, ongoing physical contact and sexual behavior, identity as a couple, familiarity and knowledge about each other's lives.

"**MIECHV**" means the Maternal Infant and Early Childhood Home Visiting federal grant program, which supports evidence-based home visiting services for expectant and new parents with children up to kindergarten entry age who live in communities that are at-risk for poor maternal and child health outcomes.

"**NFP**" means the Nurse-Family Partnership evidence-based Home Visiting Model. This model is designed to improve (1) prenatal and maternal health and birth outcomes, (2) child health and development, and (3) families' economic self-sufficiency and/or maternal life course development.

This model is designed for first-time, low-income mothers and their children and includes one-on-one home visits by a trained registered professional nurse to participating clients. Visits begin early in the woman's pregnancy and conclude when the child turns 2 years old.

"**PAT**" means the Parents as Teachers evidence-based Home Visiting Model. The goal of this model is to provide parents with child development knowledge and parenting support, provide early detection of developmental delays and health issues, prevent child abuse and neglect, and increase children's school readiness. The model includes one-on-one home visits, monthly group meetings, developmental screenings, and linkages and connections for families to needed resources. The model serves families for at least two years between pregnancy and kindergarten.

Article 2
BACKGROUND

2.1 **Background.** Since 2010, the MIECHV supports pregnant people and parents with young children who live in communities that face greater risks and barriers to achieving positive maternal and child health outcomes. Families choose to participate in Home Visiting Model programs, and partner with health, social service, and child development professionals to set and achieve goals that improve their health and well-being.

Article 3
POPULATIONS SERVED

3.1 **Eligible clients.** The Grantee shall ensure all Home Visits are provided exclusively to families who meet the eligibility criteria outlined in Attachment C.

3.2 **Priority populations.**

(1) When enrolling new families, the Grantee shall give priority to families according to the following criteria, as listed in 42 U.S.C § 711:

(A) low income (at or below 100% of the federal poverty level);

(B) pregnant and under 21 years of age;

(C) history of child abuse or neglect, or history of interactions with child welfare Services;

(D) history of substance abuse or in need of substance abuse treatment;

(E) tobacco use;

(F) low student achievement;

(G) a child with developmental delays or disabilities; or

(H) a household member who is serving or has served in the U.S. armed forces.

(2) Following the completion of the Population Assessment, detailed below, the Grantee shall implement identified strategies to recruit and retain these populations.

3.3 **At-risk counties.** The MIECHV authorizing statute defines at-risk communities as those communities with concentrations of the indicators listed above for priority populations. A statewide needs assessment identified the following counties as at risk: Cache, Carbon, Davis, Duchesne, Emery, Grand, Iron, Morgan, Salt Lake, San Juan, Sanpete, Tooele, Utah, Wasatch, Washington, Weber. MIECHV services must be provided within these counties. The Grantee shall provide services to families residing only in the county or counties identified in their application and approved by DHHS.

Article 4
PROGRAM CAPACITY

4.1 **Program maximum service capacity**.

(1) The Grantee shall establish an annual maximum service capacity, or total possible number of families that could be enrolled at one point in time if the program were to operate with a full complement of hired and trained Home Visitors funded by MIECHV. This caseload number is subject to DHHS approval.

(2) This caseload number must increase each year at a consistent rate (such as 10% growth each year). This rate of increase is subject to DHHS approval.

(3) This caseload number does not change if the program is not fully staffed.

(4) The Grantee shall establish and execute a plan to maintain continuity of services to home visiting families if a Home Visitor is on extended leave or leaves the organization.

(5) Programs that have been active for a year or longer shall remain at least 85% of their maximum service capacity.

4.2 **Home visitor caseload.**

(1) The caseload per 1.0 FTE Home Visitor is as follows:

(A) NFP: 25 families; and

(B) PAT: 18 families;

(2) The caseload for part time employees is be prorated based on their FTE;

(3) Caseloads may be reduced for Home Visitors in proportion to the hours served in the following roles, subject to DHHS approval:

(A) The program's CQI representative;

(B) A lead Home Visitor who conducts data quality assurance, system coordination, or

other duties outside of the scope of direct service delivery to families; or

(C) A supervisor who carries a small caseload.

(4) New Home Visitors must build up to a full caseload of clients in accordance with NFP or PAT requirements listed above:

(A) Full caseloads must be obtained by the end of nine months, beginning with the completion of NFP or PAT training;

(B) For Home Visitors at 1.0 FTE, home visitors must add two to three families to their caseload each month; and

(C) For Home Visitors less than 1.0 FTE, Home Visitors shall add one to two families to their caseload each month.

4.3 **Cost per family.** Funding will increase in conjunction with the expansion rate outlined in the program maximum service capacity, using an annual cost per family fee structure, which may be adjusted annually per inflation and available funding.

Article 5
PROGRAM STAFFING

5.1 **Staffing requirements.**

(1) The Grantee's implemented Home Visiting Model must meet specified staffing requirements for supervisors, Home Visitors, and administrative staff in accordance with the Grantee's approved budget.

(2) The Grantee shall provide DHHS with the name, email, and phone number of the following individuals who serve as Grantee's points of contact:

(A) Program CQI representative;

(B) Program supervisor, as described by the Home Visiting Model;

(C) Program administrator; and

(D) Financial officer.

5.2 **Home Visitor staffing.** The Grantee shall hire and retain Home Visitors to provide home visiting services to qualifying families in alignment with the selected Home Visiting Model requirements and MIECHV Program requirements.

(1) The Grantee shall work to recruit, hire, and retain Home Visitors who can meet the needs of the families served.

(2) Home Visitors must be at least 0.5 FTE and serve the appropriate pro-rated caseload, as described in the home visitor caseload.

(3) Home Visitors must only work in one of two Home Visiting Models listed in the background.

(4) The Grantee shall provide DHHS with the name and email of all Home Visitors within 72 hours of their start date.

(5) The Grantee shall post all new Home Visitor positions by July 1st of each year. Exceptions may be granted by DHHS on a case by case basis.

5.3 **Supervisor staffing.** The Grantee shall hire and retain appropriate supervisors to coordinate, manage, and oversee the program while also providing reflective supervision for Home Visitors in accordance with NFP or PAT model requirements. The Grantee must implement staffing ratios must as follows:

(1) for NFP, there shall be at least one supervisor for every eight Home Visitors, regardless of Home Visitor FTE;

(2) for PAT, there shall be at least one supervisor for every 12 Home Visitors, regardless of Home Visitor FTE; and

(3) for both PAT and NFP with only one supervisor across both models, DHHS must approve the supervisor-to-Home Visitor ratio.

5.4 **Administrative staffing.** The Grantee shall hire and retain appropriate administrative staffing. Administrative duties include:

(1) monitoring program outcomes, and continuously improving the program, using data-driven approaches;

(2) overseeing data quality assurance;

(3) ensuring the completion of deliverables in Article 7;

(4) other duties, as required by the Home Visiting Model; and

(5) budgetary/financial oversight of this funding.

5.5 **Training and professional development.** The Grantee shall:

(1) ensure Home Visitors and supervisors receive program-specific training and ancillary training according to the standards specified by the Home Visiting Model;

(2) ensure that program supervisor, administrator, Home Visitors, and other relevant staff attend all DHHS required training, including:

(A) at least two Infant and Early Childhood Mental Health Consultation sessions each year of this grant;

(B) annual DHHS MIECHV training; and

(C) other training, identified by DHHS;

(3) maintain documentation of all training received by each Home Visitor and supervisor.

5.6 **Turnover.** The Grantee shall:

(1) provide written notification to DHHS of each employee's separation within 72 hours of the employee's notice of departure/termination of employment. This includes Family Medical Leave Act periods taken by Grantee staff.

(2) conduct an exit interview of all staff leaving the Home Visiting Model to determine any patterns for staff departures. Any patterns identified must be reported during the next DHHS annual site visit.

(3) take immediate steps to refill staff positions as they are vacated.

Article 6
HOME VISITING SERVICES

6.1 **Adherence to federal program requirements.** The Grantee shall adhere to federal MIECHV program requirements.

6.2. **Model implementation.** The Grantee shall:

(1) implement the Home Visiting Model(s) with fidelity to the design and standards established by each model's national service organization;

(2) remain in good standing with the Home Visiting Model(s) national organization; and

(3) obtain written prior approval from DHHS and the Home Visiting Model's national service organization prior to any anticipated change to model implementation.

6.3 **Responsive service delivery.** The Grantee shall:

(1) provide services with the Home Visiting Model that are responsive to the populations served; and

(2) provide program education materials in languages needed to reach the populations to be served.

6.4 **Outreach, intake, screening and enrollment.** The Grantee shall:

(1) conduct community-wide outreach, engagement, and recruitment activities to enroll and retain families in need of home visiting services in the county/counties to be served;

(2) establish relationships with tribal communities to address unmet needs and potential partnerships to deliver home visiting services to their communities;

(3) identify and support families to enroll in the Home Visiting model best suited for their needs;

(4) avoid dual enrollment of families in more than one Home Visiting Model or program run by another agency;

(5) develop consent procedures informing families of the voluntary nature of services; and

(6) track trends related to the population served and adjust program plans to assure that families from populations listed above and 42 U.S.C § 711 are prioritized for services.

6.5 **Service plans, assessments, and screenings.** The Grantee shall:

(1) develop and update a service plan or goal plan for each participant within the timeframe required by the Home Visiting Model;

(2) complete required assessments within the timeframe required by the model and the MIECHV program funding. See Attachment B for a list of DHHS-approved validated assessment tools for MIECHV; and

(3) use results of all assessments to ensure families are provided the services, education and referrals appropriate to their needs.

6.6 **Virtual service delivery.** The Grantee shall ensure that all virtual or telehealth services are in alignment with DHHS's definition and guidelines for virtual services, as approved by the Health Resources and Services Administration.

6.7 **Visit completion rate.** The Grantee's Home Visitors shall conduct home visits according to the schedule recommended by the Home Visiting Model and at a minimum, two visits per month.

(1) Programs are expected to maintain an average overall "completed visit" percentage of 85% for the previous twelve calendar months;

(2) Home Visitors are individually expected to maintain an average "completed visit" percentage of 85%;

(3) If a Home Visitor's visit percentage is 60% or lower for two consecutive months, the following shall occur:

(A) the Grantee shall develop and address the underperformance in a Corrective Action Plan, in collaboration with DHHS, as outlined in the corrective action plan section; and

(B) DHHS shall reduce the salary and benefits reimbursement requests by the Grantee for the underperforming employee for each month of underperformance, proportionate to the percentage that the average visit percentage falls under 60%. For example, if a Home Visitor's completed visits averaged 50% for three months, that employee's reimbursement will be reduced by 20% for three months using the following calculation: ($\frac{60-50}{60}$ = 0.20); and

(4) Programs shall develop strategies to retain families in the program, minimize attrition, and meet visit completion requirements.

6.8 **Waiting lists.** The Grantee shall:

(1) avoid waitlisting families when there are open home visiting slots offered by another local program (for example, by establishing referral partnerships with the other program);

(2) develop a client waiting list once the program reaches full caseload capacity in alignment with the Home Visiting Model(s) implemented;

(3) inform DHHS when a waitlist has been developed;

(4) refer families to other supportive services, such as Help Me Grow Utah, if they are placed on a waitlist;

(5) fill program capacity vacancies from the waiting list within five business days from the date a vacancy becomes available; and

(6) align with population requirements in Article 3.

6.9 **Client non-engagement.** The Grantee shall:

(1) follow the Home Visiting Model's guidelines regarding client non-engagement; and

(2) automatically close a client's case file after 90 days if the client does not participate in a home visit. DHHS must approve any exceptions.

6.10 **Referral network development and maintenance.** The Grantee shall build and maintain a referral network in support of the program's recruitment and enrollment process.

(1) Referrals to the Grantee's program shall include, at a minimum, WIC, local health departments, family planning clinics, prenatal care (OB/GYNs, Family Practice, Nurse Practitioners,), hospitals, clinics, Help Me Grow Utah, Baby Watch Early Intervention providers, and tribal communities.

(2) l Respond to all referrals made to the Grantee's program with the status of referrals and timelines for enrollment within two business days of receiving the referral.

(3) Referral sources from the Grantee's program must include, at a minimum, mental health providers, intimate partner violence services, substance use treatment services, Help Me Grow Utah, Baby Watch Early Intervention, primary care providers, WIC, tribal communities and State of Utah maternal and child health services.

(4) The Grantee shall follow up on all referrals made from the Grantees program to inquire the status of the referral and timeline within two business days of providing the referral.

(5) The Grantee shall track all referrals to and from the home visiting program to ensure appropriate contact and initiation of services occurs.

(6) If requested by DHHS, provide families with the option of signing a universal consent and track and update it annually in documentation.

6.11 **Additional recruitment activities.** To support families who are experiencing intergenerational poverty, the Grantee shall contact families who self-identify or who have signed formal releases of consent to have their information shared with local health departments and other state agencies to inform them of resources and programs available to promote positive health outcomes.

Article 7
ADDITIONAL DELIVERABLES

7.1 **Policies and procedures.**

(1) New Grantees shall submit a policy and procedure manual for DHHS approval within six months of the grant effective date.

(2) The Grantee shall submit a policy and procedure manual during the annual site visit for DHHS approval.

(3) The Grantee shall submit any updated policies and procedures to DHHS during monthly monitoring calls.

7.2 **Community Advisory Board.** The Grantee shall establish and maintain a Community Advisory Board or participate in at least one local community collaboration supporting the development of the local early childhood system.

(1) Topics discussed must include:

(A) sharing available, relevant, aggregated program data contributing to community needs, assessment, setting a common agenda, or other local initiatives;

(B) promoting shared messaging and materials from the collaboration among families

and staff; and

(C) discussing new innovative, collaborative and effective ways to serve families with each Home Visiting Model implemented.

(2) Document and report twice annually to DHHS on these activities.

7.3 **Early childhood system coordination.** The Grantee shall:

(1) work with local Baby Watch Early Intervention IDEA Part C entities through regular coordination meetings, referrals, and staff training on each other's services;

(2) work with Help Me Grow Utah staff for outreach and recruitment activities, and training opportunities to deepen staff knowledge and expertise in early childhood;

(3) work with tribal communities to coordinate, establish referral partnerships, and to provide services to their communities;

(3) work with and refer to the State of Utah maternal and child health service programs; and

(4) complete a report documenting the local home visiting and early childhood system landscape within the awarded service area and submit the associated documentation by the end of this grant's first year. DHHS shall support the Grantee, to identify gaps and overlaps in the existing continuum of evidence-based and non-evidence based home visiting services, and further strengthen the Grantee's program and role within the system.

7.4 **Population assessment.**

(1) The Grantee shall, with DHHS support, complete a population assessment once during the grant period, to identify the populations in highest need of home visiting services in the area.

(2) Populations are identified in the priority populations section and Attachment C.

(3) The Grantee shall submit documentation of the completed assessment, including concrete strategies, policies, and procedures to recruit and retain these populations.

(4) The Grantee shall complete and submit the assessment by the end of this grant's second year, with implementation of identified strategies, policies and procedures occurring during the grant's third year.

7.5 **Annual work plan and technical assistance priorities.** The Grantee shall provide DHHS with an updated work plan each year, along with a list of technical assistance priorities to support local implementation of the MIECHV program.

7.6 **Family/Caregiver engagement.** The Grantee shall support DHHS with family or caregiver engagement activities when requested.

7.7 **Continuous quality improvement plan engagement.** The Grantee shall participate in activities to support DHHS's HRSA-approved CQI plan. Participation includes:

(1) providing resources and support for one staff person to serve on the statewide CQI workgroup;

(2) engaging in DHHS-facilitated CQI coaching activities;

(3) embedding the state CQI project into scheduled staff meetings and reviewing data periodically;

(4) utilizing data for CQI to enhance program operation, decision-making, and individualized services;

(5) sharing regular updates on local engagement with the CQI project in monthly DHHS virtual monitoring meetings; and

(6) ensuring attendance of one supervisor and the CQI workgroup representative at one in-person meeting per year.

Article 8
DATA, REPORTING & QUALITY ASSURANCE

8.1 **Data Sharing and Confidentiality.** The Grantee shall:

(1) use DHHS provided data sharing and confidentiality forms and shall have all new clients sign the forms during the intake process. These forms include:

(A) Consent to Share Information for Child Protective Records Review; and

(B) Informed Consent, Universal Consent and Shared Information Notice;

(2) provide DHHS with access to Home Visiting Model data to meet MIECHV requirements.

8.2 **Data collection.** Grantee shall collect and report all data required in Attachment E, along with all data required under the MIECHV program, regardless of alignment and requirements of the Home Visiting Model.

8.3 **Data entry and record keeping.** Grantee shall maintain individual records that conform with Home Visiting Model and DHHS requirements.

(1) all client data must be stored and maintained in the Home Visiting Model's database;

(2) client data must be entered in the Home Visiting Model's database according to model requirements, within three business days of each visit and no later than the fifth business day of the following month; and

(3) The Grantee shall ensure that all developmental screening data is entered into the Home Visiting Model's database, as well as DHHS's Brookes Online system within three business days of each visit.

8.4 **Data quality assurance.** The Grantee shall allocate appropriate time and resources to ensuring accuracy and quality of all data required under the MIECHV program. This includes:

(1) budgetary allocation for quality assurance activities by non-Home Visitors;

(2) extraction and submission of client-level, program-level, and quality assurance data requested by DHHS ahead of monitoring meetings; and

(3) participation in technical assistance to improve local quality assurance processes.

8.5 **Data analysis.** The Grantee shall participate in data analysis by using necessary tools, methods, procedures, and technology to support MIECHV reporting requirements.

8.6 **Reporting.** The Grantee shall submit monthly reports to DHHS with required data. See Attachment F for a full list of data elements.

8.7 **Staff training on data quality assurance.** The Grantee shall:

(1) provide training at the local level on data transmission, privacy, safety procedures, data collection, data entry, and data quality assurance in order to meet MIECHV reporting requirements; and

(2) ensure relevant MIECHV-funded staff attend DHHS-required training and meetings on data, reporting, and quality assurance.

Article 9
ADMINISTRATIVE REQUIREMENTS

9.1 **State Supervisor Meetings.**

(1) The Grantee's home visiting supervisor shall participate in monthly DHHS "HVP State Supervisory Monthly Meetings".

(2) If unavailable for the meeting, the Grantee supervisor/administrator shall notify DHHS via email and send a representative to the meeting.

9.2 **Monthly Monitoring.** The Grantee shall:

(1) ensure supervisors participate in monthly DHHS virtual monitoring meetings. DHHS may also request that others attend;

(2) submit required reports prior to each monitoring meeting;

(3) assure data quality of all submitted reports; and

(3) ensure supervisors provide as much notice as reasonably possible for the need to reschedule monthly monitoring meetings.

9.3 **Site visits.** The Grantee shall allow at least one DHHS on-site monitoring visit per year to confirm compliance with grant requirements .

(1) At a minimum, site supervisor and administrator shall be present for site visits. DHHS shall request other site staff to be present as needed.

(2) Home Visitors shall be available to address DHHS questions within two business days.

9.4 **Corrective Action Plans.** If DHHS identifies the Grantee is noncompliant with any grant elements of, the Grantee shall develop corrective action plans in conjunction with DHHS and include strategies and timelines for correcting and preventing these issues.

9.5 **Prior Approvals.** Grantee shall obtain prior written approval from DHHS for:

(1) Expenditures that are not included in the budget;

(2) Changes to the budget in excess of 25% for any category;

(3) Any changes to Home Visitor and supervisor FTEs that do not align with approved budget; and

(4) Out-of-state travel (e.g., conferences, trainings, in-services, registrations) that is not directly related to credentialing and accreditation by the evidence-based Home Visiting Model being implemented.

Article 10
OUTCOMES

10.1 **Outcomes.** The outcomes for this grant are inclusive of six federally mandated benchmark areas for the MIECHV Program:

(1) Improved maternal and newborn health;

(2) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits;

(3) Improved in school readiness and achievement;

(4) Reduction in domestic violence;

(5) Improved in family economic self-sufficiency; and

(6) Improved coordination and referrals for other community resources.

10.2 **Performance Metrics.** The Grantee shall collect and report data on the following federally defined performance measures for all MIECHV families served by the Grantee using DHHS-approved assessment tools outlined in Attachment D, when applicable:

(1) Improved maternal and newborn health, which includes:

(A) Preterm birth: Percent of infants (among mothers who enrolled in home visiting prenatally before 37 weeks) who are born preterm following program enrollment;

(B) Breastfeeding: Percent of infants (among mothers who enrolled in home visiting prenatally) who were breastfed any amount at six months of age;

(C) Depression screening: Percent of primary caregivers enrolled in home visiting who are screened for depression using DHHS-approved assessment tool within three months of enrollment (for those not enrolled prenatally) or within three months of delivery (for those enrolled prenatally);

(D) Well-child visits: Percent of children enrolled in home visiting who received the last recommended visit based on the American Academy of Pediatrics schedule;

(E) Postpartum care: Percent of mothers enrolled in home visiting prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within 8 weeks (56 days) of delivery; and

(F) Tobacco cessation referrals: Percent of primary caregivers enrolled in home visiting who reported using tobacco or cigarettes at enrollment and were referred to tobacco cessation counseling or services within three months of enrollment.

(2) Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits, which includes:

(A) Safe sleep: Percent of infants enrolled in home visiting that are always placed to sleep on their backs, without bed-sharing and without soft bedding;

(B) Child injury: Rate of injury-related visits to the emergency department during the reporting period among children enrolled in home visiting; and

(C) Child maltreatment: Percent of children enrolled in home visiting with at least one investigated case of maltreatment following enrollment within the reporting period.

(4) Improvement in school readiness and achievement, which includes:

(A) Caregiver/parent-child interaction: Percent of primary caregivers enrolled in home visiting who receive an observation of caregiver-child interaction by the Home Visitor using a validated tool;

(B) Early language and literacy activities: Percent of children enrolled in home visiting with a family member who reported that during a typical week s/he read, told stories, and/or sang songs with their child daily, every day;

(C) Developmental screening: Percent of children enrolled in home visiting with a timely screen, as defined by MIECHV, for developmental delays using a parent-completed and DHHS-approved assessment tool; and

(D) Behavioral concern inquiries: Percent of postnatal home visits where primary caregivers were asked if they have any concerns regarding their child's development, behavior, or learning.

(5) Reduction in domestic violence, which includes IPV screening: Percent of primary caregivers enrolled in home visiting who are screened for IPV within six months of enrollment using the DHHS-approved assessment tool.

(6) Improvements in family economic self-sufficiency, which includes:

(A) Primary caregiver education: Percent of primary caregivers who enrolled in home visiting without a high school degree or equivalent who subsequently enrolled in, or maintained continuous enrollment in, middle school or high school, or completed high school or equivalent during their participation in home visiting; and

(B) Continuity of insurance coverage: Percent of primary caregivers enrolled in home visiting for at least six months who had continuous health insurance coverage for the most recent six consecutive months.

(7) Improvements in coordination and referrals to other community resources, which includes:

(A) Completed depression referrals: Percent of primary caregivers referred to services for a positive screen for depression, measured the DHHS-approved assessment tool, who receive one or more service contacts;

(B) Completed developmental referrals: Percent of children enrolled in home visiting with positive screens for developmental delays, measured the DHHS-approved assessment tool, who receive services in a timely manner; and

(C) IPV referrals: Percent of primary caregivers enrolled in home visiting with positive screens for IPV, measured by the DHHS-approved assessment tool, who receive referral information for IPV resources.

10.3 **Outcome Reporting.** Grantee shall report on these outcomes monthly, at a minimum, during the regularly scheduled monitoring calls/activities.

Article 11
FINANCIAL ADMINISTRATION

11.1 **Budget.** Grantee shall:

(1) Adhere to DHHS-approved budget;

(2) Ensure no more than 10% of the grant amount, or up to the applicant organization's federally approved indirect rate, may be spent on costs associated with administering the grant;

(3) Request prior approval from DHHS for budget adjustments in excess of 25% of any budget category;

(4) Submit a revised budget to DHHS within ten business days of the request for a budget adjustment; and

(5) Ensure that changes to expenditures do not go into effect until DHHS provides written approval and acceptance of the revised budget to the Grantee.

11.2 **Invoicing.** Grantee shall submit invoices to DHHS:

(1) on the expense reimbursement form provided by DHHS;

(2) with scanned or electronic copies of documentation justifying the expense; and

(3) no later than the 25th of every month following the month in which the expenditures were made, unless other prior arrangements are made with DHHS.

11.3 **Funding information.** For the first year, an estimated $4.2 million is available for these services across all agreements.

11.4 **Reimbursement.**

(1) DHHS will only reimburse for allowable expenditures in accordance with state, DHHS, and federal regulations, including but not limited to 45 CFR Part 75 and the HHS Grants Policy Statement.

(2) DHHS agrees to reimburse Grantee up to the maximum amount of this agreement for allowable expenditures directly related to the program made by Grantee according to the provisions of the agreement, including the DHHS-approved budget.

(3) DHHS shall not reimburse expenditures reported after the 25th of the following month in which the expenditures were made, unless arrangements are made with DHHS in advance.

(4) DHHS agrees to reimburse Grantee employee salary and benefits expenses per month, according to the following standards:

(A) For full time Home Visitors, DHHS agrees to reimburse the Subrecipient for 100% of the Home Visitor's salary and benefit expenses, so long as the Home Visitor meets the requirements outlined in the Home Visitor caseload and visit competition rate sections.

(B) For part time Home Visitors, DHHS agrees to reimburse the Grantee in a prorated amount to the Home Visitor's actual hours worked, so long as the Home Visitor meets the requirements outlined in the home visitor caseload and visit competition rate sections.

11.5 **Performance Based Funding.**

(1) DHHS may review Grantee's performance during the grant effective term and reserves the right to decrease or terminate funding for failure to meet the grant terms. A reduction in funding will be based on the element out of compliance and the portion of the budget allocated for that element.

(2) If Grantee fails to comply with a formal Corrective Action Plan, Grantee's funding will be terminated.

(3) Prior to DHHS reducing or withholding reimbursement for performance failures, Grantee may make a written request to waive or mitigate reimbursement reductions and describe any relevant extenuating circumstances. DHHS will review the request to determine whether any waiver or mitigation of reimbursement reductions is appropriate.

(4) If Grantee has not spent 50% of the total grant funds by the end of the third quarter of each grant year, DHHS may reduce the grant amount for the remainder of the grant term. Prior to reducing funds for this reason, DHHS will thoroughly review the program budget, expenditures, and activities with Grantee.

Attachment C. MIECHV eligibility guidelines

(1) All families shall enroll voluntarily.

(2) The federal grant requires that priority shall be given to families that meet at least one of the following MIECHV eligibility criteria:

(A) low income (at or below 100% of the federal poverty level);

(B) pregnant and under 21;

(C) history of child abuse or neglect, or history of interactions with child welfare services;

(D) history of substance abuse or in need of substance abuse treatment;

(E) tobacco use;

(F) low student achievement;

(G) a child with developmental delays or disability; and

(H) a household member who is serving or has served in the U.S. armed forces.

(3) Families may be enrolled according to a tiered system based on the number of eligibility criteria and income. Families must meet the eligibility criteria according to the following table at the time of enrollment:

% of Federal Poverty Level	Number of MIECHV priority population characteristics that must be met by family
At or below 185%	1 (must have 1 characteristic in addition to low-income)
186% - 250%	2 (must have 2 characteristics other than income)
251% - 300%	3 (must have 3 characteristics other than income)
301% and above	Does not qualify

(4) Following criteria in parts 1-3 programs shall determine family eligibility based on model requirements. Programs shall reach out to the model for further clarification on these items.

(A) For NFP, clients shall be:

(i) a first time mom;

(ii) low income; and

(iii) enrolled prenatally (before 28 weeks)

(B) For PAT, clients shall include the following:

(i) A child younger than age 6; or

(ii) A pregnant woman.

(iii) All families shall meet at least one of the following PAT Eligibility Criteria or "stressors":

(a) child abuse/neglect;

(b) child with disability or chronic health condition;

(c) death in immediate family;

(d) foster care or other temporary caregiver;

(e) high school diploma equivalency not attained;

(f) housing instability;

(g) intimate partner violence;

(h) low Income (at or below 185% of the federal poverty level);

(i) military deployment;

(j) parent incarcerated during child's lifetime;

(k) parent with disability or health condition;

(l) parent with mental health issues;

(m) recent immigrant or refugee family;

(n) substance use disorder;

(o) very low birth weight and preterm birth; and

(p) young parents (under 21).

(5) If the program has open spots, enrollment priority shall be given to those who meet multiple MIECHV eligibility criteria before model eligibility.

Attachment D. Department-approved assessment tools

The Home Visiting Program maintains a HRSA-approved Performance Measurement Plan to ensure accuracy in all data reported for the MIECHV program. The following assessment tools are currently approved for use by local implementing agencies receiving MIECHV dollars:

(1) The Ages and Stages Questionnaire-3 (ASQ-3) Developmental Screening

(A) This must be administered according to the Home Visiting Model requirements and MIECHV requirements.

(B) This must be entered into the Home Visiting Model's database as well as the DHHS Brookes ASQ Online system.

(2) The Edinburgh Postpartum Depression Screening

(A) This must be administered according to assessment instructions.

(B) This must be entered into the Home Visiting Model's database.

(3) HOME Assessment for parent/caregiver-child interaction, which must be administered according to assessment instructions; and

(4) HITS domestic violence screening tool, which must be administered according to the recommendations of the Home Visiting Model.

In the event any of these tools are changed, the Home Visiting Program will provide adequate notice and training for each subrecipient to implement the tool and update associated data collection processes.

Attachment E. Data reporting elements

All subrecipients must submit data to DHHS to meet MIECHV requirements, which includes all MIECHV performance measures and demographic data. Additional qualitative and quantitative data requested by DHHS may include:

(1) a summary of activities, achievements, and qualitative information (outcome/results), which may include brief anecdotal success stories;

(2) an unduplicated count of children, adults, and families, including demographic data on children and families served through the scope of work;

(3) current caseloads, completed visits, and visit completion rate, by Home Visitor;

(4) the number of families that are newly enrolled, exited, on hold/extended leave, on the waitlist;

(5) any staffing changes and updates to the organizational structure; and

(6) other items as identified in the course of agreement monitoring and program administration.

Attachment F. Records for DHHS Review

Files requested for review by DHHS may include:

(1) documentation of Home Visiting Model is implemented to fidelity;

(2) completed background checks on home visiting staff;

(3) documentation supporting all expense invoices submitted to Department for reimbursement;

(4) documentation of staff training;

(5) documentation of Community Advisory Board meeting(s);

(6) policy and procedure updates;

(7) waiting list documentation;

(8) documentation of reflective supervision;

(9) documentation of staff meetings, such as minutes;

(10) client consent forms, including signed confidentiality forms;

(11) planning documents for home visits;

(12) documentation of recruitment efforts;

(13) documentation of referral network development, tracking and maintenance activities;

(14) community agreements;

(15) engagement with local Baby Watch Early Intervention IDEA Part C and Help Me Grow Utah;

(16) documentation of liability insurance;

(17) documentation of Workers Compensation Insurance; and

(18) documentation of compliance to the FFATA.

DHHS may update this list to ensure compliance with state statutes and the federal statute authorizing the MIECHV program and to conduct appropriate monitoring of the scope of work.